Global Health Policy:
Exploring the Rationale for Health in Foreign Policy
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Executive Summary

Health is more prominent on global policy agendas now than it has been in decades. Global funding for health has increased, and global health concerns have gained more prominence in foreign policy discourse. Several countries have issued statements or formal policies on health as a foreign policy issue (e.g., Sweden, Norway, the UK, Switzerland, France, Brazil, Thailand, Indonesia, Senegal and South Africa) while others have committed to increased participation in and support for global health goals (e.g. countries of the International Health Partnership + Initiative). In November 2008 fifty-five nations sponsored a UN General Assembly Resolution on global health and foreign policy, urging member states ‘to consider health issues in the formulation of foreign policy.’ In sum, there is a broad and growing normative base supporting health arguments in foreign policy deliberations.

But how should such arguments be framed, and what is the theoretical and empirical rationale for advancing them? This is an important question since it is generally accepted in policy theory that the framing of an issue is critical in path-dependent fashion to the types of interventions that then fall within the negotiation space. Political contestation often revolves around how an issue is framed. It is accepted that there will be conflicting aims in foreign policy that may worsen, rather than improve, global health equity. How well these conflicts are managed may depend on how well versed health diplomats are in the various framings and arguments supporting health in foreign policy.

There are a limited number of major global health frames that can be summarized as follows:

- Health and security
- Health and development
- Health and global public goods
- Health and trade
- Health and human rights
- Health and ethical/moral reasoning

**Health and Security**

The most frequently encountered health and foreign policy frame is that of security. Security has at least three major aspects: national security (border protection); economic security (growth and competitive advantage); and human security (capacities for individual flourishing).

The major health arguments associated with national and economic security are that:
• Unchecked disease can lead to economic decline, failed states and domestic/regional conflict, posing national security risks and economic costs (or loss of future gain) with knock-on health effects in countries not directly affected by the disease. These costs could include military, peace-keeping and post-conflict interventions resulting in less public revenue for domestic health spending. There is some evidence of failed states leading to increased risk of regional or global terrorism. Disease-related economic losses in failed states can also lead to a downward negative health/negative growth spiral, with trade-related economic losses to other countries.

• Global health security requires global interventions to reduce the risk of pandemic disease arising from increased movements of people and goods, changes in infectious disease range and increased capacity of probable point-source countries to confine outbreaks. National health security now requires global health security which, in turn, is only as strong as its weakest link. This implies a national self-interest to strengthen weak links.

• Global health negotiations, while usually topic-specific, should consider the impacts on both national and global health security of foreign policies that may be ‘off-topic’. The foreign policies of countries with which one is negotiating for health purposes may pose health risks (however indirect) to one’s own country or countries of strategic or development importance. For purposes of greater policy coherence, these should be identified and form part of the negotiation.

Health and human security is rarely referenced in existing policy statements on health and security. Rather, it is subsumed within statements on health and development. Areas of conflict in health and security arguments include trade and economic interests (e.g. defence exports vs. multilateral agreements limiting arms trade).

There are risks inherent in framing health in the ‘high politics’ of national or economic security. One of these is a triaging of global health support based upon self-interest and geopolitical strategic interests. Evidence that this occurs is strong. Another is that such a triage reverses the historic concern with improving health equity as an ethical commitment, inherently ‘good’ in its own right. A third concern is that the securitization of specific disease risks (such as HIV/AIDS and pandemic influenza) has led to global financing of these disease risks disproportionate to the burden they represent. Finally, evidence suggests that the self-interest of ‘high politics’ has not sustained foreign policy support for health in the past and is unlikely to do so in the future.

Health and Development

There is a longer history of health foreign policy being framed in development terms. Until recently, health improvements were seen primarily as positive externalities to economic growth. Over the past decade a growing body of evidence shows that improvements in health (and other social determinants of health, such as education, sanitation and gender empowerment) are associated with economic growth. Health spending is as much an investment as it is a cost, or an intrinsic public good.

Development arguments overlap with security argument in the concept of human security. This provides one of several rationales arising from the development frame:

• Global health security is premised on improving human security. Human security requires ensuring capacities to prevent or treat disease problems. The human security approach has wide international acceptance and is premised less on national security (protecting citizens from external risks) than on promoting domestic freedoms from fear and want through empowerment strategies (developing capacities). This implies a better balance between global collaboration for diseases posing a risk to citizens of wealthier nations and diseases having the greatest burden worldwide, many of which are largely confined to poorer developing countries in tropical regions.

• All foreign policy decisions should be scrutinized for the probable effect on another country’s ability to meet or make consistent and substantial progress towards the Millennium Development Goals. The MDGs constitute a global compact amongst the world’s nations to lessen poverty and health-related
barriers to development with defined goals and targets. While all MDGs have important bearing on health, several are regarded as health-specific. Progress on these health MDGs has lagged, with the goals and targets unlikely to be met by many countries. This implies a scaling-up of donor assistance, but also ensuring that other foreign policy goals (related to security or trade) are coherent in improving countries’ abilities to achieve the MDGs.

• Increased health development assistance is required for prevention and intervention into chronic, non-communicable diseases if the global burden of disease facing poorer countries, and their economic and social costs, are to be reduced. The MDGs and other global health initiatives focus primarily on infectious disease. Chronic disease is eclipsing infectious disease in many low-income countries creating additional burdens on development.

• Health development assistance can improve receiving countries’ economic performance creating positive trade-related economic externalities (benefits) to donor countries; but such benefits should be secondary to the constitutive (non-instrumental) importance of improving health equity globally as committed in the MDGs.

• Health development assistance, to continue receiving public and political support, needs to show results; but such results should incorporate long-term health system strengthening and improvements in social determinants of health and not simply short-term disease-specific gains. Evidence supporting long-term positive effects of health development interventions exist, and should be used in presenting arguments for increased and improved health development financing. However this requires careful delineation of results and measures of health gains (which may be slow in showing improvements, particularly in least-developed or fragile-state countries) to avoid a triage of support by short-term results or by more capable/less-needy nations.

• Aid flows constitute a small portion of global financial flows. Though other financial flows (notably foreign direct investment) are likely to slow down due to the global credit crunch, such investment (properly regulated and directed) can benefit a country’s economic development, growth and health. Wealthier countries with private and public investment portfolios can improve health development in poorer countries if such investments are managed to balance better profit needs of investors with health promotion needs of recipient countries.

• Increasing migration of lesser-skilled workers from low-income countries can aid health and development through remittances while meeting high-income country labour needs. Migration policies biased towards highly skilled workers from low-income countries, particularly health workers, can undermine health and development in the source country despite the value of remittances. Voluntary codes for ethical recruitment of such workers can offer the flexibility governments need to negotiate interventions to deal with the global health human resources shortage. But voluntary codes lack any force on compliance other than moral suasion; framework conventions and treaties may have more effect.

While the health and development frame has attracted the greatest policy attention and documentation, it is weakened by ongoing limitations in the aid architecture, inadequacies in levels of aid support, the failure of many donor countries to fulfill commitments, aid disbursements on the basis of donor strategic interests and a focus on aid to the exclusion of other foreign policies affecting developing countries’ health and development potential. There is also a risk that the instrumental arguments for health and development will lead to a return on investment approach biasing aid towards short-term results or easier gains. At the present time, there is no indication that countries adopting explicitly, or by association, a commitment to health and foreign policy do better in the level and targeting of their health aid disbursements.

There are trenchant critiques of foreign aid based on arguments of dependency, fungibility, corruption (capital flight), lack of harmonization and high transaction costs. There is also evidence supporting the value of foreign aid which should be considered before engaging in policy discussions where increases in, or improving the efficiency and effectiveness of, foreign aid are potential topics.
There are several potential conflicts between health and the development, national security and trade frames. Trade-related arguments are taken up later. Where national security concerns may conflict with health and development is when the constrained logic of national security (protection of national citizens) directs foreign policy away from global health equity as a public good in its own right.

**Health and Global Public Goods**

The concept of global public good (GPG) offers one of the strongest theoretical arguments for global health policy, but is rarely encountered in official policy statements and may be more implied than explicit. Public goods arise from market failures that are only overcome by public provision or regulation as a form of collectivization of both costs and benefits. No consensus exists on the boundaries demarcating a ‘global’ public good from one that is international (a few nations only), regional (a geographic clustering of nations), club (a political clustering of nations), national or local. However, peace, prevention of pandemics, financial stability, human rights, free access to knowledge and a stable climate all have characteristics of such goods.

Principal arguments from a frame of global public goods, overlapping but differing from those within the frames of security and development, include:

- Public goods in the form of public health interventions reduce the burden of communicable disease and are cost-effective. To the extent that such interventions reduce the risk of cross-border disease transmission and improve the economies of developing countries, it also constitutes an indirect form of global public good. Yet funding for such goods lags considerably behind funding for specific disease interventions, or for health care. Some evidence for a 90/10 balance exists (i.e., 10 percent of disease-based interventions allocated for public health programs providing public goods).

- The global risk of pandemic influenza is potentially very large. Its prevention demands international cooperation. That cooperation rests on mutual benefits which the use of Intellectual Property Rights (IPRs) can prevent. This requires assertive pursuit of different reward mechanisms for new drug developments that derive from international viral sample or other knowledge-sharing systems to avoid IPRs preventing supply of a global public good.

- The ability to provide evidence is an important asset health brings to global foreign policy and arguments for global public goods for health. However, evidence is often equivocal or only available post hoc. This is especially the case for a key global public good of climate stability. This requires (a) agreements on how ‘weak’ evidence should be used in urgent cases (taking into account the precautionary principle) and (b) an understanding of when evidence-based arguments may not form the strongest rationale for health diplomacy.

- There are two linked arguments for actions on climate stability as a global public good. The first is the disproportionate historic responsibility of wealthier countries to act in the three areas of stabilization (emissions reduction, clean technology and demand reduction) inherent in the Kyoto Protocol, while allowing poorer countries to first increase, and then cap and reduce their emissions. The second is the need to advance mitigation and adaptation efforts. As with health and development, both arguments imply a need for resource transfers from richer to poorer countries.

- Global trade and investment in alcohol and unhealthy foods are associated with increased burdens of disease related to alcohol abuse and poor dietary environments and choices. There are public health arguments for strengthening global efforts to reduce the health harms associated with these products through global health conventions. Such conventions remain ‘soft law’ though they have persuasive force within countries. The time and effort involved in creating such conventions may dissuade their future pursuit, despite their public good effect, unless there is public (civil society) support, strong evidence and a group of like-minded countries willing to initiate the process. It is not clear if there is sufficient country, civil society and evidence support at this time for conventions on alcohol and unhealthy foods; but this could change with sufficient health advocacy.
While potentially powerful because of their origins in economic theory, hence crossing-over to the language of finance and treasury departments, global public good arguments for health are weakened by a relative paucity of action.

Climate stability, regarded as one of the most serious global public goods confronting the planet, is mired in equity issues: financing and commitments for assistance to low- and middle-income countries are widely regarded as inadequate, and have not been kept by high income countries. Most financing for climate stabilization and adaptation for developing countries are as loans and not grants, at odds with ‘common but differentiated responsibility’ principle underlying multilateral agreements on climate change. More concerted global policy actions may be hard to achieve because the climate change effects are not yet sufficiently serious to challenge shorter-term foreign policy ‘high politics’ of national security and economic interest of high-income countries. Similarly, wealthier nations wanting the ability to claim IPRs on vaccine products arising from study of shared viral samples have prevented agreement on benefit-sharing in the prevention of pandemic influenza, attesting to narrow economic interests trumping broader global public goods.

There is little reference to ‘global financial turbulence’ as a global public ‘bad’ requiring mitigation or prevention in existing global health policies. Proposals by the G20 to exercise stronger banking regulations announced in April 2009 and subsequently are regarded by some as insufficient to prevent recurrent crises in the future.

**Health and Trade**

Short-term economic interests that undermine shared and proportional responsibilities for global public goods also dominate in the health and trade frame. Diffusion of health technologies through global trade or exchange has contributed greatly to worldwide health improvements and, hence, global health and national security. Trade in health goods and services can also have negative consequences with respect to equity in access.

While a rules-based global trading system is regarded as another global public good, the definition and enforcement of those rules is dependent upon countries’ economic and political power and past development history. Global and regional trade treaties are regarded by many (but not all) development economists as one of the forces driving an ‘asymmetrical globalization’ which has allocated greater economic benefits to countries with greater wealth, more developed domestic markets, advanced technologies and other factor endowments.

While evidence for/against different positions with respect to trade liberalization can be found, a ‘weight of evidence’ approach becomes important in advancing a health equity argument for trade policy flexibilities. The precautionary principle that has long defined public health intervention can be invoked when, in the face of incomplete or conflicting evidence, and the potential of serious and pervasive health risks, the benefit of policy doubt should be given to human health. Specific arguments arising from trade follow:

- Evidence suggests that equity in health service access improves with the breadth and depth of risk-pooling and extent of public regulation. Private financing is best left to ‘top-ups’ for wealthy individuals, and private provision (profit or not-for-profit) should be carefully regulated under public contracts. The growth of unregulated commercialization of health services, partly aided through trade, has been costly, ineffective and worsened inequalities. Experimentation in trade in services may be desired, but committing to liberalize such services in trade treaties without a full assessment of the long-term health equity effects should be avoided. Public consultations with civil society organizations can strengthen the negotiation position to ‘carve out’ such services from trade treaty commitments.

- ‘Health tourism’ can promote economic growth and, potentially, reduce the migration of health workers in search of greater practice opportunity. But private health care provision to foreign consumers can also squeeze out providers in public systems to citizens, worsening access for national residents, especially poorer groups less able to afford private care.
The progressive realization of several important human rights treaties (to health, to water, to food, to development) may be in conflict with progressive liberalization obligations under the General Agreement on Trade in Services. A full assessment of human rights obligations potentially affected by all trade treaty negotiations (not simply those covering services) should precede any commitments and guide new trade proposals.

Increased imports of health-damaging products (e.g. tobacco, alcohol, unhealthy foods) are generally associated with increased health harms. Efforts to control such trade may conflict with trade treaty obligations. Governments have an interest in protecting citizens from health hazards, including those associated with dangerous products or abuse of products causing health harm to self or others. Evidence shows that restricting access to such products via pricing and availability can reduce population health harms. But if such regulations restrict imports in ways that discriminate favourably towards domestic products (whether or not that was their intent) they are likely to be seen as protectionist under various trade rules. This demands careful efforts to ensure that regulatory restrictions are framed entirely as health protective measures, and demonstrate that they are least trade-restrictive.

Increases in global trade through liberalization (removal of border barriers to foreign goods and capital) have long been argued as essential means to improve growth, development and subsequent health in low- and middle-income countries. Evidence both for and against this general pattern can be found. While on average liberalization is associated with better growth, the relationship is not automatic and much depends on the careful sequencing of commitments and the retained policy space of governments to ensure that development proceeds in an equitable fashion.

Despite the potential benefits of liberalization, low- and middle-income countries in particular are vulnerable to two negative effects: increased economic insecurity through competitive pressures and labour market changes, and decreased public revenues through loss in tariffs. Enhanced social protection measures can buffer some of the economic insecurities associated with the closure of uncompetitive domestic industries, but the increased informalization of labour markets and loss of tariffs weakens many countries’ ability to do so. This demands careful consideration in all trade treaty negotiations of pre-existing economic, labour, education and policy conditions, as well as a country’s factor endowments and development needs and potential. This further implies far greater levels of ‘aid for trade’ and general development assistance transfers to compensate for such short-to medium-term losses.

Present multilateral trade negotiations include pressure on low- and middle-income countries to lock-in and reduce tariffs on imports of economic interest to high- and other middle-income countries. This can reduce the flexibilities they may need for development purposes and the revenues they require from tariffs. Evidence of health and development consequences of the potential gains/losses of differing approaches to tariffs reduction, with an emphasis on reducing both poverty and inequality, should be inform trade negotiation positions, rather than arguments from liberalization-related economic gains alone. Negotiating trade positions in greater coherence with health equity gains can be strengthened politically through public consultations with civil society organizations.

The rationale that extended intellectual property rights (IPRs) are essential to finance research and development for new drugs is weak. Increase in the reach and strength of IPRs can reduce the ability of developing countries to provide access to essential medicines. Various trade treaty negotiations and other legislative or policy means have been used to reduce existing flexibilities under the TRIPS agreement. Pressure on low- and middle-income countries to increase IPRs by removing flexibilities agreed to under multilateral negotiations can increase costs and decrease access to essential medicines in poorer countries. This can increase the risk of epidemic disease, costs associated with untreated chronic disease, growth in trade in counterfeit drugs and development of more drug-resistant strains of disease, all of which can pose global health security risks and loss of economic opportunities for all countries. As well, lack of profitable markets for medicines in low- and some middle-income countries is a disincentive to private-sector initiated research. These conditions create urgency for
agreement on non-IPR systems of new drug and health technology development, especially given the potential of alternative financing models.

- Civil society organizations have played important roles in reducing the extension of IPRs in ways that threaten access to essential medicines. Given the potential for conflicting foreign policy agendas between health equity and trade-related IPRs such organizations can be effective public allies in swaying majority political opinion in favour of health equity.

There is evidence of conflict/incoherence between countries’ trade policies (economic interests) and health and development policies. This incoherence presents the greatest challenge to global health diplomacy. The global financial crisis both complicates and heightens the responsibilities for health-based arguments in trade negotiations – whether to avoid a protectionist spiral of uncertain environmental, social and economic consequences, or to ensure that efforts to complete the Doha Development round (now seen by some as a priority to avoid prolonging the global recession) is much more heavily influenced by health equity concerns and development outcomes aligned better to the Millennium Development Goals.

**Health and Human Rights**

Human rights treaties are widely regarded as having primacy over other international treaties when conflicts arise. The preservation of human life and health are at the base of such treaties and their obligations on states parties. This is supported by many existing global health policy statements. UN Special Rapporteurs on several of these rights, notably the right to health, have pointed to existing and potential sources of conflict between trade treaties and health rights. Evidence suggests that the stronger the force of these rights in domestic legislation, the more persuasive they can be in foreign policy negotiations.

- Key human rights treaty obligations framing global health diplomacy are found in Article 12 and General Comment 14 of the International Covenant on Social, Economic and Cultural Rights – the ‘right to the highest attainable standard of physical and mental health.’ The right to health, however, can be interpreted in legal decisions or national policy as an individual right only. Individual rights to treatment have been used to force public payment of costly medicines with opportunity costs to other facets of public health access. International legal scholars argue that human rights emphasis should be placed on poorer and more vulnerable populations. This requires greater attention to collective rights. Collective rights are implied in General Comment 14 on the right to health, and are explicit in the Declaration on the Right to Development. Though the right to development is not a binding treaty, it is considered to have some standing in international human rights law and strong normative support through UN agencies and in the context of the Millennium Development Goals. This tension between individual and collective rights requires careful consideration in how health rights inform foreign policy debates and decisions.

- Human rights treaties impose core obligations on states parties. States parties are also obliged to ensure that their foreign policies, other international treaties into which they enter or negotiate, and non-state actors within their jurisdiction operating nationally or internationally do not infringe upon their own ability, or that of other states, to meet their obligations under human rights treaties. This implies the necessity of human rights impact analyses of all major foreign policy and international treaty negotiations.

- Health is considered a basic right, since it is foundational to the enjoyment of most other human rights. The foundational quality of health is reinforced in the normative prominence it receives in the Millennium Development Goals. At a minimum, states’ foreign policies should not lead to other states reducing in any way the present level of the realization of the right to health.

- Developing countries, even with enhanced development assistance from wealthier nations and under conditions of more favourable trade, may lack resources for rapid progression in the realization of all human rights. Though human rights are nominally indivisible, there are arguments for prioritization in the protection of some rights over others as being fundamental to the enjoyment of other rights.
An analysis of core or priority rights, consistent with moral arguments respecting human dignity and capabilities, include the following:

1. The inherent right to life.
2. Components of the right to the highest attainable standard of physical and mental health.
3. Parts of the right to adequate education.
4. The right to freedom of thought, conscience, and religion.
5. The rights to peaceful assembly, freedom of association with others, and the right to take part in the conduct of public affairs and to vote.

Opinions on the argumentative value and policy effectiveness of human rights treaty obligations vary. There is no effective enforcement mechanism unless international treaty rights are written into national laws, although adoption of an Option Protocol could allow individuals to petition for their rights directly to the UN Economic and Social Council. Like any discourse advancing the possibility of global justice, rights-based arguments are easily dismissed by a realist ideology as romanticism, a waste of energy or, worse, diverting attention from the real work of growing economies or fighting the war on terror. Some activist scholars and civil society organisations, in turn, argue against the present emphasis on human rights, which still remain more individual than collective rights, for their lack of class and political economy analysis. At the same time, human rights are considered the most globalized political value-statements of our time. Their specific obligations on states can and should be used to advance global health equity arguments within foreign policy deliberations.

**Health and Ethical/Moral Reasoning**

Human rights codify into binding obligations what moral or ethical reasoning has posited as essential responsibilities people have to one another, imperfectly mediated through state systems. But the legalistic language and problematic individual nature of these rights has some legal and philosophical scholars claiming that without a more explicit set of ethical principles against which decisions can be appraised, the high politics of foreign policy might always override the low politics of global health.

States, the institutions they create and the persons who function within them are moral actors. A key moral theme in Western societies, and possibly universal across societies, is human dignity. This moral axiom demands respect for the autonomy of individual and extends to the provision of core resources for the capabilities people require to live valued lives. At present, arguments from values or ethics (or calling on arguments to specify moral or ethical reasoning) are not common in policy discourse, although reference to social justice as an overarching ethic is frequently encountered.

- Respect for human dignity or human flourishing has long been accepted in many philosophical (ethical, moral) traditions. Basic to dignity is the autonomy of individuals, not simply as isolated rational agents but as persons whose identities and capabilities are embedded in social relations with others. Autonomy is usually presumed when people have freedom of choice; such freedom also requires conditions in which choices can not only be made, but also be considered or conceived as real possibilities. Capabilities philosophers have identified core sets of capabilities, and human rights treaties have listed core obligations for the fair provision of resources required by individuals to develop them. Foreign policies should be appraised against these capabilities and human rights obligations.

- Health is considered to have ‘special importance’ in peoples’ lives, and in their ability to enjoy both dignity and personal security. Capabilities for health are also prerequisite to people being able to acquire other capabilities for human flourishing (e.g. education, meaningful work). When conflicts between health and provision for other social goods or economic interests arise in foreign policy considerations, health should be given ‘special importance’ rather than treated as simply another negotiable (hence tradable) item.
• Social justice is the dominant ethical theory by which societal decisions about distributive and redistributive allocation of resources for health and other capabilities are made. Equity is at the core of social justice theory with two differing but non-exclusive conceptions: equality of opportunity (an emphasis on horizontal equity and procedural justice) and equality of outcome (an emphasis on vertical equity and substantive justice). Foreign policies should have explicit or implicit reference to a theory of social justice (and not simply invoke the term); and, in keeping with the social justice consensus of moral philosophers, should identify how the policy will improve the conditions for capabilities of the least advantaged.

• Moral philosophers have provided arguments supporting both equality principles. There is robust moral consensus emphasizing opportunity over outcome, and improving the situation of the least advantaged. Applied to health, substantive improvements in the health and the conditions for health (peoples’ capabilities to be healthy) would be a minimum consideration in any foreign policy. There is less moral consensus on acceptance of increasing inequalities even if such inequalities might lead to improving the situation of the least advantaged.

• While most social justice theorists focus on the nation state, others extend this to global political relations. In recent decades an overemphasis on equality of opportunity has been used to argue for minimal state interventions in market economies for redistributive (social welfare) spending. However, fairness in equality of opportunity requires that all persons have the same initial capabilities (horizontal equity: likes treated as likes). Since this is not the case with substantial inequalities between individuals and groups persisting and, in many instances, growing, fairness requires measures to ensure that disproportionately greater resources for capabilities are provided to historically least advantaged. Horizontal equity without vertical equity (procedural justice without substantive justice) is ethically questionable. This argument applies globally as well, with evidence of better off nations having achieved this status partly through the exploitation of poorer nations, and through control over economic institutions that sustain these historically created inequalities. As moral actors, better off states, and those governing them or upholding the global economic institutions sustaining inequalities, have obligations for rectification and for change in how such institutions and their policies function.

• Individual choices can affect others directly and indirectly, which places some limits on what societies consider the acceptable range of freedoms. Morally, these limits are generally assumed to be best determined through deliberative and transparent means. Ethically-informed deliberative processes to arrive at some meaningful outcome are argued as having three principle components: publicity (transparency in process, a comprehensive rationale, and public argument and evidence); relevance (trust in actors/institutions by recipients, opportunity for wide participation, and interventions based on recipients’ needs, values and aspirations); and revisability (policies and programs can be challenged over time and improved, and individuals and institutions can be held accountable to purpose).

**Final Argument**

There is a copious body of evidence and argument that health advocates can bring to foreign policy deliberations. But there remain deep contradictions between national and economic security interests, and global health equity interests. Even when evidence of longer-term national and economic security exists, shorter-term economic interests often prevail. The politics of power and elite interests, and of countervailing civil society mobilizations, cannot be ignored in advancing global health equity positions in foreign policy. Experience suggests that global health equity concerns are more likely to be taken seriously in foreign policy discussions to the extent they have been publicly endorsed or promoted by government leaders, who are then held accountable to these endorsements by other political processes and civil society pressures.
La santé occupe aujourd’hui une place plus importante que jamais dans les programmes d’action mondiaux. L’aide financière mondiale pour la santé a augmenté, et les questions de santé mondiale prennent de plus en plus de place dans les politiques étrangères. Plusieurs pays ont émis des déclarations ou des politiques formelles sur la santé dans le cadre de leur politique étrangère (Suède, Norvège, Royaume Uni, Suisse, France, Brésil, Thaïlande, Indonésie, Sénégal et Afrique du Sud), alors que d’autres se sont engagés à accroître leur participation et leur soutien à l’égard des objectifs en matière de santé mondiale (pays du Partenariat international pour la santé et initiatives apparentées). En novembre 2008, cinquante cinq pays ont appuyé une résolution prise à l’assemblée générale des Nations Unies à propos de la santé mondiale et de la politique étrangère, qui préconise aux États membres de tenir compte des questions de santé dans la formulation de leur politique étrangère. Bref, il existe une base normative solide et croisante à l’appui de l’intégration d’arguments en faveur de la santé dans les délibérations sur les politiques étrangères.

Mais comment mettre en contexte de tels arguments, et quelles sont les justifications théoriques et empiriques qui les appuient? Il s’agit là d’une question importante, puisqu’il est généralement accepté en théorie des politiques que le contexte d’un enjeu, à cause de son assujettissement à un cheminement, est déterminant dans le choix des types d’intervention qui seront mis en œuvre dans l’espace de négociation. La contestation des politiques tourne souvent autour de la façon dont le contexte d’un enjeu est présenté. Il est admis que certains des objectifs des politiques étrangères seront contradictoires et aggraveront, au lieu d’améliorer, l’équité en santé mondiale. Le succès de la gestion de ces conflits pourrait dépendre de la connaissance qu’ont les diplomates chargés des questions de santé des divers contextes et arguments à l’appui de la santé dans les politiques étrangères.

Les contextes de santé mondiale sont peu nombreux; on peut les résumer aux principaux contextes suivants :

- Santé et sécurité
- Santé et développement
- Santé et biens collectifs mondiaux
- Santé et commerce international
- Santé et droits de la personne
- Santé et éthique
**Santé et sécurité**

Le contexte de santé et de politique étrangère le plus courant est celui de la sécurité, qui compte au moins trois principaux volets : la sécurité nationale (protection des frontières), la sécurité économique (croissance et avantages concurrentiels), et la sécurité humaine (possibilités d’épanouissement personnel).

Les principaux arguments en matière de santé associés à la sécurité nationale et économique sont les suivants :

- Une maladie négligée peut entraîner un déclin de l’économie, la déroute des États et des conflits intérieurs ou régionaux, constituer un risque pour la sécurité nationale, accroître les coûts (ou la perte de gains futurs) et avoir des répercussions sur la santé dans des pays qui ne sont pas directement touchés par la maladie. Ces coûts peuvent comprendre les interventions militaires, les initiatives de maintien de la paix et les mesures après conflit, et entraîner une réduction des recettes publiques consacrées à la santé nationale. Dans certains cas, la déroute de l’État peut mener à un risque accru de terrorisme régional ou mondial. Les pertes économiques attribuables à la maladie dans un État défaillant peuvent également instaurer un cercle vicieux de mauvaise santé et de croissance négative entraînant des pertes économiques liées au commerce international dans d’autres pays.

- La sécurité de la santé mondiale exige des mesures internationales, afin de réduire le risque de pandémie découlant des mouvements accrus de personnes et de marchandises et des changements dans l’ampleur d’une maladie infectieuse, ainsi que l’amélioration de la capacité à confiner l’épidémie des pays constituant une source ponctuelle probable. La sécurité de la santé nationale doit aujourd’hui s’accompagner d’une sécurité de la santé mondiale, dont la robustesse dépend du maillon le plus faible. Il en va donc de l’intérêt national de renforcer ces maillons faibles.

- Les négociations en matière de santé mondiale, bien qu’elles portent généralement sur un thème spécifique, doivent tenir compte des répercussions sur la sécurité de la santé nationale et mondiale des politiques étrangères qui peuvent paraître « hors sujet ». Les politiques étrangères des pays avec lesquels on négocie sur des questions de santé peuvent poser des risques pour la santé (aussi indirects soient ils) pour son propre pays, ou pour d’autres pays importants sur le plan de la stratégie ou du développement. Pour améliorer la cohérence des politiques, celles ci doivent être recensées et être prises en compte dans le cadre des négociations.

La santé et la sécurité humaines sont rarement mentionnées dans les politiques existantes sur la santé et la sécurité. Elles sont plutôt englobées dans des énoncés sur la santé et le développement. Les arguments relatifs à la santé et à la sécurité sont incompatibles avec d’autres intérêts, notamment les intérêts commerciaux et économiques (p. ex., exportations de défense et ententes multilatérales restreignant le commerce d’armes).

L’inclusion de la santé dans le contexte de la « haute politique » de la sécurité nationale ou économique présente des risques inhérents. L’un de ces risques est l’aiguillage du soutien de la santé mondiale en fonction d’intérêts personnels et d’avantages stratégiques géopolitiques. Les preuves de l’existence d’un tel aiguillage sont solides. Un autre risque est que ce type d’intervention renverse les tendances historiques considérant l’amélioration de l’équité en santé comme un engagement éthique, intrinsèquement « bon ». Un autre risque est que la titrisation de certains risques de maladie (comme le VIH/SIDA et la grippe pandémique) mène à un financement mondial de ces risques hors de proportion par rapport au fardeau qu’ils représentent. Enfin, des faits montrent que les intérêts de la « haute politique » n’ont jamais été dans le sens du soutien d’une politique étrangère en matière de santé et ne le feront pas plus dans l’avenir.

**Santé et développement**

On définit depuis plus longtemps la politique étrangère en matière de santé dans le contexte du développement. Jusqu’à tout récemment, les améliorations de la santé étaient principalement considérées comme des effets externes positifs de la croissance économique. Depuis dix ans, les faits montrent de plus en plus que les améliorations de la santé (et d’autres déterminants sociaux de la santé, comme l’éducation,
l’hygiène et la participation des femmes au marché du travail) sont associées à la croissance économique. Les dépenses en santé constituent à la fois un investissement et un coût, et la santé représente un bien collectif intrinsèque.

Lorsqu’il est question de sécurité humaine, les arguments de développement recoupent ceux de la sécurité. Le contexte du développement débouche donc entre autres sur les justifications suivantes :

• La sécurité de la santé globale repose sur l’amélioration de la sécurité humaine. La sécurité humaine exige la mise en place de capacités permettant de prévenir ou de traiter les problèmes liés à la maladie. L’approche de la sécurité humaine est largement acceptée à l’échelle internationale, et repose moins sur la sécurité nationale (c. à d. la protection des citoyens des risques externes) que sur la promotion de la libération de la crainte et de la misère grâce à des stratégies d’autonomisation (c. à d. de renforcement des capacités). Cela implique un meilleur équilibre entre la collaboration mondiale à l’égard des maladies présentant un risque pour les citoyens de pays plus riches et des maladies constituant les plus grands fardeaux dans le monde, dont bon nombre sont en grande partie confinées dans des pays pauvres et en développement des régions tropicales.

• Toutes les décisions en matière de politique étrangère doivent faire l’objet d’un examen rigoureux afin d’en déterminer les effets possibles sur la capacité d’autres pays à atteindre les Objectifs du Millénaire (OMD) ou à réaliser des progrès constants et importants à l’égard de ces objectifs. Les OMD constituent un pacte mondial entre les pays du monde en vue d’éliminer la pauvreté et les obstacles au développement liés à la santé en fixant des buts et des cibles précis. Bien que tous les OMD touchent de près la santé, plusieurs sont considérés comme étant propres à la santé. Les progrès à l’égard de ces OMD sont lents ; bon nombre de pays n’atteindront probablement pas les buts et les cibles établis. Cela signifie qu’il faut accroître l’aide offerte par les donateurs, mais aussi qu’il faut s’assurer que les autres buts en matière de politique étrangère (liés à la sécurité ou au commerce) sont cohérents et permettent d’améliorer les capacités des pays à atteindre les OMD.

• Si l’on veut réduire le fardeau mondial des maladies auxquelles sont confrontés les pays pauvres, et par la même occasion les coûts économiques et sociaux qui en découlent, il faut augmenter l’aide au développement en santé pour la mise en œuvre d’initiatives de prévention et d’intervention touchant les maladies chroniques et non transmissibles. Les OMD et d’autres initiatives en santé mondiale sont principalement axées sur les maladies infectieuses. Dans beaucoup de pays à faible revenu, les maladies chroniques sont plus importantes que les maladies infectieuses, ce qui alourdit le fardeau qui nuit au développement.

• L’aide au développement en santé peut améliorer le rendement économique des pays bénéficiaires tout en créant des effets externes (avantages) économiques positifs en matière de commerce pour les pays donateurs ; de tels avantages devraient toutefois être secondaires par rapport à l’importance constitutive (c. à d. non instrumentale) de l’amélioration de l’équité en santé dans le monde, conformément aux OMD.

• Pour continuer à bénéficier d’un soutien public et politique, l’aide au développement en santé doit produire des résultats ; de tels résultats devraient toutefois comprendre le renforcement à long terme des systèmes de santé et l’amélioration des déterminants sociaux de la santé, et non seulement des gains à court terme concernant une maladie spécifique. Il existe des preuves à l’appui des effets positifs à long terme des interventions liées au développement de la santé, qui devraient être utilisées dans les arguments visant à augmenter et à améliorer l’aide financière au développement en santé. Pour ce faire, il faut toutefois soigneusement délimiter les résultats et les mesures des gains en matière de santé (qui sont parfois lents à révéler des améliorations, notamment dans les pays moins développés ou dont l’État est fragile) pour éviter l’aiguillage du soutien en fonction des résultats à court terme ou à destination de pays mieux nantis.
• Les apports d’aide représentent une faible partie des apports financiers mondiaux. Bien que le resserrement du crédit à l’échelle mondiale risque de ralentir les autres apports financiers (notamment les investissements directs de l’étranger), de tels investissements, réglementés et orientés de manière appropriée, peuvent être avantageux pour le développement économique, la croissance et la santé d’un pays. Les pays les mieux nantis dotés de portefeuilles de placements privés et publics peuvent contribuer à améliorer le développement en santé dans les pays plus pauvres si les investissements sont gérés de manière à favoriser l’équilibre entre l’appétit des investisseurs pour le profit et les besoins de promotion de la santé des pays bénéficiaires.

• La migration croissante de travailleurs peu qualifiés en provenance de pays à faible revenu qui envoient de l’argent à leur famille restée au pays peut contribuer à la santé et au développement, tout en répondant aux besoins en main d’œuvre des pays à revenu élevé. Les politiques de migration favorisant les travailleurs hautement compétents provenant de pays à faible revenu, notamment dans le domaine de la santé, peuvent nuire à la santé et au développement dans les pays d’attache en dépit des fonds qui y sont envoyés par les immigrants. Des codes volontaires pour le recrutement éthique de tels travailleurs peuvent offrir aux gouvernements la souplesse nécessaire pour composer avec la pénurie mondiale de ressources humaines en santé. Toutefois, l’application d’un code volontaire n’est pas exécutoire et ne dépend que du degré de persuasion qu’on arrive à exercer ; des conventions et traités cadres pourraient être plus efficaces.

Bien que la santé et le développement représentent le contexte ayant suscité la plus grande attention dans les politiques et les publications, les résultats sont affaiblis par les limites permanentes de l’architecture d’aide, l’insuffisance des niveaux d’aide, le défaut de nombreux pays donateurs à respecter leurs engagements, le versement d’une aide en fonction des intérêts stratégiques des donateurs et l’insistance sur l’aide à l’exclusion de tout autre élément de politique étrangère touchant le potentiel des pays en développement en matière de santé et de développement. Il existe également un risque que les arguments instrumentaux en faveur de la santé et du développement mènent à une approche du rendement du capital investi privilégiant une aide axée sur les résultats à court terme ou sur la facilité de réalisation de gains. À l’heure actuelle, rien n’indique que les pays qui s’engagent explicitement ou par association à mettre en œuvre une politique étrangère tenant compte de la santé obtiennent de meilleurs résultats quant à l’importance et au ciblage de l’aide financière offerte en matière de santé.

L’aide étrangère fait l’objet de critiques incisives fondées sur des arguments de dépendance, de fongibilité, de corruption (fuite de capitaux), de manque d’harmonisation et de coûts de transaction élevés. Il y a aussi des preuves à l’appui de l’importance de l’aide étrangère, dont il faut tenir compte avant de s’engager dans des débats sur les politiques dans le cadre desquels l’augmentation ou l’amélioration de l’efficacité et de l’efficacité de l’aide étrangère sont susceptibles d’être abordées.

Il existe plusieurs conflits potentiels entre les contextes de la santé et du développement, de la sécurité nationale et du commerce international. Les arguments relatifs au commerce international sont abordés plus loin. Les enjeux de sécurité nationale risquent d’entraîner un conflit avec la santé et le développement lorsque la logique restreinte de la sécurité nationale (c. à d. la protection des citoyens du pays) éloigne la politique étrangère de l’équité en santé mondiale en tant que bien collectif en soi.

Santé et biens collectifs mondiaux

La notion de bien collectif mondial est associée à l’un des arguments théoriques les plus solides en faveur d’une politique de santé mondiale, mais elle figure rarement dans les énoncés de politique officiels et est peut-être plus implicite qu’explicite. Les biens collectifs découler de défaillances du marché qui ne peuvent être surmontées que par une prestation publique ou une réglementation visant à collectiviser les coûts et les avantages. Il n’existe pas de consensus quant à ce qui caractérise un bien collectif « mondial » par rapport à un bien collectif international (quelques pays seulement), régional (ensemble de pays géographiquement liés), dit de club (ensemble de pays politiquement liés), national ou local. Cependant, la paix, la prévention des pandémies, la stabilité financière, les droits de la personne, l’accès libre aux connaissances et un climat stable possèdent toutes les caractéristiques de tels biens.
Les principaux arguments relatifs aux biens collectifs mondiaux, dont certains recoupent ceux des contextes de la sécurité et du développement, comprennent ce qui suit :

- Les biens collectifs sous forme de mesures de santé publique réduisent le fardeau que représentent les maladies contagieuses et sont rentables. Dans la mesure où de telles mesures réduisent le risque de transmission transfrontalière des maladies et améliorent l’économie des pays en développement, elles constituent également une forme indirecte de bien collectif mondial. Pourtant, l’aide financière relative à ce type de biens est considérablement inférieure à celle qui est consacrée aux mesures visant une maladie spécifique ou aux soins de santé. Certains faits indiquent un rapport de 90 10 (c. à d. que 10 p. 100 de l’aide visant une maladie spécifique est allouée à des programmes de santé publique offrant des biens collectifs).

- La probabilité d’une pandémie de grippe est très élevée. La prévention d’un tel événement exige une coopération internationale, qui dépend des avantages mutuels que le recours aux droits de la propriété intellectuelle peut empêcher. Il faut donc poursuivre activement la mise en place d’autres mécanismes de récompense pour l’élaboration de nouveaux médicaments à partir d’un échantillon viral international ou d’autres modes de partage des connaissances pour éviter que les droits de propriété intellectuelle n’entraînent la prestation d’un bien collectif mondial.

- La capacité à fournir des preuves constitue un atout important pour l’intégration de la santé aux politiques étrangères mondiales et aux arguments en faveur de biens collectifs mondiaux en matière de santé. Toutefois, de telles preuves sont souvent ambiguës ou connues seulement post hoc. C’est notamment le cas pour la stabilité du climat, l’un des principaux biens collectifs mondiaux. Il faut donc (a) s’entendre sur la « robustesse » des preuves nécessaire dans les cas urgents (compte tenu du principe de précaution) et (b) acquérir une compréhension des situations où des arguments fondés sur des preuves ne justifient peut être pas une intervention diplomatique en santé.

- Il existe deux arguments liés entre eux à l’égard des mesures relatives à la stabilité du climat en tant que bien collectif mondial. Le premier concerne la responsabilité historique disproportionnée des pays riches en matière d’intervention dans trois secteurs de stabilisation (réduction des émissions, adoption de technologies propres et réduction de la demande) enchaînée dans le Protocole de Kyoto, tout en permettant aux pays pauvres de d’abord augmenter, puis de plafonner et ensuite de réduire leurs émissions. Le deuxième concerne la nécessité de faire progresser les initiatives d’atténuation et d’adaptation. Comme pour la santé et le développement, ces deux arguments sont associés au transfert de ressources des pays riches vers les pays pauvres.

- Le commerce international et les investissements relatifs à l’alcool et à des aliments nuisibles pour la santé sont associés à des fardeaux accrus de maladies liées à l’abus d’alcool et à un mauvais environnement et à de mauvais choix alimentaires. Certains arguments de santé publique prônent le renforcement des initiatives mondiales visant à réduire les méfaits pour la santé associés à ces produits par le truchement de conventions sur la santé mondiale. De telles conventions n’ont pas un caractère obligatoire, mais demeurent des instruments persuasifs pour les pays signataires. Le temps et les efforts nécessaires à la négociation de telles conventions peuvent toutefois constituer un obstacle, en dépit de leur importance pour le bien collectif, à moins que l’initiative ne bénéficie du soutien du public (société civile), que les preuves à l’appui des bienfaits soient solides et qu’un groupe de pays aux vues similaires acceptent d’amorcer le processus. Il n’est pas certain, à l’heure actuelle, qu’il existe un soutien suffisant de la part des pays et de la société civile ni des preuves solides à l’appui de conventions visant l’alcool et les aliments malsains, mais la situation pourrait changer si le plaidoyer en faveur de la santé se fait convaincant.

En dépit de leur puissance potentielle attribuable à leurs racines dans la théorie économique, ce qui fait qu’ils emploient le même langage que les ministères des finances et du Trésor, les arguments relatifs aux biens collectifs mondiaux en matière de santé sont affaiblis par la rareté relative des mesures.
La stabilité du climat, considérée comme étant l’un des biens collectifs mondiaux présentant le plus grand défi à l’échelle planétaire, s’embrouille dans des enjeux d’équité : l’aide financière et les engagements en matière d’assistance aux pays à revenu faible ou moyen sont largement considérés comme inadéquats, et les pays à revenu élevé n’ont pas tenu leurs promesses. La majeure partie de l’aide financière offerte aux pays en développement pour la stabilisation du climat et l’adaptation se fait sous forme de prêts, et non de contributions, ce qui va à l’encontre du principe de « responsabilité commune mais différenciée » qui sous-tend les ententes multilatérales sur le changement climatique. Il pourrait être difficile de mettre en œuvre un plus grand nombre de mesures stratégiques mondiales concertées, parce que les effets du changement climatique ne sont pas encore suffisamment graves pour menacer la politique étrangère à plus court terme axée sur la « haute politique » que privilégient les pays riches pour des raisons de sécurité nationale et d’intérêts économiques. Par ailleurs, les pays mieux nantis souhaitant bénéficier de droits de propriété intellectuelle sur des vaccins issus de l’étude d’échantillons viraux partagés ont contrecarré la conclusion d’une entente sur le partage des avantages pour la prévention de la grippe pandémique, ce qui montre que leurs propres intérêts économiques passent avant le bien collectif mondial.

Dans les politiques en matière de santé mondiale, on parle rarement des « bouleversements financiers mondiaux » comment étant un « mal » collectif mondial qu’il faut soulager ou prévenir. Certains considèrent que les propositions formulées depuis avril 2009 par le G20 concernant la mise en place d’une réglementation plus rigoureuse du secteur bancaire ne suffiront pas à prévenir les crises récurrentes dans l’avenir.

**Santé et commerce international**

Les intérêts économiques à court terme qui nuisent aux responsabilités partagées et proportionnelles en ce qui concerne les biens publics mondiaux dominent également dans le contexte de la santé et du commerce international. La diffusion des technologies de santé par le biais du commerce ou d’échanges internationaux a grandement contribué à améliorer la santé à l’échelle mondiale et, en conséquence, la santé et la sécurité nationale mondiales. Le commerce de produits et de services de santé peut aussi avoir des répercussions négatives sur l’équité de l’accès.

Bien qu’un système de commerce mondial axé sur des règles soit considéré comme étant aussi un bien public mondial, la définition et la mise en application de ces règles dépendent du pouvoir économique et politique des pays et de leurs antécédents en matière de développement. Beaucoup d’économistes spécialisés en développement (mais pas tous) considèrent les traités de commerce mondiaux et régionaux comme étant l’un des facteurs favorisant une « mondialisation asymétrique », qui procure plus d’avantages économiques aux pays les plus riches, dont les marchés intérieurs sont les plus développés et possèdent des technologies avancées ainsi qu’une dotation en facteurs de production.

Même s’il existe des preuves en faveur ou en défaveur des différentes positions en matière de libéralisation du commerce, une approche du « poids de la preuve » revêt une certaine importance pour appuyer la souplesse des politiques en matière de commerce comme argument en faveur de l’équité en santé. Le principe de précaution qui a longtemps déterminé les interventions en santé publique peut être invoqué lorsque, en présence de preuves incomplètes ou contradictoires et de risques graves et importants pour la santé, le bénéfice du doute stratégique devrait être accordé à la santé humaine. Les principaux arguments liés au commerce sont les suivants :

- Certains faits semblent indiquer que l’équité en matière d’accès aux services de santé s’améliore avec l’étendue et le niveau de la mise en commun des risques et avec la portée de la réglementation publique. Il est préférable de considérer l’aide financière privée comme un complément que peuvent se permettre les mieux nantis, et la prestation privée (à des fins lucratives ou non) devrait être soigneusement réglementée aux termes de marchés publics. La croissance de la commercialisation non réglementée de services de santé, facilitée en partie par le commerce international, s’est révélée coûteuse et inefficace et a accentué les inégalités. Il pourrait être souhaitable d’expérimenter le commerce de services de santé, mais il faudrait probablement éviter de s’engager à libéraliser de tels services dans le cadre de traités commerciaux avant d’avoir effectué une évaluation complète des effets à long terme sur l’équité en santé. Des consultations publiques auprès des organismes...
de la société civile pourraient renforcer la position de négociation afin de soustraire ces services des engagements aux termes des accords commerciaux.

- Le « tourisme santé » peut promouvoir la croissance économique et éventuellement réduire la migration des travailleurs de la santé à la recherche de meilleures occasions de carrière. Toutefois, la prestation de soins de santé privés à des consommateurs étrangers peut également s’accaparer les travailleurs du réseau public destiné aux citoyens, ce qui réduit l’accès aux services de santé pour les résidents nationaux, particulièrement pour les groupes les plus pauvres qui ne sont pas nécessairement en mesure de se payer des soins privés.

- La conclusion progressive de plusieurs accords importants sur les droits de la personne (droit à la santé, droit d’accès à de l’eau potable, droit à l’alimentation, droit au développement) pourrait aller à l’encontre des obligations de libéralisation progressive prévues dans l’Accord général sur le commerce des services. Une évaluation complète des obligations en matière de droits de la personne qui pourraient être touchés par toutes les négociations relatives à des accords commerciaux (et non seulement ceux touchant les services de santé) devrait précéder tout engagement et orienter les nouvelles propositions commerciales.

- Les importations accrues de produits néfastes pour la santé (tabac, alcool, aliments malsains) sont généralement associées à une augmentation des problèmes de santé. Les mesures visant à limiter ce type de commerce sont susceptibles de contrevenir aux obligations prévues dans les accords commerciaux. Les gouvernements ont intérêt à protéger leurs citoyens contre tout danger pour leur santé, y compris ceux qui sont associés à des produits dangereux ou à l’abus de produits causant du tort aux personnes qui en consomment ou à autrui. Les faits montrent que la restriction de l’accès à de tels produits en imposant une tarification et en limitant la disponibilité peut réduire les torts causés à la santé de la population. Toutefois, si une telle réglementation restreint les importations d’une manière discriminatoire favorisant (délibérément ou non) les produits intérieurs, elle risque d’être perçue comme une mesure protectionniste en vertu de diverses règles de commerce international. Il faut donc être prudent et s’assurer que les restrictions de la réglementation sont conçues entièrement comme des mesures de protection de la santé, et faire la preuve qu’elles n’entraînaient pas le commerce.

- La hausse du commerce international attribuable à la libéralisation (élimination des obstacles frontaliers visant les biens et les capitaux étrangers) a longtemps été considérée comme essentielle à la croissance, au développement et à la santé dans les pays à revenu faible ou moyen. Les faits montrent que ce modèle comporte à la fois des avantages et des inconvénients. Bien qu’en règle générale la libéralisation soit associée à une meilleure croissance, cette relation n’est pas systématique et dépend beaucoup de l’attention accordée à l’échéancier des engagements et de l’espace politique conservé par les gouvernements pour s’assurer que le développement se déroule de manière équitable.

- En dépit des avantages potentiels de la libéralisation, les pays à revenu faible ou moyen sont particulièrement vulnérables à deux effets défavorables, soit une insécurité économique accrue en raison des pressions concurrentielles et du changement du marché de l’emploi, et des recettes publiques réduites à cause de la diminution des droits perçus. Des mesures de protection sociale améliorées peuvent contrebilancer en partie les insécurités économiques associées à la fermeture d’industries intérieures non concurrentielles, mais l’informalisation accrue des marchés du travail et la diminution des tarifs douaniers réduisent la capacité de beaucoup de pays à cet égard. Il faut donc, dans le cadre de la négociation d’accords commerciaux, tenir soigneusement compte des conditions préexistantes de l’économie, de la main d’œuvre, de l’éducation et des politiques, de la dotation en facteurs de production du pays, ainsi que de ses besoins et de son potentiel en matière de développement. Cela implique donc des niveaux beaucoup plus importants d’« aide pour le commerce » et de transferts d’aide au développement général pour compenser de telles pertes à court et à moyen terme.
• Dans le cadre des négociations actuelles visant la conclusion d’accords commerciaux multilatéraux, on exerce des pressions sur les pays à revenu faible ou moyen pour les inciter à garantir et à réduire les tarifs douaniers sur les importations revêtant un intérêt économique pour les pays à revenu élevé ou moyen. De telles mesures risquent de réduire la souplesse et les revenus constitués par les tarifs douaniers dont les pays ont besoin pour se développer. Les faits concernant les conséquences sur la santé et le développement des gains et pertes potentiels associés aux différentes approches de réduction des tarifs douaniers, notamment en ce qui concerne la diminution de la pauvreté et des inégalités, devraient éclairer les positions de négociation des accords commerciaux, plutôt que servir uniquement d’arguments en faveur des gains économiques liés à la libéralisation. Des positions de négociation commerciale mieux harmonisées aux gains en matière d’équité en santé peuvent être renforcées sur le plan politique par l’entremise de consultations publiques auprès des organismes de la société civile.

• Les motifs à l’appui de l’idée que des droits de propriété intellectuelle étendus sont essentiels au financement de la recherche et du développement visant à trouver de nouveaux médicaments sont peu convaincants. L’augmentation de la portée et de la robustesse des droits de propriété intellectuelle pourrait réduire la capacité des pays en développement à fournir l’accès à des médicaments essentiels. Divers instruments de négociation d’accords commerciaux et d’autres moyens législatifs ou stratégiques ont été utilisés pour réduire les assouplissements prévus aux termes de l’Accord sur les ADPIC. Les pressions exercées sur les pays à revenu faible ou moyen pour rehausser les droits de propriété intellectuelle en éliminant les assouplissements convenus dans le cadre de négociations multilatérales sont susceptibles de faire augmenter les coûts et de réduire l’accès à des médicaments essentiels dans les pays pauvres. Cette situation pourrait à son tour accroître le risque d’épidémie et les coûts associés aux maladies chroniques non traitées, augmenter le trafic de médicaments contre-faits et favoriser l’apparition de souches résistantes aux médicaments – tous des facteurs présentant des risques pour la sécurité de la santé mondiale et entraînant la perte de débouchés économiques pour tous les pays. En outre, l’absence de marchés rentables pour les médicaments dans les pays à faible revenu et dans certains pays à revenu moyen dissuade la réalisation de recherches dans le secteur privé. À cause de ces conditions, il devient urgent de conclure des ententes concernant des mécanismes non axés sur les droits de propriété intellectuelle pour la mise au point de nouveaux médicaments et de technologies relatives à la santé, notamment en raison du potentiel que présentent les autres modèles de financement.

• Les organismes de la société civile ont joué des rôles importants dans la réduction de l’étendue des droits de propriété intellectuelle de manières qui mettent en péril l’accès à des médicaments essentiels. Compte tenu du risque de conflits entre les programmes de politique étrangère touchant l’équité en santé et les droits de propriété intellectuelle en rapport avec le commerce international, ces organismes pourraient constituer des alliés publics efficaces pour faire pencher la balance de l’opinion politique majoritaire en faveur de l’équité en santé.

Des faits indiquent un conflit ou une incohérence entre les politiques sur le commerce international (intérêts économiques) et les politiques sur la santé et le développement. Cette incohérence représente le plus grand obstacle à la diplomatie en matière de santé mondiale. La crise financière mondiale complique et rehausse les responsabilités relatives aux arguments en matière de santé dans le cadre des négociations commerciales – qu’il s’agisse d’éviter une escalade de protectionnisme ayant des conséquences environnementales, sociales et économiques incertaines, ou de s’assurer que les efforts visant à achever la mise en œuvre du programme de Doha pour le développement (que certains considèrent maintenant comme une priorité pour éviter de prolonger la récession mondiale) sont largement influencés par les enjeux d’équité en santé et que les résultats des initiatives de développement sont mieux harmonisés aux Objectifs du Millénaire pour le développement.
Santé et droits de la personne

Les traités en matière de droits de la personne sont généralement considérés comme ayant prépondérance sur les autres traités internationaux lorsque surviennent des conflits. La préservation de la vie et de la santé humaines constituent les fondements de tels traités et des obligations des États signataires, comme en témoignent de nombreux énoncés de politique en matière de santé mondiale en vigueur. Les rapporteurs spécialisés des Nations Unies sur plusieurs de ces droits, notamment le droit à la santé, ont souligné des sources existantes et potentielles de conflit entre les accords commerciaux et les droits en matière de santé. Les faits indiquent que plus ces droits sont solidement inscrits dans la législation intérieure, plus ils ont de poids dans les négociations relatives à la politique étrangère.

- Les principales obligations prévues dans les traités relatifs aux droits de la personne sur lesquels repose la diplomatie en santé mondiale sont énoncées à l’article 12 et dans l’Observation générale n° 14 du Pacte international relatif aux droits économiques, sociaux et culturels – le « droit à toute personne de jouir du meilleur état de santé physique et mentale qu’elle soit capable d’atteindre ». Le droit à la santé peut toutefois être interprété, dans le cadre des décisions de justice ou des politiques nationales, comme un droit individuel seulement. Les droits individuels de recevoir des traitements ont été utilisés pour forcer certains États à payer les médicaments coûteux, au détriment d’autres facettes de l’accès à un système de santé public. Les juristes internationaux soutiennent que les droits de la personne devraient mettre l’accent sur les populations les moins bien nanties et les plus vulnérables. Pour ce faire, il faut accorder davantage d’attention aux droits collectifs, qui sont implicites dans l’Observation générale n° 14 sur le droit à la santé, et explicités dans la Déclaration sur le droit au développement. Bien que cette déclaration ne constitue pas un traité ayant force exécutoire, elle a un certain poids en matière de droits de la personne à l’échelle internationale et bénéficie d’un solide soutien normatif au sein des organismes des Nations Unies et dans le contexte des Objectifs du Millénaire pour le développement. En raison de cette tension entre les droits individuels et collectifs, il faut faire preuve de prudence en ce qui concerne la façon dont les droits à la santé sont pris en compte dans les débats et les décisions en matière de politique étrangère.

- Les traités en matière de droits de la personne imposent des obligations de base aux États signataires. Ceux-ci sont également tenus de s’assurer que leur politique étrangère, les autres traités internationaux auxquels ils participent ou qu’ils négocient et les acteurs non gouvernementaux relevant de leur compétence et exerçant des activités nationales ou internationales ne portent pas atteinte à leur propre capacité, ou à celle d’autres États, à s’acquitter de leurs obligations aux termes des traités en matière de droits de la personne. Il convient donc d’analyser les répercussions sur les droits de la personne de toute politique étrangère et de toute négociation de traité international d’importance.

- La santé est considérée comme un droit fondamental, puisqu’elle est essentielle à la jouissance de la plupart des autres droits de la personne. Le caractère fondamental de la santé est renforcé par l’importance normative que lui confèrent les Objectifs du Millénaire pour le développement. À tout le moins, la politique étrangère d’un État ne doit pas inciter d’autres États à réduire de quelque façon que ce soit le niveau actuel de respect du droit à la santé.

- Les pays en développement, même avec l’aide au développement améliorée offerte par les nations plus riches et des conditions commerciales plus favorables, n’ont pas nécessairement les ressources pour une progression rapide vers le respect concret de tous les droits de la personne. Même si les droits de la personne sont supposément indivisibles, des arguments ont été formulés en faveur de la priorité de protection de certains droits particuliers, considérés comme nécessaires à la jouissance d’autres droits. Une analyse des droits de base ou droits prioritaires, conforme aux arguments éthiques concernant le respect de la dignité et des capacités humaines, a débouché sur ce qui suit :

1. Le droit inhérent à la vie.
2. Certains éléments du droit de jouir du meilleur état de santé physique et mentale qu’il soit possible d’atteindre.
3. Certains éléments du droit à une éducation adéquate.
4. Le droit à la liberté de pensée, de conscience et de religion.
5. Le droit à la liberté de réunion pacifique et d’association, et le droit de participer à la conduite des affaires publiques et de voter.

Les opinions à propos de la valeur argumentative et de l’efficacité stratégique des obligations prévues dans les traités en matière de droits de la personne divergent. Il n’existe aucun mécanisme d’exécution efficace à l’exception de l’intégration des droits visés par des traités internationaux aux lois nationales, quoique l’adoption d’un protocole facultatif pourrait permettre aux personnes de revendiquer la reconnaissance de leurs droits directement auprès du Conseil économique et social des Nations Unies. Comme dans tout discours en faveur d’une justice mondiale, les arguments relatifs aux droits sont facilement rejetés par les idéologistes réalistes comme étant des idées romantiques, un gaspillage d’énergie ou pire, une diversion de l’attention qui devrait être consacrée aux véritables initiatives de croissance de l’économie ou de lutte contre le terrorisme. Certains universitaires activistes et organismes de la société civile, quant à eux, s’opposent à l’orientation actuelle des initiatives relatives aux droits de la personne, qui sont davantage axées sur les droits individuels que sur les droits collectifs et qui ne sont pas fondées sur des analyses pertinentes des classes et de l’économie. Parallèlement, les droits de la personne sont considérés comme l’enjeu de l’heure des valeurs politiques. Les obligations particulières qu’ils imposent aux États peuvent et doivent être utilisés pour faire valoir les arguments en faveur de l’équité en santé mondiale dans le cadre des délibérations relatives aux politiques étrangères.

**Santé et éthique**

Par l’entremise de systèmes d’État, les droits de la personne codifient, de manière imparfaite, en obligations exécutoires ce qu’un raisonnement moral ou éthique pose comme une responsabilité fondamentale des êtres humains les uns envers les autres. Toutefois, à cause du jargon juridique et de la nature individuelle problématique de ces droits, certains juristes et philosophes soutiennent que sans un ensemble plus explicite de principes éthiques au regard desquels les décisions peuvent être évaluées, la haute politique des politiques étrangères aura toujours le dessus sur la basse politique de la santé mondiale.

Les États, les institutions qu’ils créent et les personnes qui y jouent un rôle sont des acteurs moraux. L’un des principaux thèmes moraux dans les sociétés occidentales, et probablement dans toutes les sociétés, est la dignité humaine. Cet axiome moral en appelle au respect de l’autonomie des individus et s’étend à la prestation de ressources de base pour donner aux gens les capacités dont ils ont besoin pour mener une vie valorisante. À l’heure actuelle, les arguments liés aux valeurs ou à l’éthique (ou le recours à des arguments pour préciser un raisonnement moral ou éthique) ne sont pas courants dans les discours sur les politiques, bien que l’on mentionne souvent la justice sociale comme un enjeu éthique primordial.

- De nombreuses traditions philosophiques (éthique, morale) ont depuis longtemps admis le principe du respect de la dignité humaine ou de l’épanouissement humain. Cette dignité repose sur l’autonomie des personnes, non seulement en tant qu’agents rationnels distincts mais aussi en tant que personnes dont l’identité et les capacités sont enchâssées dans leurs relations sociales avec autrui. L’autonomie s’entend généralement de la liberté de choix; une telle liberté est associée à des conditions dans lesquelles il est non seulement possible de faire des choix, mais aussi au fait que ces choix sont considérés ou conçus comme des possibilités réelles. Les philosophes s’intéressant aux capacités ont cerné un ensemble de capacités de base, et les traités relatifs en droits de la personne énumèrent des obligations de base concernant la prestation des ressources nécessaires aux individus pour se développer. Les politiques étrangères devraient être évaluées au regard de ces capacités et obligations en matière de droits de la personne.

- La santé est considérée comme ayant une « importance particulière » dans la vie des gens, dans leur capacité à jouir d’une certaine dignité et d’une sécurité personnelle. Les capacités en santé sont
préalables à l’acquisition d’autres capacités favorisant l’épanouissement (p. ex., éducation, travail valorisant). Lorsque surviennent des conflits entre la santé et la prestation d’autres biens sociaux ou des intérêts économiques dans le cadre de l’établissement d’une politique étrangère, on devrait toujours accorder à la santé une « importance particulière », et non la traiter comme n’importe quel autre élément négociable (donc, échangeable).

• La justice sociale représente la théorie éthique dominante en vertu de laquelle sont prises les décisions sociales en matière de distribution et de redistribution des ressources en matière de santé et d’autres capacités. L’équité constitue un élément fondamental de la théorie de la justice sociale, et comporte deux volets distincts mais non exclusifs : égalité des chances (axée sur une équité horizontale et une justice procédurale) et égalité des résultats (axée sur l’équité verticale et une justice substantielle). Les politiques étrangères devraient renvoyer explicitement à une théorie de justice sociale (et non simplement mentionner l’expression) et, conformément au consensus des philosophes moraux à propos de la justice sociale, préciser comment la politique améliorera les conditions permettant aux moins bien nantis de développer leurs capacités.

• Les philosophes moraux ont formulé des arguments à l’appui des deux principes d’égalité. Il existe un consensus moral solide en faveur de l’égalité des chances par rapport à l’égalité des résultats, et de l’amélioration de la situation de la santé des moins bien nantis. En matière de santé, l’amélioration substantielle de la santé et des conditions permettant la santé (capacités des gens leur permettant d’être en santé) devrait être à tout le moins prise en considération dans le cadre de toute politique étrangère. Le consensus moral est moins clair en ce qui concerne l’acceptation d’inégalités croissantes, même si ces inégalités peuvent améliorer la situation des moins bien nantis.

• Bien que la majorité des théoriciens de la justice sociale se concentrent sur l’État nation, d’autres élargissent leur réflexion aux relations politiques mondiales. Ces dernières décennies, on a beaucoup insisté sur l’équité des chances pour défendre des interventions minimales de l’État dans les économies de marché pour les dépenses de redistribution (sécurité sociale). Toutefois, pour assurer l’équité du principe d’égalité des chances, toutes les personnes doivent posséder les mêmes capacités initiales (équité horizontale : les semblables sont traités de la même manière). Comme ce n’est pas le cas et que les inégalités substantielles entre les personnes et les groupes subsistent et, dans de nombreux cas, s’accentuent, l’exercice d’une équité exige la prise de mesures pour s’assurer que les ressources nécessaires au développement des capacités sont attribuées de manière disproportionnée en faveur des moins bien nantis. L’équité horizontale sans équité verticale (la justice procédurale sans la justice substantielle) soulève des questions sur le plan éthique. Cet argument s’applique également à l’échelle mondiale, où il est clair que les nations les plus riches ont acquis leur statut en partie par l’exploitation des pays plus pauvres, et par le contrôle des institutions économiques qui soutiennent ces inégalités créées au fil du temps. En tant qu’acteurs moraux, les États les mieux nantis, et ceux qui les gouvernent ou qui maintiennent les institutions économiques mondiales qui perpétuent les inégalités, ont l’obligation de corriger la situation et de modifier la façon dont fonctionnent ces institutions et leurs politiques.

• Les choix individuels peuvent avoir des conséquences directes ou indirectes sur autrui, ce qui impose des limites à ce qu’une société considère comme une gamme de libertés acceptable. Sur le plan moral, on présume généralement qu’il vaut mieux déterminer ces limites par des moyens délibératifs et transparents. Certains soutiennent que pour en arriver à des résultats de valeur, il faut mettre en œuvre des processus délibératifs éclairés sur le plan éthique dotés de trois éléments principaux : publicité (transparence du processus, justification exhaustive, débat public et preuves à l’appui), pertinence (confiance des bénéficiaires à l’égard des acteurs et institutions, possibilité d’une participation élargie et interventions fondées sur les besoins, les valeurs et les aspirations des bénéficiaires), et caractère révisable (les politiques et les programmes peuvent être remis en question et améliorés, et les personnes et les institutions peuvent être tenues responsables à l’égard des objectifs).
Argument final

Les défenseurs de la santé peuvent apporter un très grand nombre de preuves et d’arguments dans le cadre des délibérations sur les politiques étrangères. Il n’en demeure pas moins qu’il existe des contradictions profondes entre les intérêts de la sécurité nationale et économique, et ceux de l’équité en santé mondiale. Même lorsqu’il y a des avantages à long terme pour la sécurité nationale et économique, les intérêts économiques à court terme l’emportent souvent. La politique du pouvoir et des intérêts de l’élite, et la mobilisation compensatrice de la société civile, sont des facteurs qu’on ne peut pas ignorer si l’on veut soutenir une position en faveur de l’équité en santé mondiale dans les politiques étrangères. L’expérience montre que les questions d’équité en santé mondiale sont plus susceptibles d’être prises au sérieux dans les discussions à propos des politiques étrangères si elles ont été appuyées ou promues publiquement par les chefs des gouvernements, qui sont ensuite tenus responsables de donner suite en vertu d’autres processus politiques et des pressions de la société civile.
Introduction

Health is more prominent on global policy agendas now than it has been in decades. Global financing for health has increased from around USD 5.6 billion in 1990, to over USD 21.8 billion in 2007 in tandem with a rise in the number of global health initiatives. Several of the Millennium Development Goals refer specifically to health, and all address its social determinants. Twice health has been identified as a global security issue by the United Nations Security Council, with reference to HIV/AIDS; and concerns over pandemic disease (notably pandemic influenza) and bioterrorism retains health’s position in the foreign policy agendas of many of the world’s nations. In considering health’s new found prominence, it is helpful to distinguish an older (and still existing) paradigm of international health, from a newer (and still emerging) one of global health:

**International health**: relates to health practices, policies and systems in countries other than one’s own and stresses more the differences between countries than their commonalities.

**Global health**: refers to health issues where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states, and are thus beyond the capacity of individual countries to address through domestic institutions. Global health is focused on people across the whole planet rather than the concerns of particular nations. Global health recognises that health is determined by problems, issues and concerns that transcend national boundaries.

This emerging paradigm is now finding its place in public policy and international diplomacy.

In September 2006, the foreign ministers of seven countries met and formed the Global Health and Foreign Policy Initiative “to increase awareness of health as a cross-cutting foreign policy issue.” In March 2007, this group issued the Oslo Ministerial Declaration identifying ‘global health’ as “a pressing foreign policy issue of our time.” The Declaration committed its signatories to focus on strengthening cooperation for global health security, reinforce health as a key element in development, affirm the right of countries to use

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3 Norway, France, Brazil, Indonesia, Senegal, South Africa and Thailand

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of flexibilities within the TRIPS agreement to access medicines and strengthen the role of health in conflict and crisis management and reconstruction. It invited other countries to join them. While limited in the scope of its initial goals, the Declaration was clear that:

Health is deeply interconnected with the environment, trade, economic growth, social development, national security, human rights and dignity. In a globalised and interdependent world, the state of global health has a profound impact on all nations – developed and developing. Ensuring public health on a global scale is of benefit to all countries.

Though it marked a new turning point, the Oslo Declaration was not the start of recent interest in health and foreign policy. Sweden, in 2003, passed a law requiring it to report annually to parliament on how it was ensuring all of its foreign policy areas, including health, worked towards a common goal for global development. As one example of Sweden’s enactment of this legislation, it has gained distinction as a leading force in efforts to reduce sugar production in the European Union, in order to enable developing countries to secure a stronger market position. In the same year Switzerland released its Health Foreign Policy document and Norway created a Policy Coherence Commission which examined in detail how its foreign policies contributed to, or impeded, development in low- and middle-income countries. The Commission released its report in September 2008. A month later, the UK launched its new Health is Global: a UK Government Strategy 2008-13, although work on this included a white paper released in 2007.

Some health actions have followed (or indeed been precedents to) these policies. The International Health Partnership+ (IHP+), established in 2007, is regarded as one of the tangible outcomes of a stronger focus on health in foreign policy. The IHP+ commits almost 40 donor and recipient countries and the ‘H8’ (Health Eight) multilateral organizations to implement key measures of the Paris Declaration on Aid Effectiveness with respect to several of the health-specific Millennium Development Goals. The 2008 G8 Summit in Toyako, Japan, dealt extensively with the issue of health system strengthening in developing countries and the role of G8 countries in supporting such strengthening; albeit reflecting more an international than a global health model of collaboration. The 2009 Annual Ministerial Review held by the UN Economic and Social Policy Council is devoted to global public health; and in November 2008 fifty-five nations sponsored a UN General Assembly Resolution on global health and foreign policy, urging member states ‘to consider health issues in the formulation of foreign policy’.

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8 Federal Office of Public Health (FoPH), Swiss Health Foreign Policy: Agreement on Health Foreign Policy Objectives (2006).
9 PCC 2008.
10 DoH 2008.
12 WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria, and the Bill and Melinda Gates Foundation
Table 1: Health and Foreign Policy Key Documents

<table>
<thead>
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<th>Title (Abbreviated)</th>
<th>Country, Year</th>
<th>Comment, Source</th>
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<tbody>
<tr>
<td>Swiss Health Foreign Policy: Agreement on Health Foreign Policy Objectives *</td>
<td>Switzerland, 2006</td>
<td>Published by Federal Office of Public Health and Federal Department of Foreign Affairs: <a href="http://www.bag.admin.ch/org/01044/index.html?lang=en&amp;download=M3wBPgDB/8ull6Du36WenqQ1NcTjaXZqgWfJp3Uhmifhnapmcmc7Zi6rZngCkkIZZtHh/bKbXrZ6ihuDZz8mMps2gpKfo">www.bag.admin.ch/org/01044/index.html?lang=en&amp;download=M3wBPgDB/8ull6Du36WenqQ1NcTjaXZqgWfJp3Uhmifhnapmcmc7Zi6rZngCkkIZZtHh/bKbXrZ6ihuDZz8mMps2gpKfo</a></td>
</tr>
<tr>
<td>Health is Global: a UK Government Strategy * *(UKHG) and (UKHG Annex)</td>
<td>UK, 2008</td>
<td>Issued by the Department of Health: <a href="http://www.dh.gov.uk/publications">www.dh.gov.uk/publications</a></td>
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</tbody>
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Notes:
- * indicates a key document
- # indicates an objective
- § indicates a declaration
- † indicates a strategy
### Table: Global Health Frames

<table>
<thead>
<tr>
<th>Frame</th>
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<tr>
<td>Health and Global Public Goods</td>
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<td>Health and Trade</td>
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<td>Health and Human Rights</td>
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<td>Health and Ethical/Moral Reasoning</td>
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Within these different statements one can find multiple ways in which health is framed as a foreign policy issue. It is generally accepted in policy theory that the framing of an issue is critical in path-dependent fashion to the types of interventions that then fall within the negotiation space. If global health is seen principally as a matter of national security, negotiation space may be confined to prevention of pandemic disease through, in part, ensuring compliance with the International Health Regulations or ensuring equitable access to treatment. If global health is approached primarily as an obligation under international human rights treaties the negotiating space becomes much larger. Political contestation often revolves around how an issue is framed.

There are a limited number of major global health frames within foreign policy that can be summarized as follows:

- **Health and security**
- **Health and development**
- **Health and global public goods**
- **Health and trade**
- **Health and human rights**
- **Health and ethical/moral reasoning**

These global health frames, most of which have some presence in existing policy statements on health and foreign policy, are not mutually exclusive although they may not be congruent. As the Swiss *Health Foreign Policy* expresses:

> It is not possible to avoid conflicts of interest. Therefore, one of the main tasks is to carefully weigh up the different interests in specific cases, and to reconcile national priorities with international developments, in order, as far as possible, to avoid an inefficient or incoherent approach.

Such reconciliation, however, may also require a more specific set of rationalizations for why one global health frame should take precedence over another, since ‘the relationship between health and foreign

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15 This list was first generated for a public lecture sponsored by the Flinders University of South Australia, March 2005. The unpublished paper was shared with researchers working on the global health white paper for the UK, and appears to have had resonance with their own thinking as similar frames are used in its policy reports. A revised article based on the 2005 lecture was later published as: R Labonté, Global Health in Public Policy: Finding the Right Frame? (*Critical Public Health*: 2008 18(4)) 467-482. A more recent paper was published in 2010 as: R Labonté & M Gagnon, Framing Health and Foreign Policy: Lessons for Global Health Diplomacy (*Globalization and Health* 2010 6:14:1-22).

16 FoPH 14. The Swiss experience to date suggests that ‘health ministries must...be able to accept compromise with other ministries, even in health negotiations.’ (World Health Organization, *Foreign Policy and Global Health: Six national strategies*, (Geneva: 2009) FTD Draft Working Paper, forthcoming). The issue remains: how much compromise?
policy is...complex and often contested.'17 If nothing more, the arguments for a particular global health policy18 position should be explicit.

Each of the global health frames offers a rationale for why global health diplomacy is important. This paper examines these rationales with the intent of summarizing a short guide for more explicit agenda setting in global health diplomacy. In doing so, it draws upon government policy statements, academic literature, the opinions of persons presently engaged in pushing the global health foreign policy agenda19 and, to a limited extent, the policy actions that so far are linked to new thinking in health and foreign policy.

**Health and security**

Security arguments figure prominently in global foreign health policies and practices. They may well be the dominant rationale used to position health higher in foreign policy negotiations, with the securitization of health now claimed to be ‘a permanent feature of public health governance in the 21st century.’20 The Oslo Declaration, as justification for global health diplomacy, cites ‘our common vulnerability’ which demands ‘mutual collaboration for global health security.’21 The shape of this vulnerability is varied.

Some arguments are made by invoking national security and find such expression as ‘risk of infection by American citizens [and] US military personnel abroad’ and ‘increased political and economic instability in strategically important countries because of failures by their government to control the [HIV] pandemic.’22 The security needs identified in such statements are two-fold: prevention of disease contracted abroad (an emphasis on global citizens rather than on global pathogens), and prevention of disease-induced failed states and geopolitical instabilities. Both arguments can be found in several of the existing policy statements on global foreign health, but especially the concern with the role disease might play in economic decline and regional conflict. As the UK Health is Global, drawing on findings from the 2001 WHO Commission on Macroeconomics and Health, asserts:

> A healthy population is fundamental to prosperity, security and stability – a cornerstone of economic growth and social development. In contrast, poor health does more than damage the economic and political viability of any one country – it is a threat to the economic and political interests of all countries.23

The Norwegian Foreign Minister is even blunter:

> I realised that health was not just the province of health ministers, finance ministers, presidents, prime ministers, but also of foreign ministers; because health disasters are also a cause of conflict. They are a cause of environmental degradation and of collapsing and failing states.24

The Oslo Declaration similarly argues that:

> It is generally acknowledged that threats to health may compromise a country’s stability and security.....As part of efforts to promote peace and security, women, children, and men whose lives are under

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18  In keeping with how it is frequently referenced, the term ‘global health policy’ will be used to describe both the content of and efforts to move health issues higher into foreign policy agendas. These functions – defining the content of such a policy, its rationale for inclusion in foreign policy and the strategies for gaining support across government and how it can be negotiated successfully between governments – constitute the full range of activities subsumed under the new term, global health diplomacy. This paper addresses only the rationale for inclusion of health issues in foreign policy.

19  Sources for these opinions come from participation in several meetings involving such individuals convened in the first half of 2009.


21  Oslo Declaration 1373-1378.


23  DoH 7. Emphasis added.

threat must be helped to survive and maintain good health. Lack of access to health services can in itself have a destabilising effect. The need to preserve life and health is a useful starting point for peace building "before logic breaks down" into full conflict.\(^{25}\)

There is an emerging if still uncertain literature on the relationship between epidemic disease, poverty, state failure and conflict. Historically, epidemics have been both cause and consequence of conflict. Evidence of the link between conflict and disease remains robust. The reverse relation between disease and conflict, however, concerns primarily correlations between infant and maternal mortality and the likelihood of failed states in African partial democracies. This can contribute to increased domestic or regional conflict. A further relationship between the prevalence of HIV/AIDS and civil conflict has been found;\(^{26}\) ‘while not in and of itself a casus belli, HIV is exacerbating the existing social, ethnic and political tensions that have historically fed intrastate and interstate conflict in Africa.’\(^{27}\) African demographics associated with HIV/AIDS, specifically a bulging cohort of males aged 15 – 29, is also thought to contribute to an increased risk of ‘coalitional aggression’.\(^{28}\) High infant and under-5 mortality rates, low openness to trade and incomplete democratization are also associated with domestic instability and conflict.\(^{29}\) The potential for epidemic disease to contribute to failed states through economic collapse thus remains both empirically and theoretically strong; and with such failure the probability of civil conflict increases.\(^{30}\)\(^{31}\)

The rationale for intervening in epidemics in such countries follows two main logics, both of which cohere with the ‘high politics’ of foreign policy: national security and economic interests.\(^{32}\)

The first line of reasoning is that epidemic-associated national conflicts could become regional; and that they could also abet a growth in terrorist activities whose ‘cells,’ like pathogens, diffuse rapidly across borders. While poverty, either as a cause or an effect of epidemic disease, is not associated with terrorism per se, impoverished regions of poorer countries have been argued to afford sympathetic (or coerced) haven for terrorist groups.\(^{33}\) There is also an association between state failure (measured by civil conflicts, political crises and massive human rights violations) and terrorism (measured by threatened or actual use of illegal force and violence); and with increased rates of terrorist attacks and fatality rates.\(^{34}\) The disease-fuelled and poverty-associated regional conflicts causing the greatest human suffering (Sudan and, until very recently, the Great Lakes Region of Africa), however, have little direct spill-over risks to countries not directly involved; although some argue that African failed states can eventually become sources of wider conflicts or terrorist acts in high-income countries.\(^{35}\) The potential regional conflicts posing the greatest security risks

25 Oslo Declaration 1373-1378.
29 P Hotez *Appeasing Wilson’s ghost: The expanded role of the new vaccines in international diplomacy,* (CBACI Health and Security Series Occasional Paper 3: 2002). The association with trade openness is not intuitively obvious, although other research suggests it may be due to more rapid diffusion of health technologies and improved accountability in democratic functioning.
32 DP Fidler, *Health and foreign policy: a conceptual overview* (London: The Nuffield Trust: 2005). International relations theory ranks foreign policy objectives in a hierarchy of descending importance from national security (material interests/high politics) to economic interests to development to human dignity/humanitarian aid (normative values/low politics). The assumption is that ‘high politics’ framing is more likely to lead diplomacy and policy decision-making than ‘low politics’ framing.
33 The 2008 UK National Security Strategy, for example, argues that ‘together, poverty, disease, and inequality can undermine political and economic development, fuel instability, increase the risk of violent conflict, and create grievances which can be exploited by violent extremists.’ See: Cabinet Office, *The National Security Strategy of the United Kingdom: Security in an interdependent world,* (Cm7291: Mar 2008) 19.
to other nations are those in south Asia and the Middle East, where historic enmities may be a larger factor than either disease or poverty, though there is likely entwinement.\textsuperscript{36}

The second line of reasoning is less direct. Epidemics dampen economic growth and increase poverty, which reduces potential markets for other countries’ exports or reliable sources of imports of economic and/or health-specific (e.g. food products) interest.

Three other rationales have been offered in the name of security.

\textbf{Conflict Prevention}

The first of these regards health as a means to prevent recurring conflict when rebuilding failed states or reconstructing after disasters. Here humanitarian ideals predominate over more explicit or implied self-interested arguments. The UK \textit{Health is Global} policy states this clearly:

\begin{quote}
War, violent conflict and chronic instability affect health directly…access to and provision of healthcare becomes more difficult and is often a low priority for countries in conflict.

Improving access to basic healthcare may have an important role to play in this approach [to conflict prevention, management and resolution], both to meet humanitarian needs and to support peace-building efforts.\textsuperscript{37}
\end{quote}

This echoes an argument made by the Oslo Declaration, which adds the importance of setting out ‘clearer principles for better health security as a means for re-establishing peace, trust, and legitimacy of government’.\textsuperscript{38} The Swiss \textit{Health Foreign Policy} similarly references arguments for humanitarian aid in crisis and emergency situations, though commits itself only to ‘improving the efficiency’ and not the quantity of such aid. Humanitarian health response to ‘natural’\textsuperscript{39} disasters may be one of the easier global health policies on which to gain broad governmental support. Such disasters are often seen as short-term with victims who lack culpability in their misfortune while public support (hence political support) is often quick and generous. Political and public support for health humanitarian intervention over a long-term reconstruction period, however, is more difficult to sustain as media attention moves elsewhere; ‘one challenge is to make a neglected crisis visible and not let action be driven by media attention.’\textsuperscript{40} This challenge may be even harder to meet if the disaster involves long-standing conflicts where local political leaders are viewed as partly (or wholly) responsible and the countries are not of importance to other foreign policy goals of wealthier nations.\textsuperscript{41}

\textbf{Humanitarian Law}

International humanitarian law (as distinct from appeal to humanitarian aid, which is normative or ethical in nature) provides a second and differing argument for global health policy. Such law lays out the rules for the

\textsuperscript{36} Many forecasters are predicting increased risk of conflict as a result of worsening economic conditions in the aftermath of the global recession. Countries facing the highest risk of internal conflict based on 2007 year assessments include India, Afghanistan, Iraq, Bangladesh, Lebanon, Haiti, Ethiopia and 16 other African countries; others cite a high potential within China, despite its low risk in 2007, or between India and Pakistan. Overall, some 49 countries in 2005 were considered ‘anocratic’ states, an unstable blend of autocracy and democracy considered to be at considerable risk of domestic or regional conflict (see Hewitt et al 2008). In what can only be described as dystopian investment advice, a March 2009 business column suggested that the recession-fuelled increased risk of conflict could give otherwise failing investors a rosier option: if ‘large-scale military conflict is coming our way, it’s a good time to buy into U.S. defence suppliers’ (\textit{Globe and Mail, Report on Business}: 14 March 2009) 1.

\textsuperscript{37} DoH Annex 17.

\textsuperscript{38} Oslo Declaration 1373-1378.

\textsuperscript{39} The ‘…’ are used deliberately. The notion of ‘natural’ disaster is challenged by reference to many ecological disasters (apart from earthquakes and volcanic eruptions) involving some human cause (where people settle, how they build, climate change); and that a ‘natural’ disaster of similar ecological scale in a wealthy country may result in much less human or material damage than in a poor one for numerous reasons (poor building construction, lack of resources for preparedness, population density), none of which are ‘natural’.

\textsuperscript{40} Oslo Declaration 1373-1378.

\textsuperscript{41} Hence the large sums on aid and debt cancellation for Afghanistan and Iraq committed by the US, the UK and other donor countries (USD 17.5 billion in 2006), in contrast to the aid sums spent in Darfur and the Great Lakes Region of Africa (USD 2.8 billion in the same year). These figures exclude the costs of military intervention. See OECD-DAC, \textit{Development Co-Operation Report 2007} (9(1) 2008a) 71.
conduct of hostilities and, with it, obligations on states for certain forms of protection to non-combatants.\textsuperscript{42} These protections forbid attacks on things essential for the survival of the population, including health care facilities and health care workers, food supplies, drinking water installations and irrigation works. Two Articles of the 1949 Geneva Conventions and its 1977 Additional Protocol 1 have been cited as obligating some form of third party state action when violations occur.\textsuperscript{43} Not all legal scholars treat such law as ‘obliging’ third party states, so much as permitting them to act if they so choose. What this action might entail remains imprecise. However, ‘there have constantly been resolutions by the Security Council, the General Assembly, and the Commission on Human Rights reaffirming or implying the application of human rights in situations amounting to armed conflict.’\textsuperscript{44} An important exception may be the incidental killing or injury of civilians during war which is accepted under International Humanitarian Law, if ‘proportional’ to the military advantage anticipated, but not under human rights law. Human rights arguments for global health policy are dealt with later in this paper.

More specific reference to International Humanitarian Law is made in relation to the 2008 Convention on Cluster Munitions.\textsuperscript{45} Norway played a prominent role in promoting this Convention\textsuperscript{46} and is one of 24 countries to have ratified it.\textsuperscript{47} The UK Health is Global commits to its ratification and implementation and the UK is one of the Convention’s 104 signatory countries. It also commits to promoting and improving the effectiveness of the Biological and Toxic Weapons Convention. The UK goes one significant step further and states that:

One of our primary objectives is to reach a globally supported, legally binding treaty which will set out clear standards for the international trade in conventional arms without impinging upon legitimate, responsible defence exports. The treaty should address the impact of arms transfers on development, and should be robust enough to stop arms flows that fuel violent conflict, particularly in the world’s poorest countries.\textsuperscript{48}

From a global health perspective, this is an important goal. It is reiterated in the UK’s overall set of foreign policy initiatives (\textit{Better World, Better Britain}) with which the Health is Global policy must ‘dovetail’\textsuperscript{49}, specifically a commitment to ‘tackle the threat posed by conventional weapons to humanitarian, UK, regional and global stability.’\textsuperscript{50} Small arms have been aptly called the true ‘weapons of mass destruction’ for the large, if in recent years decreasing, toll in deaths they cause in conflicts around the world, principally in developing countries. What becomes problematic in the UK commitment is the meaning of ‘legitimate, responsible

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\textsuperscript{42} Much of the content of International Humanitarian Law is on treatment of war-prisoners, a topic marginal to the issue of global health policy \textit{per se}.

\textsuperscript{43} Article 1 of the Geneva Conventions states, in part, the obligation ‘to…ensure respect for these Conventions under all circumstances;’ while Article 89 of Additional Protocol 1 elaborates countries’ obligations ‘in situations of serious violations … to act, jointly or individually, in co-operation with the United Nations and in conformity with the United Nations’ Charter.’ In a 2008 address to the European Parliament, the President of the International Committee of the Red Cross noted that ‘this provision is today generally interpreted as enunciating both a positive responsibility and a legal obligation for third States not involved in an armed conflict to act, whether through bilateral or multilateral channels, to ensure that the belligerents comply with the law and to use their influence to stop the violations. This should at least entail, in my view, an “obligation of means” for States to take all appropriate measures possible in an attempt to end IHL violations.’ 29 October 2008. Official Statement; \textit{Respect for International Humanitarian Law - A major challenge, a global responsibility}; Dr Jakob Kellenberger, President of the ICRC, European Parliament, ( Brussels: 16 Sept 2008) http://www.icrc.org/web/eng/siteeng0.nsf/html/ihl-statement-160808?opendocument. Accessed 4 March 2009.

\textsuperscript{44} C Droge, \textit{The interplay between international humanitarian law and international human rights law in situations of armed conflict} (\textit{Isr. L. Review:} 2007 40(2)) 316.

\textsuperscript{45} On coming into force (which occurs 6 months after ratification by 30 countries) the Convention requires States Parties to clear lands with such munitions within 10 years, to eliminate all stockpiles of such munitions within 8 years and to cease any development, production or acquisition of such munitions.


\textsuperscript{48} DoH Annex 21.

\textsuperscript{49} DoH 15.

defence exports. The UK is one of the world’s largest arms exporters. A 2004 study estimated the government spends between a half and almost one billion pounds annually in subsidies to its arms industry. While the government has been credited with several new initiatives to manage better its global arms trade, it has also come under criticism for failing to enforce its own policies. The involvement of senior elected officials in recent instances of arms sales controversies (notably, but not exclusively, arms sales to Saudi Arabia) has led at least one watchdog group to question whether the policy to export strategic goods wherever possible introduces tensions within Government policy in relation to international commitments and initiatives undertaken by the Department for International Development and Foreign and Commonwealth Office, again indicating a potential conflict in foreign policy goals. The UK is not alone: the Centre for Global Development’s Commitment to Development Index project scores the UK, France and the United States poorly for the scale of their arms exports to countries with poor democratic accountability.

Pandemic Preparedness

It is the last of the security arguments, however, that looms largest in global health policy: the fear of disease pandemics. As the Oslo Declaration expressed:

Other new and re-emerging infectious diseases (avian influenza, SARS, XDR-TB, malaria, polio, plague, dengue fever and so forth) do not respect geographical borders and can only be tackled successfully if nations work together.

To this might be added the somewhat unexpected 2009 H1N1 (‘swine flu’) pandemic, although critics of the increase in factory farming of pigs have long warned of the risk of rapid viral mutations.

Historically, Thailand and the UK both credit SARS as the precipitant to their efforts in global health policy, and their adoption of the International Health Regulations (discussed later in this paper). Thailand adds that shared global disease surveillance makes simple economic sense, since ‘no country has enough capacity to cope on its own with a public health emergency of international concern.’ This is not necessarily a call for a more vigilant cordon sanitaire. The UK is explicit that its policy intent is to ‘protect the health of the UK,’ reminiscent of a defensive system of border protections, but goes on to note that it can only do so ‘by tackling health challenges that begin outside our borders.’ It recognizes that ‘a globalised, interdependent world, characterised by the increasing movement of individuals and populations – and where disease recognises no borders – means that health has become a global issue.’

The Oslo Declaration describes efforts against such threats or risks as ‘national health security,’ a variation of a government’s overall obligation to defend ‘the state from external attack.’ But national health security is no longer a matter of one state or government alone; it has become inherently global in which ‘global health security is only as strong as its weakest link.’ This implies the need to strengthen the weakest links through ‘global mechanisms and other measures that enable countries to make an informed and coordinated response.’ Yet at the same time, ‘preparedness’ – the cross-cutting theme of global health policy – is ‘based on a capacity to identify health risks and threats’, including those that may be outcomes of the foreign

52 These criticisms include failure to deal seriously with corruption in the arms trade, to monitor adequately export of arms components, to prevent export of arms to countries where there is risk of their use to repress human rights or to countries under an EU arms embargo, to report on deliveries (and not only export licenses) for arms shipment, and to ensure transparency in the disposal (destruction or export) of surplus military arms. See M Curtis et al 2007.
55 Oslo Declaration 1373-1378
57 DoH 8.
58 DoH 7.
policies practised by individual nations. Does this forebode international cooperation or conflict? If nothing more, it requires astute analysis of the potential health risks embodied in the full range of other nations’ foreign policies.

In summary, the national security frame offers five rationales for global health policy:

1. Reduced risk of infection to citizens or military abroad
2. Reduced risk of disease-associated poverty leading to failed states and regional conflict, with potential risk to other countries’ citizens, or to costs associated with intervening or declining trade opportunities
3. Prevention of recurrent conflict when rebuilding failed states, or intervening in disaster
4. Prevention of death or injury due to violations of International Humanitarian Law, or to the proliferation of munitions and small arms that pose risks to non-combatants
5. Prevention of pandemic disease through increased national and global preparedness

All five rationales are consistent with the often explicit self-interest that underpins most policy statements supporting global health policy. The UK Health is Global is straightforward in stating that one of the criteria for its selection of its areas for action is ‘whether the UK stands to benefit directly from engaging in the issue, for example, where there are clear links to the health of the UK population.’ The need to argue benefits within a country’s borders was stated by most of the country panellists recounting their global health diplomacy experiences during a 2009 workshop in Bangkok; and the Oslo Declaration itself intones that ‘powerful synergies arise when national interest coincides with the need for concerted regional and global action.’

**Limits to Securitization**

But what happens when foreign policy’s ‘high politics’ of national security and economic interests collide with the ‘low politics’ needs for global development and humanitarian aid? It may be possible to argue enlightened security self-interest for most global health development and aid interventions over a long-term, although international relations scholars argue that this risks rendering the concept of national security imprecise if not meaningless. There is also considerable evidence of a short-term *realpolitik* in which narrowly viewed domestic interests trump those of longer-term global health need.

The securitization of health also disproportionately directs funding and attention to those ills deemed politically to be national security risks, with funding for HIV/AIDS and pandemic influenza the present exemplars.

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59 Oslo Declaration 1373-1378.
60 DoH 18. One could regard this as simply an enlarged *cordon sanitaire* that simply extends the border controls to this or that external country or region of particular momentary risk.
62 Oslo Declaration 1373-1378. Nationally, Thailand makes the same argument for its foreign health policy, that it has been ‘driven not so much by policy prescription but more by [a] convergence of interests’. See World Health Organization, *Foreign Policy and Global Health: Six national strategies*. (Geneva: 2009) FTD Draft Working Paper, forthcoming. This ‘muddling through’ to policy coherence may reflect how much public policy is made. But it raises the question of whether, as the Swiss country case argued, it is now important that explicit policy guidelines be developed to sustain health’s position in foreign policy decision-making. Such policy guidelines would need to do more than indicate that potential conflicts arise; it would have to give some argument for where a particular bias in policy negotiations should be directed when such contradictions are confronted.
63 S Peterson 46. Similar arguments have been made with respect to rational actor theories of collective action (whether intra- or international), where evidence of altruism or other motives for acting are said to be simply other forms of rational cost/benefit assessment. Knoke disputes these arguments in support of other motives that cannot be so easily subordinated to any one encompassing explanatory theory. See: D Knoke. *Organizing for Collective Action: The Political Economies of Associations*. (Hawthorne, NY: Aldine de Gruyter: 1990).
65 This is not to imply that funding for and attention to pandemic preparedness is unnecessary or for HIV/AIDS sufficient; merely that they remain disproportionate to other global health needs. However, an indicative figure comes from an evaluation of World Bank health funding from 1997 – 2006: 60 percent of communicable disease resources went to HIV/AIDS programs (which...
France's two 'thematic ambassadors' working between its Ministries of Health and of European and Foreign Affairs, for example, are dedicated to HIV/AIDS and to pandemic influenza.66

Such designation is not based upon the global burden of disease, since easily preventable maternal and childhood illnesses and a number of so-called 'neglected diseases' exact a higher toll in poorer countries than does HIV. Rather, the securitization of health risks privileging those diseases most likely to inconvenience national security, global trade and finance or to travel to high-income nations, reversing 'international health responses' from their historic 'people-centred values to a narrower understanding of health as a national security risk.'67

Thus, the UK House of Lords 2008 report on intergovernmental management of global communicable diseases focused on HIV/AIDS, tuberculosis, malaria and avian influence 'as working examples of how [intergovernmental organizations] are going about their task.'68 While not intended to be exclusive to these diseases, debate on the report prompted the comment that, in overlooking 'the neglected tropical diseases,' it did so because 'those diseases are less likely to have an impact in Britain.'69 It has been further argued that public health appeals to national security in global health policy could actually undermine what such appeals are attempting to promote (greater global health security) by relieving 'westerners of any moral obligation to respond to health crises beyond their own national borders, unless or until those crises directly and immediately impact national security.'70

The limitation of the self-interest/national security argument for global health policy is recognized by some pronouncements, such as the Oslo Declaration:

In our time, the pursuit of pure self-interest of nations might undermine the solutions that respond to the challenges of growing interdependence. We must encourage new ideas, seek and develop new mechanisms for partnerships, and develop new paradigms of cooperation. This new reality creates a need to find shared values that are embodied in the relations between countries.71

According to international relations scholars, narrow self-interest has failed historically to motivate any sustained commitment to international health cooperation72, implying that other motivations or values are at work or need to be.

It is curious, then, that there is little mention in official policy statements or background discussion papers on global foreign policy of the concept of human security. The concept is referenced twice in the Oslo Declaration (without definition or elaboration), only once in the UK Health is Global Annex (in relation to global warming) and not at all in five of six background country papers prepared for a meeting on global health policy convened by the World Health Organization in January 2009.73 The exception was the country reportedly did poorly in achieving targets), compared to only 3 percent for malaria and 2 percent for tuberculosis (which reportedly were much more successful). Meanwhile resources for family planning and malnutrition plummeted (C Dugger, Report Says Bank's AIDS Efforts Are Failing' (New York Times: 30 April 2009)).

70 S Peterson 46. A similar concern has been hinted at in the elevation of development (more generally) as one of three foreign policy arms in the US 2002 National Security Strategy, alongside diplomacy and defence. Does such elevation increase support for enhanced and more effective development assistance, or increase the subordination of such assistance to defence priorities?
71 Oslo Declaration, 1373-1378.
72 S Peterson 2002.
73 The country case studies lacking any reference to human security included Switzerland, the UK, France, Brazil and Norway; yet two of these countries (Switzerland and Norway) were among the 13 founding members of the 1999 Human Security Network.
case study from Thailand, which argued that this concept was a guiding principle in its foreign policy.\textsuperscript{74} In contrast to national security, human security focuses on the protection of ‘the vital core of all human lives in ways that enhance human freedoms and human fulfilment.’\textsuperscript{75} Human security is people-centred rather than state-centred, with particular emphasis placed on promoting freedom from fear or want, and on vulnerable populations.\textsuperscript{76} Two main strategies have been posited, ‘those that shield people from crucial and pervasive threats (protection strategies) and those that enable people to develop the capacity to cope with difficult situations (empowerment strategies).’\textsuperscript{77}

Human security arguments remain marginal in the security literature precisely because they do not adopt the traditional approach to national security’s emphasis on physical threats to the state. At the same time, human security arguments are considered to be potential entry points for insertion of global health issues within larger foreign policy discussion. Positioning security in human, and not simply national, terms forces open debate on policy measures beyond a country’s national security interests, regardless of whether such interests are viewed as protection from military, terrorist or pandemic attack. It drives foreign policy consideration to a larger set of international responsibilities and creates an argumentative path into other global health policy frames.

**Health and development**

The most prominent of these other global health policy frames is that of development. The UK Health is Global argues that its foremost aim is ‘to use health as an agent for good in foreign policy,’ and ‘to promote health equity within and between countries through our foreign and domestic policies.’\textsuperscript{78}

Health has long been one of the desired outcomes of development, in which economic growth and enhanced social protection are regarded as precursors to an epidemiological transition from a ‘low-income/high-fertility/high-mortality’ to a ‘high-income/low-fertility/low-mortality’ profile, marked by a shift in burden from acute infectious to chronic non-communicable disease. This describes some aspects of health development. It remains partly true for countries at very low levels of wealth and consumption although, as has been pointed out, ‘a country need not be rich to be healthy, and countries can become wealthier without parallel gains in health.’\textsuperscript{79} Moreover, and with the sole exception of sub-Saharan Africa, chronic disease now outstrips infectious disease as the leading cause of death in developing countries, without substantial eradication of either poverty or infectious disease in many instances.\textsuperscript{80}

While it could be that ‘global health security’ is thought to subsume human security, the former is still referenced primarily in relation to pandemic preparedness while the latter is considerably broader in scope.


\textsuperscript{76} R Labonté 467-482. A limitation of the human security approach may be its emphasis on vulnerable populations. This might lead to individual or small-scale and shorter-term interventions that ignore the distributional gradient in health status, weakening longer-term cross-class forms of solidarity for sustained state investments, whether domestic or international. For purposes of greater policy coherence, it is also important that such an approach analyze why some populations are more vulnerable than others.

\textsuperscript{77} M Reich, and K Takemi. G8 and strengthening of health systems: follow-up to the Toyako summit. (The Lancet: 15 January 2009 6736(08)).

\textsuperscript{78} DoH 8.


Health Development as Investment

Recent studies have found that state investments in health and education have been important in explaining why some countries have experienced rapid economic growth, while others have not.81 These findings reverse conventional wisdom: health is no longer seen simply as a consequence of growth, but as one of its engines. This argument is posited as one of the major reasons for advancing health in foreign policy, as Norway’s foreign minister noted in a recent speech:

We need to find new ways of portraying health expenditures as more than costs, but also as an investment. And we need to develop a new language and a new mindset that will enable us to reach and communicate with the real circles of power… We need to get to the core of the economic dimension and speak a language that people with power really understand.82

The Minister continued that ‘we need to convince political leaders that if we do these things, there will be more to share,’83 implying the importance of national economic interests in investments to improve global health. While avoiding the reduction to economics, the Oslo Declaration makes a similar argument: that ‘health is a key element in strategies for development and for fighting poverty’ and a ‘main component of the Millennium Development Goals (MDGs), which point to the interconnectedness of the structural causes of poverty and under-development.’84 The Swiss Health Foreign Policy states simply that ‘development is not possible without health.’85

Whether expressed in economic or development terms, the risk of this particular rationale is that it leads to an expectation of a return on investment. Development financing has become increasingly framed by reference to performance-, results- or outcome-based criteria. If genuinely involving ‘country-ownership’ in criteria definition86 such measures can allow for a better assessment of aid effectiveness and avoid problems of aid fungibility, where donor funding allows for diversion of public revenues into other forms of spending of less developmental value.87 Carried to an extreme, however, results-based funding requirements could favour projects with short-term deliverables at the expense of long-term infrastructure, or those countries with greater existing public capacities at the expense of more fragile or vulnerable states.

The argument for results is also in line with a long-standing concern that aid must be shown to ‘work’ in order to ‘retain the support of taxpayers.’88 The fungibility of aid, particularly when given as general budget support rather than for particular projects, makes such causal relations hard to establish. The recent resurgence of government and civil society activism around aid, after a decade of decline during the 1990s, has been accompanied by renewed critiques of aid as dependency-producing with little to show in terms of development returns over a half century of effort.89 Africa is the generally cited example, having received almost USD 1 trillion in aid over the past 50 years without developing economically to the extent of other global regions. This reasoning, however, ignores the forced opening of many African economies under structural adjustment, which fast-growing Asian countries did not experience. Africa also lost as much or more of its aid receipts over this same period in capital flight (sometimes due to corruption abetted by donor countries), profit repatriation (to corporations generally based in donor countries) and the recycling

82 J Støre 2008.
84 Oslo Declaration 1373-1378.
85 FoPH 8.
86 World Bank: 2008. The 2008 MDG Monitoring Report specifically recommends that any such evaluation framework should ‘be focused on results-based indicators relevant to the national development plan, and not simply on global program indicators’ 109.
87 Collier, for example, estimates that ‘around 40 percent of Africa’s military spending is inadvertently financed by aid’, P Collier 103.
89 W Easterly, The White Man’s Burden: Why the West’s Efforts to Aid the Rest Have Done So Much Ill and So Little Good. (New York: Penguin Press: 2006).
of aid funds back to the donor countries for the purchase of their goods and services (tied aid, technical cooperation). Questions of aid effectiveness and value cannot be isolated from such larger political and economic patterns of power.

Aid problems are less now than in the past, with increasing evidence that aid, administered transparently and in ways that builds local infrastructure and human capital (including health), can improve economic growth. While aid-dependency issues remain, so does the inability of many small, land-locked or otherwise ‘poverty-trapped’ African countries to raise through their own taxes sufficient revenues to fund even a fraction of the estimated minimum requirements for health. Such capacity may be at least two decades away, assuming consistent growth rates at 5 to 8 percent/annum (which is now unlikely), with parallel growth in government revenue (for which some evidence exists) and a higher government priority for health and education financing (for which evidence remains somewhat mixed). In short: for all of its historic problems, there will remain a need for some form of aid transfers if global health, through improvements in the health of the world’s poorest regions, is to be ‘secured.’

**Global Normative Commitments Inherent in the Millennium Development Goals**

The MDGs form the backdrop to all of the state initiatives in global health policy that are framed around development. This reflects the breadth of international agreement on the goals and the scale of attention they have been given by aid donor and recipient countries and multilateral/UN agencies. It is the slow progress towards the MDGs in many countries, notably on maternal mortality, that led to the *Oslo Declaration* in the first place: ‘if nothing changes, many countries will not attain the health-related MDGs by 2015.’ Several

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93 Collier describes four poverty traps: conflict, natural resources (primary commodities), landlocked with ‘bad neighbours’ and poor governance in a small country. Based on his assumptions about economic growth through improving manufacturing and export-earnings as the most sustainable form of poverty reduction, he also argues that grant aid should be for technical assistance for growth-related infrastructure rather than for social development through health and education. These, he implies, would be better supported by freed-up domestic resources no longer going to infrastructure, thereby avoiding Dutch disease and dis-incentivizing export-oriented growth. He nonetheless concludes that, disbursed wisely, aid remains an important element in stimulating growth and reducing the potential for conflict, the latter particularly so in post-conflict states. P Collier 2007.


95 Author’s calculations based on Sachs’ figures and World Bank *World Development Indicator* data sets.

96 Between 2001 and 2006, government revenue in sub-Saharan Africa swelled from USD 70 billion to 180 billion, while ODA disbursements increased from around USD 20 billion to just below 40 billion. See (OECD-DAC: 2008a) 27.

97 S Gupta and S Tareq, *Mobilizing Revenue*, (Finance and Development: September 2008) 44-48. Some African countries presently receiving large portions of their health budget from development assistance may be able to ‘wean’ themselves off aid if they reduce military expenditures, increase domestic taxation and give greater spending priority to health. But at least six African countries receiving more than 40 percent of their health budget in aid, if they fulfilled these criteria, would still be 1/3rd to 2/3rd below the estimated minimum per capita expenditure for the most basic of health interventions. Moreover, much of the expenditure would still be regressive out-of-pocket spending. See JM Krigia and AJ Diarra-Nama, *Can countries of the WHO African Region wean themselves off donor funding for health?*, and G Ooms and W Van Damme, *Impossible to ‘wean’ when more aid is needed*, (Bulletin of the World Health Organization: November 2008 86(11)) 889-894.

98 The multinational *Global Campaign for the Health Millennium Development Goals*, launched in 2007 and involving many of the same countries that were signatory to the *Oslo Declaration*, reported that: ‘while we are half way to 2015, we are much less than half way to achieving most of the MDGs In particular, the health MDGs are behind schedule. At the current pace, the child mortality goal will not be achieved until 2045; our promise on maternal health will not be fulfilled and in some regions maternal mortality rates will be worse. There are positive signs that malaria and tuberculosis can be controlled by 2015, and while we are rapidly increasing the number of people on AIDS treatment new HIV infections are still growing fast.’ (September 2007) 3 [www.norad.no/default.asp?FILE=items/9244/108/GlobalCampaignHealthMDGs.pdf](http://www.norad.no/default.asp?FILE=items/9244/108/GlobalCampaignHealthMDGs.pdf). Accessed 24 February 2009. One positive exception to an otherwise fairly bleak forecast has been a dramatic decline in deaths from measles (68% globally, 91% in Africa between 2000 and 2007); see (OECD-DAC: 2008a) 28.

99 *Oslo Declaration* 1373-1378. Other commentators argue that, even if much changed in the way countries approached ‘global health security’ and the MDGs, many countries would still not be able to meet them. The MDGs would remain, however, as
global health policy initiatives specifically emphasize the ‘broken health systems,’ lack of ‘universal health-care coverage’ and ‘human resources for health crisis’ as partial causes of slow progress in the MDGs\(^{100}\), with ‘the health targets of the MDGs…least likely to be met,’ demanding ‘a coherent strategy and decisive action.’\(^{101}\)

The MDGs, while ‘being partly responsible for revitalising interest in global health’\(^{102}\) have not been without criticism:

1. They lack equity stratifiers; countries can achieve them by improving the health of the better off while worsening that of the poor.
2. There is little reliable data available to track progress in many countries.
3. They are silent on the causes of the problems that they commit the ‘global community’ to address.
4. They lack ambition.\(^{103}\)

Some of these criticisms are being addressed. Nor are the social determinants of health ignored in the arguments for global health policy. The Swiss policy references the importance of ‘the primary determinants of health such as income, education, nutrition, the environment and water, as well as social factors such as discrimination against women.’\(^{104}\) The UK policy commits to various measures to increase awareness of and reduce health risks related to climate change, noting the importance of ‘climate change and environmental factors’ as a means ‘to improve global health security.’\(^{105}\) Its umbrella foreign policy, \textit{Better World, Better Britain}, states more strongly a commitment to promote a ‘low carbon’ global economy, one means of which is ‘increased international commitment to achieve the Millennium Development Goals.’\(^{106}\) A novel initiative cited by France as one of its best instances of global health diplomacy was its leadership in creating the UNITAID airline tax, which collected USD 320 million in 2007 and expects to increase that amount to USD 500 million in 2009. Over 85 percent of UNITAID funds are allocated to low-income countries and all are spent exclusively for purchase of drugs and diagnostics associated with HIV/AIDS, malaria and tuberculosis.\(^{107}\)

\textbf{Development and Securitization}

There are some consistencies in the logic for health development and the ‘high politics’ arguments for health and national security. The UK policy states that ‘improving global health is vital if we are to achieve the Government’s domestic and international objectives,’ which hints opaquely at aspirational targets.

100 Oslo Declaration 1373-1378, DoH, FoPH.
101 DoH 8.
102 Oslo Declaration 1373-1378.
103 R Labonté 467-482. The lack of ambition applies especially to the extreme poverty goal, based on the USD 1/day (recently adjusted to USD 1.25/day) level of consumption. It is the only MDG goal that is presently ‘on track’ to being achieved, at least globally, largely because its baseline year was \textit{ex post} backdated to 1990 from 2000. Even so, almost half of 149 developing countries lack quality data on poverty reduction, making the global measure largely an effect of poverty reduction in China and, to a lesser extent, India. Other research has argued for an ‘ethical poverty line’ of between USD 2.80 and USD 3.90/day in consumption, estimated to yield average ‘ethical’ life expectancies of between 70 and 74 years. Over half the world’s population lives below this poverty line and at current rates of growth and poverty reduction, cutting ‘ethical poverty’ by half would take between 116 and 209 years – calculations made before the 2008 surge in food commodity prices and the present recession. See World Bank, \textit{Global Monitoring Report 2008: MDGs and the Environment}, (Washington, World Bank: 2008); P Edward, The ethical poverty line: A moral quantification of absolute poverty, \textit{(Third World Quarterly: 2006 27 (2))} 377–393; D Woodward and A Simms, \textit{Growth Isn’t Working: The unbalanced distribution of benefits and costs from economic growth.} (London: New Economics Foundation; 2006); \url{http://www.neweconomics.org/NEF/070625/NEF_Registration070625add.aspx?returnurl=/gen/uploads/hrfu5w555mzd3f55m-2vqwty502022006112929.pdf} Accessed 1 March 2008; and \textit{Global Health Watch 2: An Alternative World Health Report}, (London: Zed Books: 2008).
104 FoPH 8.
105 DoH 9; and DoH Annex 115.
106 DSOs, There is no specific MDG related to climate change or low carbon growth; presumably this cross-reference is to Goal 7 on environmental sustainability.
national security issues. More explicitly, the Health is Global policy is expected to cohere with that country’s ‘first’ National Security Strategy, released in 2008. The first statement of this latter strategy is clear: ‘Providing security for the nation and for its citizens remains the most important responsibility of government.’ Pandemics are lumped together with ‘international terrorism, weapons of mass destruction, conflicts and failed states…and trans-national crime’ as the modern threats to security. By inference, intervention into pandemics would be justified only in relation to the ‘most important responsibility of government’—protection of British citizens. This arguably creates a tension between the Health is Global aim to promote health equity (which is normative and free of condition) and the constrained logic of security. The National Security Strategy itself acknowledges that UK efforts to reduce extreme poverty will lead to increased demand for scarce food and water resources, driving up food prices in particular; and that the UK (still one of the world’s wealthiest nations) should prepare for this to protect its own citizens. The closest the Strategy comes to reconciling this difference is in stating that:

In our work with developing countries… we will focus on states and regions most likely to be affected by the combination of rapid urbanisation, high unemployment, demographic shifts, instability, and a possible further growth in violent extremism.

With earlier sections of the Strategy indicating how rapid urbanization, unemployment and demography are associated with instability and risk of extremism, this statement indicates an aid-triage by national security interests rather than by health need or even poverty reduction. Data on UK aid flows partly, although not wholly, provide evidence for this. Using conventional definitions of intrastate and interstate conflict, of the top 10 countries receiving UK bilateral assistance in 2007, five were experiencing some form of conflict (Iraq, Afghanistan, Sudan, Pakistan and India, though the latter two are considered ‘minor’ in present scale); two were possible areas of conflict (Nigeria and Bangladesh) and three were free completely of conflict (Tanzania, Ghana and Malawi). It is more difficult to assess the degree to which global health need informs UK aid decisions, although five of its top recipient countries are in the region (sub-Saharan Africa) that is most off-track for the health MDGs, and three more are in the second-ranked off-track region (south Asia). Moreover, countries in conflict may also be (and often are) facing extreme health needs.

The UK is not alone in its development assistance being disbursed by considerations other than need. Despite Norway’s high level of donor funding, and over 40 per cent of its bilateral aid going to Africa, an independent assessment found that ‘no more than 37 per cent of Norwegian bilateral and multilateral aid went to the least developed countries in 2005.’ More broadly, the 2008 assessment of progress on the MDGs notes that, in the aggregate, aid concentration tends to reflect security concerns, with bilateral aid

108 DoH 7.
110 This might also explain why non-communicable diseases rank low in aid and development discourse, and are completely absent from the MDGs. Such diseases pose considerably less risk to national or even global health security than do infectious pandemics. The only reference to non-communicable disease in the Swiss foreign health policy is to ‘maintain the level of health and productivity of the Swiss population by adapting international strategies and targets relating to fighting non-communicable diseases, particularly obesity,’ that is, to learn globally for local advantage (FoPH 14). The UK strategy is more outwards-looking, committing ‘to scale up its efforts in tackling non-communicable diseases globally, including mental health and injury prevention. We will also continue our work on key risk factors, for instance by working with WHO to develop a protocol on the illicit trade in tobacco’ (DoH Annex 45).
111 Cabinet Office 22.
112 Cabinet Office 54.
114 World Bank 2008.
115 It is also noteworthy that the UK aid budget, was one of two sectors of public spending protected from the nearly 20 per cent budget cuts announced in late 2010 by the Coalition government. Although concerns had been expressed earlier in 2010 that future UK ODA would be driven increasingly by security needs, the opposite occurred. This outcome is partly attributed to narrow definitions of ‘official’ aid demanded by the OECD Development Assistance Committee. It is likely that the UK Health is Global policy played some role in this outcome, but whether and how much is not known.
116 PCC 26.
less allocated by scale of country poverty than multilateral aid. Averages of gross bilateral aid for 2005-06 and for 2006-2007 indeed show preference towards many countries either in conflict or of economic importance (in the case of oil-rich Nigeria) to donors (Table 2).

Table 2: Gross Bilateral Aid Flows Total DAC Countries, Top Ten Recipients 2005–2007

<table>
<thead>
<tr>
<th>2005-2006</th>
<th>Country</th>
<th>Conflict Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Yes, minor</td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>No</td>
<td></td>
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<tr>
<td>Zambia</td>
<td>No</td>
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</tbody>
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<thead>
<tr>
<th>2006-2007</th>
<th>Country</th>
<th>Conflict Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>Unclear</td>
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<tr>
<td>Afghanistan</td>
<td>Yes</td>
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<tr>
<td>Indonesia</td>
<td>No</td>
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<tr>
<td>India</td>
<td>Yes, minor</td>
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<tr>
<td>Sudan</td>
<td>Yes</td>
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<tr>
<td>Viet Nam</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dem. Rep. Congo</td>
<td>No</td>
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</tbody>
</table>


Aid to China is puzzling. On the one hand, the large numbers of its population still living in poverty warrant aid considerations. Average total bilateral disbursement to that country in 2005-06 was USD 2.6 billion, falling to USD 2.4 billion in 2006-07. On the other hand, China provides its own development assistance, notably to African countries as part of agreements emphasizing ‘mutual benefit,’ totalling between USD 1 and 1.5 billion with an additional 1.3 billion in debt cancellation in 2006 – a sum roughly equal to what it receives from other donor nations. India is also becoming simultaneously an aid recipient and an aid donor. The foreign policy coherence on the part of donor nations to these two countries is not clear.

To summarize, two rationales for health as development appear in both policy discourse and practice: aid for economic return (whether to the recipient country only or to both donor and recipient) and aid for strategic (security, resource) purposes. Both rationales cohere strongly with the ‘high politics’ of national and economic security creating an obvious ‘convergence of interests’ claimed to support global health policy. But both rationales, like the security frame in which they largely fit, would see development investments allocated by some form of self-interested return which may (or may not) cohere with global health need.

Scaling-Up Health Development?
There is nonetheless evidence of normative and ethical reasoning underpinning (at least some) development intentions and investments. The Norwegian Prime Minister, for one, has highlighted the importance of assistance to countries to reach MDG 4 (reduce child mortality by two-thirds) and MDG 5 (reduce maternal mortality by three-quarters), targets which are unlikely in the short term to benefit high-income countries

117 World Bank 2008 165-166.
118 Expressing earlier concern of such a triage, the World Bank in 2006 noted that over 60 per cent of aid increases between 2001 and 2004 went to just 3 countries (Afghanistan, Iraq and Democratic Republic of Congo) which accounted for less than 3 per cent of world’s population living in extreme poverty. See World Bank Strengthening Mutual Accountability, Aid, Trade, and Governance. (Washington, DC: World Bank: 2006). The 2007 OECD-DAC Report did find that the “poverty-efficiency” of ODA, the amount disbursed by poverty need, ‘is continuing to increase’ (OECD-DAC: 2008a) 20, albeit from a very low baseline.
substantially either in terms of new markets or reduced national security risk. In 2007 Norway committed USD 1 billion in aid to the so-called ‘Health MDGs’ (MDG 4, 5 and 6)\(^{120}\), and in September 2008 announced new pledges to increase worldwide aid for the health MDGs by USD 30 billion by 2015.\(^{121}\) The *Oslo Declaration* was even more specific in using:

> ...the shared interest in global public health as rationale for giving health top priority in the national and international cross-sectoral development agenda. Push for development cooperation models that match domestic commitment and reflect the requirements of those in need and not one that is characterized by charity and donors’ national interests.\(^{122}\)

The *Declaration* later states the need to ‘honour existing financial commitments,’ and it is here that actions for many countries have spoken more softly than words. Although donors did substantially increase total aid from 2002 to 2006, in line with DAC recommendations and its 2002 Monterrey financing for development commitments, most of this came in the form of debt-relief, much of it to Iraq, Nigeria and Afghanistan. Without discounting the value of debt relief, some of which was applied to the group of ‘Heavily Indebted Poor Countries,’ most of which are in Africa, the value of new ‘programmable’ aid actually declined over the same period.\(^{123}\) The proportion of aid to least developed and low-income countries did rise, but its allocation by the number of people living in poverty fell.\(^{124}\) This appears to contradict the *Oslo Declaration*’s concern with ‘the equitable distribution of aid.’\(^{125}\) Against 2005 G8 commitments to aid increases, now abandoned by most donor nations that made them, OECD-DAC is predicting a shortfall of between USD 18 and 22 billion in 2010\(^{126}\) and a drop of three percentage points relative to GNI\(^{127}\). Overall development assistance fell by 4.5% in 2006 and by another 8.4% in 2007. By 2008 there was an estimated annual funding gap of US$10 billion to meet the health MDGs\(^{128}\). This estimate preceded the 2008 global financial crisis, which has created a USD 65 billion budget shortfall in low- and middle-income countries which aid transfers have failed to fill\(^{129}\). Finally, as the 2008 *Progress Report on the MDGs* noted, ‘scaling up of donor support to countries that are well positioned to absorb more aid has been relatively limited’ as well as episodic.\(^{130}\)

It may not be fair to level this criticism at the potential of normative arguments for global health policy based on the MDGs, since not all donor countries have recognized the linkages between health and foreign policy. Of those that have, however, none disbursed the full amounts of their committed health aid funds

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122 Oslo Declaration 1373-1378, emphasis added.
125 Oslo Declaration 1373-1378.
126 (OECD-DAC: 2010b, April 14) Development aid rose in 2009 and most donors will meet 2010 aid targets. [http://www.oecd.org/document/51/0,3343,en_2649_34447_44981579_1_1_1_1,00.html](http://www.oecd.org/document/51/0,3343,en_2649_34447_44981579_1_1_1_1,00.html). Development aid rose in 2009 and most donors will meet 2010 aid targets. Accessed 10 November 2010.
130 World Bank 2008 94.
for 2005-06, France, Norway and Switzerland came close, while the UK lagged somewhat behind.\footnote{131} In constant US dollars, total aid disbursements in 2006 (which would include funding for social determinants of health) rose for some donor countries embracing global health policy, but not for others.

Preliminary OECD-DAC for 2009 nonetheless found that overall aid levels crept slightly upwards (by 0.7\%) compared to 2008. Moreover, countries with an explicit commitment to health in foreign policy (including membership in the International Health Partnership+ Initiative, described below) outperformed other donor nations, posting a year-to-year increase exceeding 3\%.\footnote{132} The positive tally was due to increased funding generosity from just seven such countries: Belgium, Finland, France, Norway, Sweden, Switzerland and the UK. Other donor nations involved with the IHP+ (including France) saw their aid levels fall. Despite this modest increase, aid funding in the aggregate remains well below globally committed levels.

To be fair, it is not clear whether a country’s commitment to global health policy necessarily equates to increasing its volume of health aid. The Swiss \textit{Foreign Health Policy} emphasizes its commitment to ‘improve the \textit{efficiency} of multilateral players in the fields of health, development cooperation and humanitarian aid,’ but not its volume noting, instead, that ‘in view of the current budget situation, no additional human or financial resources are planned for the implementation of this agreement.’\footnote{133} This is somewhat at odds with at least one component of its policy’s stated objective, notably ‘to strengthen the global partnership for development, security and human rights, making a credible and acknowledged contribution.’\footnote{134} Its major development contribution is cited as support to the Global Fund\footnote{135}; however, and despite its policy arguing Switzerland’s importance as the seat of international organizations including the Global Fund, its overall level of generosity (both ODA in general and the Global Fund in particular) compares poorly to other countries claiming some alignment with the concept of global health policy (Table 3)\footnote{136}.

\textbf{Table 3: Summary of Development Generosity, Selective Countries and Measures}

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<tr>
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<tbody>
<tr>
<td>Switzerland</td>
<td>7.7</td>
<td>1.64</td>
<td>0.39</td>
<td>34</td>
<td>0.51</td>
</tr>
<tr>
<td>Sweden</td>
<td>9.3</td>
<td>3.86</td>
<td>1.02</td>
<td>520</td>
<td>6.21</td>
</tr>
<tr>
<td>Norway</td>
<td>4.8</td>
<td>2.73</td>
<td>0.89</td>
<td>330</td>
<td>7.64</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>61.6</td>
<td>12</td>
<td>0.51</td>
<td>1,170</td>
<td>2.11</td>
</tr>
<tr>
<td>Canada</td>
<td>33.5</td>
<td>3.86</td>
<td>0.29</td>
<td>796</td>
<td>2.64</td>
</tr>
<tr>
<td>France</td>
<td>65.1</td>
<td>10.3</td>
<td>0.47</td>
<td>2,352</td>
<td>4.01</td>
</tr>
<tr>
<td>Germany</td>
<td>82.1</td>
<td>10.28</td>
<td>0.36</td>
<td>1,221</td>
<td>1.65</td>
</tr>
</tbody>
</table>


\footnote{133} FoPH 13.
\footnote{134} FoPH 12.
\footnote{136} It is noteworthy, however, that Swiss ODA generosity is on a more recent increase, rising to 0.44/GNI in 2008, and to 0.47 in 2009. See OECD-DAC. (2010c, April 14), [Graphic data]. Retrieved November 10, 2010, from \url{http://www.oecd.org/dataoecd/17/9/44981892.pdf}.
In similar fashion, the International Health Partnership+ (IHP+), as one example of a development approach to global health policy anticipated by the Oslo Declaration, remains equivocal over whether it will deliver more health aid or only improve the efficiency and effectiveness of what is currently on offer. Launched in September 2007, with leadership from the UK and Norway, the IHP+ is intended to operationalize the Paris Declaration on Aid Effectiveness within the health sector. The Paris Declaration emphasizes the ‘harmonization’ of activities by donors and external agencies, a response to the growth in bilateral health aid and independent global health initiatives that is weakening recipient countries’ capacities to develop their own comprehensive health system plans. Harmonization, as the UK Health is Global policy explains, should lead to ‘international development agencies pooling a greater proportion of their money to finance directly the budgets of health sector plans in developing countries.’ Alongside harmonization is ‘country-ownership’ of health plans, the ‘alignment’ of external assistance to country priorities, and sustained and predictable donor funding. While still in its infancy, the IHP+’s first Ministerial Review in February 2009 reiterated signatory countries’ past commitments to aid increases but emphasized aid effectiveness over aid volume. Its first independently managed progress report (February 2010) showed slow progress and a lack of compliance with reporting by most of its bilateral donors.

There is no dispute that aid effectiveness and efficiency can be improved. But it is increasingly expected that development assistance will not simply stagnate or fall ‘off-track’ in delivery, but decline as donor countries spend more to pull their own populace out of the fallout of the global recession. While efforts have been made to advance ‘an enlightened self-interest argument for providing finance,’ invoking both national security and economic interests, initial responses do not appear to give this argument much weight. In early 2009 the Global Fund, as one example, cut project funding by 10 percent, delayed the next round of applications for new funding and expressed uncertainty about future donor pledges.

At the same time, a February 2009 World Bank policy note estimated that over 40 percent of developing countries are at high risk for rising poverty due to the global recession. Scores of these countries lack both the fiscal space and the institutional capacity to engage in the countercyclical spending now being aggressively pursued by high-income countries whose financial policies first created the present crisis. As a result, the numbers living in extreme poverty (below the adjusted USD 1.25/day level of consumption) is estimated to rise by 200 million in 2009, adding to the 160 million more estimated to have been pushed below that level last year by rises in food commodity prices. More graphically, the number of children needlessly dying annually as a result of the crisis could jump by 400,000. These estimates will magnify as the.
crisis deepens and persists unless rich nations increase their level of support to poorer ones beyond even the levels already committed, the more so since even if fulfilled, such commitments (based on percentages of GNI) will represent less actual funding as the GNIs of donor nations contract. Borrowing from the long-standing but seldom accomplished ODA metric of 0.7 percent of GNI for development aid, the World Bank is now calling for the creation of a ‘Vulnerability Fund’ for countries in greatest need of countercyclical spending, with the fund to be financed by a 0.7 percent tithe on the amount of high-income country economic stimulus spending.147

But this is only a fraction of the estimated USD 1 trillion in banking rescues, social protection and economic stimulus that developing countries will need over the next few years.148 While the G20 countries in April 2009 pledged to increase dramatically the lending capacity of the International Monetary Fund and, to a lesser degree, the multilateral development banks approaching this USD 1 trillion figure, only USD 50 billion is earmarked over the next year for the world’s low-income countries. Most of the new G20 committed funds will be through Special Drawing Rights of the International Monetary Fund, the eligibility for which is commensurate a country’s voting share at the IMF; in other words, high- and higher middle-income countries. The need for rapidly expanded aid transfer to many of the world’s poorer countries remains.

Development assistance, however, is not the only or even the best path to improved health in poorer nations (hence greater global health security) or improved development overall (hence greater global/national security). It may be necessary, but it is not sufficient. As Norway’s Policy Coherence Commission reported:

The aim here is not fighting poverty through increasing aid or loans to poor people or countries, but framework conditions that can make it easier for these countries to create long-term economic growth and reduce poverty themselves. It is important to make this distinction since the focus on the development policy is often on aid. Aid can be a crucial and necessary catalyst for contributing to development, but it is far from adequate as a tool to make this sustainable.149

As one of several instances of these ‘framework conditions’ the Commission assessed Norway’s foreign direct investment strategy. It found that very little of Norway’s foreign investment goes to Africa and much of what does is in oil production, which offers little by way of developing African economies. Even so, the small amount of such investment is greater than the (comparatively generous) amount of aid that Norway provides to Africa, ‘which illustrates how marginal the scope of the aid is in relation to other resource flows to developing countries.’150 The Commission recommended that Norway’s large ‘Government Pension Fund – Global’ be used more strategically for investments that benefit primarily the poor; that a large fund be created for investments in Africa and least developed countries151; and that emphasis in both should be on environmentally sustainable forms of economic growth and development. These recommendations were further qualified by reference to foreign direct investment yielding its greatest development potential through transfer of new technologies and managerial skills; improved social, environmental, gender equality and labour standards; provision of decent employment; inter-linkages with the local economy; and payment of taxes and royalties that contribute to domestic development financing.152 While there were dissenting opinions to these recommendations, they show the potential breadth of any serious engagement in policy coherence for development in which improved population health is considered an integral component.

Migrant Remittances and Health Development

Migration is another policy issue that has become increasingly linked to health and development and in two ways: as a source of remittances from émigré workers, and as a ‘brain drain’ of skilled and productive workers, notably health professionals, from low- to high-income countries.

148 N Birdsall, How to unlock the $1 trillion that developing countries urgently need to cope with the crisis. (Washington DC: Center for Global Development: 2009.) Available online at: www.cgdev.org/content/general/detail/14211143. Accessed 6 April 2009.
149 PCC 23.
150 PCC 27.
151 PCC 78-79.
152 PCC 58.
Remittances have become topical in development discourse. The World Bank notes that both ‘private capital and workers’ remittances have grown in importance as main sources of financing in many developing countries.’\textsuperscript{153}

Cross-border movements of people and labor are increasingly important factors affecting growth and poverty, with very sizable positive realized or potential welfare effects. Nearly 200 million people now live outside their country of birth. Recorded remittance flows to developing countries grew fourfold between 1991 and 2006 and exceeded US$200 billion in 2006—twice the amount of official assistance to developing countries.\textsuperscript{154}

Remittances finance primary consumption including costs of food, shelter, health and education and so can and do play an important role in poverty alleviation. But they are private transfers. Their impact on overall health and social development is ambiguous, especially since many émigrés capable of providing remittances come from families already comparatively better off in their home land. Although most developing countries provide tax exemption to remittances and some will match funds if remittances are used in specific development projects, the scale of such public good investments remains small.

There is relatively little mention of remittances in most global health policy statements. Norway’s Policy Coherence Commission argues the development importance of remittances but claims only that Norway should ease their transaction costs, since its laws presently prevent unofficial channels which are all that exist for some countries. Sweden’s 2003 law mandating annual reporting on its global development policy claims it ‘should make efforts to strengthen the development impact of remittances sent by migrants to their countries of origin.’\textsuperscript{155} This is not a view shared by many in development policy where remittances are regarded primarily as private-person flows. The UN Special Rapporteur on the Human Rights of Migrants, Jorge Bustamente, for example, recently emphasized that ‘economic development is the responsibility of states, and remittances belong to workers and their families.’\textsuperscript{156} Of greater concern to the special Rapporteur is that only 37 countries have so far ratified the 1990 UN Convention on the Protection of the Rights of Migrant Workers and Members of their Families, and none are from countries benefiting from (often temporary) migrant labour flows. The reluctance of such countries is generally attributed to the Convention’s protection of undocumented workers, the ‘privatisation’ of migration recruitment via third party agencies during the 1990s and the risks of formalizing multilateral policies on migration at the perceived loss of political support from national workforces increasingly facing fluctuations in employment.\textsuperscript{157} The UK notes in its policy that ‘international migration remains the largest factor in the growth of the UK population.’\textsuperscript{158} Despite further committing to ‘work both at home and with international partners to ensure that the legitimate rights and needs of migrants are respected’\textsuperscript{159} the UK has neither signed nor ratified the convention on migrant workers.

While some projections assume that remittances will be more ‘resilient’ than other financial flows following the global financial crisis\textsuperscript{160}, declines in remittances have already been reported in the Philippines (3%)\textsuperscript{161},

\textsuperscript{153} World Bank 2008 25.
\textsuperscript{155} Government of Sweden 39.
\textsuperscript{156} Comments made at the Global Forum on Migration and Development, Manila (27-30 October 2008).
\textsuperscript{158} DoH Annex 6
\textsuperscript{159} DoH Annex 29
Mexico (12%)\textsuperscript{162}, Kenya (38%)\textsuperscript{163} and Senegal\textsuperscript{164}, amongst numerous other countries expecting flows to contract.\textsuperscript{165} Based on projections from studies of localised crises, the UK Overseas Development Institute estimates a probable 20 percent drop in remittances in the wake of the global financial crisis, creating a decline in their annual value of USD 40 billion.\textsuperscript{166}

More controversially, Norway’s Policy Coherence Commission calls for an increase in the number of lesser skilled migrants from poorer countries beyond the European Economic Area, both to increase the flow of remittances to low-income countries and to meet its own labour needs.\textsuperscript{167} Whether such migration generosity will be adopted is less certain now than when the Commission released its deliberations, with evidence that the US and several European countries are tightening migration policies while facing considerable domestic pressure to reduce the number of annual work permits issued in the wake of the global financial crisis.\textsuperscript{168} Norway itself does not presently do well in this respect, with only a ‘small…increase in the number of unskilled workers to the country since 1990.’\textsuperscript{169} Some countries engaged in global health policy through their membership in the IHP+, such as Canada and Australia, already use point systems which bias strongly towards highly educated migrants. Such restrictions, and worsening conditions in many poorer developing countries and fragile states, are expected to incentivize illegal migration. The UK’s National Security Strategy response is to note the importance of ‘strong borders’ against such immigration.\textsuperscript{170}

Migration of Health Workers

At the same time as legal migration of lesser skilled individuals from poorer countries might slow, concerns persist that ‘poor countries are overrepresented among those that have experienced a large emigration of well-educated inhabitants.’\textsuperscript{171} In common parlance this has become known as the ‘brain drain,’ a development issue that has generated considerable global health policy attention due to the severe shortage of health workers in those developing countries facing the greatest disease burden and health system collapse. The Swiss policy describes the challenge from its vantage as ‘ensur[ing] the needs of labour markets in the industrialized countries and emerging economies are satisfied, without depriving developing countries of the health workforce they need.’\textsuperscript{172} How this might be done short of increasing the level of health aid or other resource transfers to developing countries (not a generosity in which Switzerland excels) is not clear. The Oslo Declaration is less equivocal, declaring the ‘global…maldistribution of trained health workers ‘a ‘major barrier to preparedness and to national and global health security.’

The shortage of human resources is influenced by the global economy, incentives for migration, and global negotiation on services. Such influences go beyond the health sector and can only be modified through political action at the national, regional, and global level.\textsuperscript{173}

The UK, until recently one of the principle beneficiaries of health worker migration from under-resourced countries, has dramatically increased training of its domestic supply, an approach urged by most global health policy statements. The UK is also devoting larger sums of health aid to training and retention of health workers in countries such as Malawi, where its multi-year commitment to that country’s ‘Emergency

\textsuperscript{162} M Cali et al 2008.
\textsuperscript{163} M Cali et al 2008.
\textsuperscript{165} G Alix and JM Caroit, Migrant cash lifeline slips from reach, (The Guardian Weekly: 27 February 2009) 44.
\textsuperscript{166} M Cali et al 2008.
\textsuperscript{167} PCC 2008. One of the more troubling outcomes of the global recession, however, has been a perceived increase in xenophobic anti-immigration politics across much of Europe, including the traditionally more open and social democratic nations.
\textsuperscript{169} PCC 153.
\textsuperscript{170} Cabinet Office 56.
\textsuperscript{171} PCC 140.
\textsuperscript{172} FoPH 14.
\textsuperscript{173} Oslo Declaration 1373-1378.
Human Resources Programme’ has contributed both to training, and to a sizable increase in the number of doctors (40%), clinical officers (50%) and nurses (30%) between 2003 and 2007, due largely to salary top-ups to discourage migration. In September 2008 the UK committed an additional £450 million over 3 years to support training for more health workers in eight of the world’s poorest countries. Brazil, a relative newcomer to foreign development policy, is similarly emphasizing its role in training health workers from other Portuguese-speaking countries, particularly in Africa; and in developing the health workforce through its involvement in two South-South networks, one of Portuguese-speaking countries and another of the twelve South American nations.

Such initiatives, while laudable, are most likely to be financed and governed under the rubric of official development assistance: ‘Weaknesses in health systems in many countries... constitute a major component in the international health worker crisis... [T]he fragility of health systems in many developing countries and the insufficient training and funding of health workers and the institutions they work in, remain the most fundamental problems.’ Given competing demands on (probable) declining amounts of such funds, it is unlikely that development assistance itself will stem the global migration of skilled health workers. This has given rise to a plethora of other options. Much is made in the policy discourse on the global health worker crisis of the need to ‘facilitate the use of the Diaspora in country of origin and examine the possibility of establishing multilateral and/or bilateral mechanisms that would ensure that the movement of health professionals is mutually beneficial to both sending and receiving countries.’ But there is little evidence to date of return migration or Diaspora support (apart from remittances); and even government-managed migration, such as the export of nurses from the Philippines, poses ethical concerns given reports of declining ratios of nurse/population and, in hospitals, nurses/patient in that country. Remittance earnings, however important to a developing country, should not be at the expense of access to basic health services, for which an adequate supply of health workers is prerequisite.

Most global health diplomacy on this issue has centered on the issue of recruitment. An increasing number of high-income countries benefiting from the flow of health workers have formally adopted, or informally stated adherence to, a policy or practice of no active recruitment from developing countries facing a serious shortage. Some elements of these unilateral or bilateral agreements became global, with the adoption by the World Health Assembly in 2010 of a ‘Global Code of Practice on the International Recruitment of Health...
Personnel.' France credits itself as ‘one of the few States which has provided its expertise to WHO in order to enhance the draft code of practice on the international recruitment of health personnel,’ which it marks as one of its major contributions to global health policy. The code is voluntary, which is seen by some as global health diplomacy strength:

New negotiations have been and are taking place on important public health issues: intellectual property and access to medicines, the exchange of pandemic viruses and sharing of benefits, international migration of health personnel, and the fight against smoking. In this context, increased use of legal solutions that are not binding, such as “codes,” as opposed to formal agreements, will allow progress to be made more rapidly, and with greater emphasis on consensus than would be the case if conventional treaties were prepared.

Other analysts are less sanguine; and almost half of the responses posted in the on-line discussion of the WHO’s draft code in 2008 specifically cited its voluntary nature as a serious weakness. Ultimately, such codes, whether voluntary or mandatory, fail to reflect that, as a respondent in a Canadian study on international health worker recruitment noted, ‘we’ve created a situation where we no longer have to actively recruit because of digital communications, the [reach of] health journals…and the secondary market of private recruiters…we’re slowly removing the barriers.’

Norway’s Policy Coherence Commission went further in its consideration of the health worker migration issue. It first noted that, even if Norway behaved ethically by not recruiting from and instead increasing its assistance to seriously under-resourced countries to scale up their health worker training, other free-riding nations could undermine such efforts. Secondly, it accepted that its present policy of ‘ethical’ recruitment from within high- or middle-income EEC countries would inevitably create incentives for those nations to fill their own shortages from low-income countries in crisis: ‘the domino effect that is believed to take place when Norway recruits from a country in Europe, and this country in turn recruits from other countries that finally employ personnel from developing countries.’ There is no escaping the need to increase health worker training and health system aid in those developing countries suffering both shortages and migration, despite the free-rider problem. The Policy Coherence Commission also identified various compensation schemes suggested to mitigate the subsidy from poor to rich countries: shared tax revenues, extra charges on visas transferred back to the native country, continued tax obligations in the native country and direct repayment of public education costs. These measures, it acknowledge, are challenging because health professional émigrés do not necessarily remain in the country to which they first migrate: How will such costs be equitably allocated?

Health and Global Public Goods

If such a recruitment code were to become binding, it would qualify as a global public good by virtue of its necessity to prevent (or at least to minimize) a global public bad of a pandemic arising from a depletion of health workers in low-income countries. The concept of global public good (GPG) offers one of the strongest theoretical arguments for global health policy, but is rarely encountered by name in actual policy statements. Gordon Brown, in his introduction to the UK Health is Global policy, describes ‘global health’ as ‘a force for good.’ Similar to notions of the common good frequently encountered in public health writings, the implied moral use of ‘good’ in such statements lacks the precision of ‘public good’ that derives from economics. A public good in economics has two distinguishing features:

184 See C Packer et al 2008, for a discussion of the limitations of such codes.
186 PCC 147-148.
187 DoH 3.
It is something whose use is open to all, and whose use by one does not diminish its use by others. Examples include air, water, biodiversity, peace and even – the classic example used to illustrate the concept – the order created by traffic lights.\footnote{R Labonté 473.}

Public goods classically arise from market failures due to free-riding, where those not paying for the good nonetheless benefit from its presence thereby leading to its undersupply; and from externalities arising from market transactions that create a public bad, such as pollution. These failures are only overcome by public provision or regulation as a form of collectivization of both costs and benefits.

There is no consensus on the boundaries demarcating a ‘global’ public good from one that is international (a few nations only), regional (a geographic clustering of nations), club (a political clustering of nations), national or local. Despite the global securitization of HIV/AIDS, the evidence that this poses a pandemic threat beyond certain of the world’s regions (notably sub-Saharan Africa) is weak. Weaker still are less widespread epidemics, such as malaria. With travel and migration, a stronger case for MDR-XDR tuberculosis can be made; and there is no question that prevention of pandemic influenza is a global public good.

Even when the question of boundaries is beyond dispute, there is not full agreement on what should be considered a global public good or its corollary, a global public bad: identifying such goods remains more a matter of public policy choice than of economic theory alone.\footnote{D Woodward and R Smith, Global public goods and health: Concepts and issues. in R. Smith et al (eds) \textit{Global Public Goods for Health: Health Economic and Public Health Perspectives.} (Oxford: Oxford University Press: 2003); and I Kaul, P Conceição, K Le Goulven and RU Mendoza, (eds.) \textit{Providing Global Public Goods, Managing Globalization.} (Oxford: Oxford University Press: 2003). Indeed, ‘the extent to which a good is perceived as ‘public’ does not depend as much on its inherent characteristics as on prevailing social values within a given society about what should be provided by non-market mechanisms’ (S Deneulin and N Townsend \textit{Public Goods, Global Public Goods and the Common Good.} (ESCR Research Group on Wellbeing in Developing Countries Working Paper (18 Sept 2006) 16.)}

Accepting these few ‘pure’ GPGs identifies several issues that have become part of the content of global health policy. Some of these overlap with argumentative frames already discussed, e.g. peace and security and prevention of epidemics, financial stability and fundamental human rights, a stable climate, free access to knowledge, opportunities to travel freely and globally agreed rules on trade and investment, all have characteristics of such goods. The condition of these goods is vital to the development in all countries and their inhabitants. A joint task for both rich and poor countries is therefore to strengthen the production of the global public goods and ensure that as many people as possible can benefit from them.\footnote{PCC 23. This list, with the exception of its reference to human rights, is identical to the priority global public goods identified by the 2006 International Task Force on Global Public Goods, convened by Sweden as part of its 2003 \textit{Shared Responsibility: Sweden’s Policy for Global Development}. See: International Task Force on Global Public Goods. \textit{Meeting Global Challenges: International Cooperation in the National Interest.} (Final Report. Stockholm, Sweden: 2006). \url{http://www.globalpolicy.org/soccecon/gpg/2006/09globalchallenges.pdf}. Accessed 14 March 2009.}

While the discussion below focuses on public goods that are more ‘global’ in scale, a strong argument for international assistance in public goods that are more national also exists. If the persistence of epidemic disease is developing countries is accepted as posing ‘high politics’ risks of eventual cross-border transmission or loss of economic opportunities for developed countries, there is self-interest in provision of assistance to prevent such epidemics. Yet most health aid presently goes to particular disease programs or to health care strengthening; very little goes to public health interventions that create public goods (e.g. sanitation, potable water, slum upgrading, disease surveillance and monitoring, public health regulations). It was the strengthening of such measures that reduced communicable disease and improved life expectancy in industrializing countries in the 19th century; and that is doing the same in those developing countries today that are attempting to follow a similar path. There is also evidence that such national public good/
public health programs are relatively inexpensive, while the economic savings resulting from the prevention of disease are substantial.191

**International Health Regulations**

The most frequently encountered GPG pertains to prevention of pandemics and the role of the International Health Regulations (IHR). Signatories to the Oslo Declaration commit to the early and full implementation of the International Health Regulations.192 The Swiss policy similarly promises their rapid implementation, though justified more by a need to protect the health interests of the Swiss population193 than to encourage a greater supply of GPGs. The UK policy emphasizes the importance of the IHRs as providing "the essential framework within which the world can better manage its collective defences against acute public health risks that can spread internationally and devastate human health, while avoiding unnecessary interference with international traffic and trade."194 The reference to trade has historical meaning; the first International Sanitary Conference in 1851 took place against a backdrop of the increased global movement of goods (aided by technological innovations in railway and ship transport) leading to greater risk of disease pandemics such as cholera, plague and yellow fever. The merchant class was sceptical of state quarantine measures, especially if applied differentially by countries, and pressed for international cooperation to prevent such risks in a way that would not affect global trade.195

Where the new IHRs differ from former reporting requirements is in a change in diseases for mandatory notification: gone are the 19th century ills and in place are smallpox, polio, human influenza of a new subtype and SARS. There is also a more generic requirement to report any ‘extraordinary public health event which constitutes a public health risk to other States through the international spread of disease, and may require a coordinated international response.’196 By 2006, an estimated 60 percent of 192 WHO member states were already reasonably compliant with the IHRs197 although exceptions in some areas of reporting remain.198 While there is no enforcement measure for the IHRs, the ability to use non-governmental sources of information and the inherent reciprocal self-interest is presumed to offer sufficient incentive for compliance. This may overcome free-riding, but it does not address the ‘weakest link’ problem associated with GPGs, in this instance the lack of resources for pandemic preparedness in many of the countries most likely to be sources of new pandemics. The shortfall in financing for avian and human influenza preparedness (2006-2008) in sub-Saharan Africa was estimated at USD 440 million; for East Asia and Pacific, at USD 279 million.199 Also noteworthy note is the ten years it took from initiation of revision of the IHRs in 1995 to their actual completion in 2005. Without the SARS episode in 2003, there is some question as to whether a binding legal agreement applying to all countries would ever have been reached.

192 Oslo Declaration 1373-1378.
193 FoPH 14.
194 DoH Annex 24.
Health information sharing, even when restricted to preventing pandemic influenza, has also been controversial, notably specimen-sharing. While the IHRs are ambiguous on whether States Parties are obliged to share virus specimens with WHO (Article 46 uses the term ‘facilitate’ their transport ‘for verification and public health response purposes’), there is a history of such sharing in a ‘trust-based system.’ In 2007 Indonesia stopped sharing viral samples, fearing they would be used by commercial laboratories to create patented drugs stockpiled in developed countries, and whose costs would preclude their accessibility to most developing nations. Indonesia resumed virus-sharing once WHO agreed to revise the terms of reference for collaborating laboratories to which such samples were sent; but then ceased again, claiming the it still awaited guarantees that developing countries would have fair access to any new drugs developed from such samples. Indonesia’s position, while undermining efforts at global pandemic preparedness, seems justified given that, in 2008, the US Centres for Disease Control applied for a patent on an Indonesian H5N1 influenza gene shared with it in 2005, as part of the WHO ‘trust-based system.’

In 2007, in response to developing country concern over perceived inequities in the viral-sharing system, WHO convened an Intergovernmental Working Group in Pandemic Influenza Preparedness. It was not until January 2009 that the Group released its recommendations for new terms of references for WHO-collaborating laboratories. Draft text that would preclude patenting or assertions of intellectual property rights on shared specimens in the future remains [bracketed], indicating no present agreement. Some countries (generally from the wealthier North with the technical facilities) maintained that intellectual property rights (IPRs) should be granted to reward the work of developing a vaccine, while other countries (generally from the South and supplying the biological samples) countered that the products of such research should be considered public goods. The Working Group proposes more country consultations before re-convening.

Of the country cases on global health diplomacy discussed at the Bangkok workshop in 2009, only the Thailand report singled out the issue of virus-sharing. It was quite explicit in what it believed should be the basis of proceeding in defence of a global public good:

Developing countries want to have the capacity to manufacture vaccines, conduct research on influenza viruses and perform diagnostic tests. They have asked WHO to establish an international stockpile of vaccines for H5N1 influenza. They also want WHO to set up innovative financial mechanisms to help ensure fair and equitable distribution of pandemic vaccines at affordable prices. However, the industry and research institutions have shown reluctance to part with their technological know-how. The issue is further complicated by a recent filing of a patent application by the US Centers for Disease Control (CDC), which is a WHO collaborating centre, to claim ownership of Indonesian influenza genes. The biological specimens were provided pro bono by donor countries to the WHO Global Influenza Surveillance Network (GISN) for public health characterization purposes but have somehow been expropriated by the CDC for the purposes of making proprietary claims, thus raising questions about the ethics of such practice. Many developing countries including Thailand and Indonesia have proposed that companies or research institutions should not be allowed to lay intellectual property claims on products derived from shared biological specimens... Again it will take a lot of work and diplomacy to show that it makes more sense to defend public goods instead of private interests. After all, the costs in human terms associated with collective health insecurity clearly outweigh any gains or considerations in protecting intellectual property.203

200 The trigger event was Indonesia learning that an Australian laboratory would be using one of its samples to prepare a vaccine – a use for which the country had not granted permission – and that there was no provision for benefit sharing with Indonesia.
Climate Change

A stable climate is another global public good; hence prevention of, and adaptation to, such change fall within this argumentative frame. In the Oslo Declaration, climate change is one of several health threats that link ‘global health and development.’ The Swiss health foreign policy is curiously silent on this issue, both in its text and in its policy commitments; and only two of the six country cases presented at the Bangkok workshop (the UK and Norway) refer to it. It may be that multilateral negotiations on climate change have such a powerful momentum on their own they are simply taken for granted by health diplomats.

The UK strategy, however, pays considerable attention to climate change, identifying it as one of its five priority areas for improving global health security due, in part, to the probability of it leading to conflict over natural resources. The policy emphasizes using evidence of the health impacts as a means of motivating more international action on reduction and mitigation. It reaffirms commitment to a 15 percent reduction in emissions from National Health Services organizations between 2000 and 2010. But there is some equivocation in its pronouncements, arguing the need to know ‘that decisions on adaptation and health protection measures, and their relative cost-effectiveness, are based on evidence.’ Having a solid scientific platform from which to argue has been cited as an important tool in placing global health more prominently in foreign policy decision-making. Such evidence, it is argued, cannot be ignored by decision-makers (though some policy observers may differ on this); and evidence is thought to have played an important role in gaining international agreement on the MDGs and on the Framework Convention on Tobacco Control. The UK Health is Global policy takes care to provide the evidence base for its priority action areas and to commit to a continual generation of new knowledge to guide its decision-making. At the same time, whether such evidence with respect to climate change exists a priori to the consequences of not acting is moot; and debates over how much evidence is enough, or sufficiently scientific, could lead to policy stalling.

Norway’s Policy Coherence Commission, perhaps because it is advising government policy rather than announcing it, devotes a long and more trenchant chapter on climate change, claiming it to be the most serious problem facing the world. It outlines in detail three strategies: emission control, clean technology and demand reduction. From a development perspective, it argues that coherence only exists:

If poor countries [are] given latitude to increase their emissions and rich countries finance[e] emission reductions in developing countries. Emission obligations and the financing of climate initiatives must be based on countries’ historical responsibility and economic ability, and must protect the right to development for poor countries.

While calling for investments in emissions reduction equal to 1.5 to 3 percent of Norway’s GNI, the Commission stopped short of recommending a unilateral ceiling on emissions or a reduction in its country’s own oil and gas production and exploration.

There appear, then, to be two threads of argument respecting climate change. The first is the disproportionate historic responsibility of wealthier countries to act in all three areas (emissions reduction, clean technology and demand reduction), inherent in the Kyoto Protocol, while allowing poorer countries to first increase, and then cap and reduce their emissions. The second is the need to advance mitigation and adaptation efforts. As with health and development, both arguments imply a need for resource transfers from richer to poorer countries. As with health and development, this is another area where evidence of action is less prominent than the policy language suggests.

204 Oslo Declaration 1373-1378.
205 DoH Annex 5-6.
206 DoH Annex 8.
210 PCC 115.
Using data compiled by the UK Overseas Development Institute, *The Guardian* estimated in February 2009 that, of USD 18 billion in rich country pledges to help poorer nations adapt to climate change, less than 10 percent has so far been disbursed. Least developed countries, often at greatest risk, have received only USD 47 million in the past 7 years, and often have had to wait up to 3 years to receive promised resources.²¹¹ Moreover:

\[T\]he terms of the two bilateral funds of any scale – namely the Japanese Cool Earth Partnership and the UK’s Environmental Transformation Fund – are offered largely as concessional loans. So, not only are these funds considered part of development assistance, but they are loans not grants, which means they will have to be repaid at some point. This is at odds with the alternative response to financing climate change actions under the principle of ‘common but differentiated responsibility’ and might possibly end up making it harder to find appropriate responses to climate change.²¹²

Nor is it clear if other initiatives in the recent proliferation of climate change and environmental funds will be at the expense of other forms of development assistance, rather than represent new funding.²¹³ Where there is less doubt is the inadequate scale of the pledges, even assuming they are all kept, leading to ‘calls to scale-up current finance levels by two orders of magnitude, from hundreds of millions to tens of billions a year.’²¹⁴

Finally, while wealthier countries have accepted moral responsibility for creating climate change they are likely to be much less affected than poorer countries who suffer from ‘their geographic location, topography and a lack of resources to adapt.’²¹⁵ This differential in global public ‘bad’ may account for ‘the limited effort in many Western countries’²¹⁶ noted by the Norwegian Policy Coherence Commission, a lack of ambition attributed in part to such actions not yet seriously compromising shorter-term foreign policy ‘high politics’ of national security and economic interest to tip the balance in a more climate-responsible direction.²¹⁷

**Health-Damaging Products**

The principle focus of regulation in health-damaging products has been on tobacco and the adoption of the Framework Convention on Tobacco Control (FCTC) in 2003, regarded as one of the most important ventures into global health regulation by the WHO. Like the IHRS, there was a history with WHO and tobacco

²¹⁶ PCC 30.
²¹⁷ Europe’s ‘cap and trade’ carbon system has been cited as one example of a climate change policy that attempted to balance short-term economic interests (in the form of large numbers of emission permits) with long-term environmental interests (as production increased and with it fossil-fuel energy costs, the costs of permits would increase creating market demand for alternative energy sources or greater fuel efficiency). Some initial reports, while acknowledging the problem of over-allocation of permits, maintains that it can work to reduce emissions over the longer term (e.g. AD Ellerman and P Joskow, *The European Union’s Emissions Trading System in Perspective,* Pew Centre on Global Climate Change, (Massachusetts Institute of Technology: May 2008); [http://www.pewclimate.org/docUploads/EU-ETS-In-Perspective-Report.pdf](http://www.pewclimate.org/docUploads/EU-ETS-In-Perspective-Report.pdf). Accessed 12 March 2009.) Other analysts are more critical, arguing that the trading system is predicated on making emissions regulation cheaper and fossil fuel use more efficient, uses dubious equivalence measures including offsets that may not be shown to reduce carbon content, biases against cash-strapped low-emitters in poorer countries and undermines what has been called ‘climate justice’ (e.g. L Lohmann, *Carbon Trading, Climate Justice and the Production of Ignorance: Ten Examples,* *(Development: 2008)* 1-7, [http://www.thecornerhouse.org.uk/pdf/document/Ignorance.pdf](http://www.thecornerhouse.org.uk/pdf/document/Ignorance.pdf). Accessed 12 March 2009.) Finally, the global recession has slowed production and crashed fossil fuel prices, reportedly making the cost of emission permits unsustainably inexpensive (J Glover, *Making pollution cheap,* *(The Guardian Weekly: 27 February 2009)* 20). The International Task Force on Global Public Goods (2006) argues that carbon taxes are much more efficient; only the reluc-

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control that dated back to 1971 when the World Health Assembly (WHA) requested a code of practice be developed to regulate smoking for public health purposes. Despite a call for a tobacco convention at the WHA in 1995, it was not until 2000 that a process for its creation began. The negotiating group met six times over three years. Larger and wealthier countries, including those with a strong commercial interest in tobacco products such as China and Japan, were able to send large negotiating teams. Smaller and poorer countries, increasingly seen as new markets for tobacco products as smoking restrictions and taxation policies in high-income countries reduce consumption, could afford only the one representative funded by WHO. Supported by a larger network of organizations (the Framework Convention Alliance), CSOs played an important role in countering efforts by some governments to weaken tobacco control measures within the treaty. Developing countries, notably from Africa and despite their smaller delegations, are also credited with sustaining stronger control measures in the treaty; while Brazil accords its leadership role with developing countries in FCTC negotiations as one of its major global health diplomacy contributions.

One of the criticisms of the FCTC was its avoidance of any reference to trade. In effect, the global dimension of the tobacco problem disappears in a series of requirements for domestic regulation. There is little doubt that trade liberalization in tobacco increases smoking rates. World Bank research found that reduced tobacco tariffs in a number of Asian countries resulted in a 10 percent rise in smoking rates above what it would have been without trade liberalization. The rationale for excluding trade was to avoid having to work with the World Trade Organization (WTO) in formulating the treaty. The WTO has since stated that the FCTC would be used as the scientific reference point in any tobacco-related trade disputes, but what this would mean in an actual dispute is unclear. Presumably the domestic regulations identified in the FCTC would be seen as non-discriminatory, although none of these requirements impose any restrictions on tobacco trade. A key limitation of the FCTC is that it constitutes ‘soft law,’ lacking in enforcement measures for countries that fail to abide by its protocols. The potential force of convention’s reporting requirements and their use by CSOs and other actors within countries nonetheless has engendered calls for a similar convention on alcohol and its global trade. The evidence base remains underdeveloped with respect to


224 A recent (March 2010) development using a bilateral investment treaty could begin to challenge portions of the FCTC. Bilateral investment treaties allow private corporations to sue national governments over alleged treaty violations. Philip Morris has filed an investment treaty claim against Uruguay under a Swiss-Uruguay bilateral agreement claiming that Uruguay’s requirements that eliminate misleading ‘light’ and ‘mild’ terms and require 80 percent of packaging for public health warnings violate intellectual property rights protected under the investment treaty, since the requirements may eliminate some of its brand variants from the market and infringe on the space required for its logos on packages. The case will be heard by the World Bank-affiliated International Centre for Settlement of Investment Disputes. While the Uruguayan tobacco control policies go beyond the minimum recommended in the FCTC, they are in keeping with the intent of that Convention. It is feared that the Philip Morris claim could ‘chill’ the introduction of tough tobacco control measures across Latin America. (L E Peterson, Philip Morris files first-known investment treaty claim against tobacco regulations. IAReporter 3 March 2010. [http://www.iareporter.com](http://www.iareporter.com). Accessed 5 March 2010.

a global shift to obesogenic diets resulting from a globalization of food commodity chains and retail food investment\textsuperscript{226}, although it continues to build.\textsuperscript{227} This is leading to similar calls for a convention or other multilateral codes of practice for the prevention of diet-related disease. Not all observers of global health diplomacy, however, believe that there are enough interested countries to create momentum towards new and lengthy health treaty negotiations; an alternative to a code on diet-related food trade, for example, could be broader voluntary compliance with WHO’s \textit{Global Strategy on Diet, Physical Activity and Health}.\textsuperscript{228} Nor do such health-damaging products necessarily receive any special attention in governments’ trade policies; in Thailand, for example, tariffs on all alcohol and tobacco imports will be zero by 2015 and the government’s capacity to implement measures outlined in the FCTC are considered weak.\textsuperscript{229}

A review of how WTO law affects alcohol and public health concluded that there may be more policy flexibility in trade law to regulate health-damaging products than some countries might presently presume.\textsuperscript{230} Alcohol regulations designed entirely to protect health and in ways that are ‘trade-friendly,’ for example, would not be WTO inconsistent. Other trade lawyers argue the same point.\textsuperscript{231} But any such measures that included fully or partially protectionist measures (even if that was not their intent) would face a ‘tough’ necessity test as required by WTO rules: would other measures that were less trade restrictive have done the same job? Without changes in these trade rules (e.g. reversing the burden of proof such that complaining countries had to show why a regulatory measure, even if protectionist, was unnecessary to protect public health), the resulting increase in alcohol trade will almost certainly, as with increased tobacco trade, lead to greater health harm.\textsuperscript{232}

\textbf{Scientific Knowledge}

Knowledge is perhaps the clearest example of a public good. Once knowledge is generated it can be shared, in principle, by many people at the same time and it is hard for creators of knowledge to maintain exclusive property of it. Hence, if left to market forces alone, there would always be a tendency to under invest in the generation of knowledge.\textsuperscript{233}

The benefits of scientific knowledge are generally agreed to be public goods, both local and global. Deaton, in his essay on health in an era of globalization, argues that innovations in health technology have contributed more than ‘trickle-down’ economic growth and poverty reduction to improvements in health worldwide, especially for the poor. Many of these innovations originated in wealthy countries, and ‘in this sense, the first world has been responsible for producing the global public goods of medical and health-related research and development from which everyone has benefited, in poor and now-rich countries alike.’\textsuperscript{234} In the last 20 years, however, knowledge creators have attempted to maintain exclusive property of their goods through expansion of patenting and IPRs. Undertaken primarily by companies in wealthy countries, this has led to one of the most contentious issues in contemporary global health diplomacy: that of access to essential medicines and other health technologies. This bears directly on the next global health frame, that of trade and the obvious tension that exists between knowledge as a global public good and knowledge as commercial property.


\textsuperscript{227}  C Hawkes and AM Thow, Implications of the Central America-Dominican Republic-Free Trade Agreement for the nutrition transition in Central America, (\textit{Rev Panam Salud Publica/Pan Am J Public Health} 24(5) 2008).


\textsuperscript{229}  C Blouin, N Drager and R Smith (eds.), \textit{Building a national strategy for trade and health}, (Montreal, McGill-Queens University Press, forthcoming).


\textsuperscript{231}  C Blouin et al forthcoming.

\textsuperscript{232}  B Baumberg and P Anderson 1952-1956.

\textsuperscript{233}  International Task Force on Global Public Goods xviii.

Accepting the earlier logic that epidemics, even if regionally confined to low-income country areas, constitute an indirect threat to national or global health security, the lack of adequate research on neglected diseases is a related though less contentious public good for which support is needed. The Swiss foreign health policy commits itself to 'influence the dialogue on global research priorities in the health field in order to reduce the disproportionate burden of disease in the southern hemisphere in a sustainable way,' a reference to the so-called '10/90' gap in health research (where 10 percent or less of the global health research funding goes into diseases affecting 90 percent of the world’s population, all in low- and middle-income countries).

The UK policy similarly commits to work on neglected diseases and to 'support greater research and development for new medicines and technologies that can prevent, diagnose and treat diseases of the poor.' Besides 'AIDS, TB [and] malaria' the UK cites 'neglected tropical diseases' as priorities for health research. While worldwide funding into all neglected diseases was around USD 2.5 billion in 2004, 80 percent of the funding went to the 'big three.' These diseases accounted for 125 million Disability Adjusted Life Years (DALYs), a controversial metric but the best present measure for burden of disease. Research on pneumonia and diarrheal illnesses which accounted for 165 million DALYs received just 6 percent of neglected disease funding. The authors of this study do not claim that funding should necessarily follow DALYs, but do note that politics and preferences do skew research priorities, even when the intended beneficiaries (notwithstanding first world risks of AIDS and XDR-TB) are primarily persons in low-income countries.

As with other arguments presented so far, the key empiric seems to be the penury of resources compared to need. The USD 2.5 billion amount spent on neglected diseases, which comprise the largest burden of illness for most of the world’s poor, compares with total drug research spending of USD 160 billion in 2005 (about half of which is publicly funded), an almost 100 fold difference in magnitude.

**Financial Stability and Rules-Based Trading System**

Financial stability has long been posited as a global public good for the economic development it can permit. It has also long been cautioned as a good at some peril. Financial market liberalization and the digital technology revolution, alongside banking deregulation, led to an increasing number of developing world financial crises during the 1990s (Figure 1). These crises, while having some ripple effects across other developing countries, did not significantly impact the economies of high-income nations and were viewed more as problems of poor macroeconomic policies in the affected countries than as warnings of systemic problems.

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235 FoPH 15.
236 DoH Annex 41.
237 DoH Annex 71.
Declining profit margins in goods due to overproduction in the 1970s and 1980s led many high-income countries to an increasing reliance on wealth creation through financial instruments (‘financialization’). This reliance is considered one of the reasons that regulators were blinded to the ‘toxic debt’ that led to large-scale bank failures in 2008 and the subsequent ‘credit crunch’ that has precipitated a global recession. Recreating ‘trust’ and stability in global financial markets has become one of the dominating international issues of the moment. The call for improved global regulation of financial markets (a ‘regulated capitalism’ in the words of French President Nicolas Sarkozy) has been supported by the leaders of most G20 countries, extending to international agreements on banking regulation, hedge funds and the closure of tax havens. Other analysts, however, caution that agreement on international regulations, especially if binding, may be difficult or impossible to obtain; and that stronger national regulations, if more globally implemented and enforced, could suffice. This supports the Swiss argument encountered earlier that voluntary codes may be insufficient.


241 To reduce tax evasion and avoidance, the G20 April 2009 Communiqué commits to greater transparency in information sharing between governments and banks on request, rather than as a matter of course as recommended by the international non-governmental organization, Tax Justice Network. This risks a partisan politicization of regulation of tax havens. For a time after the April Communiqué, the Swiss government backed the refusal of the Swiss-based USB to provide information requested by the US government on 52,000 Americans suspected of evading taxes before a legal agreement to disclose information on USD 18 billion in ‘secret accounts’ was finally reached in late August 2009 (N Mathiason, USB must disclose $18bn of secret accounts, (The Guardian Weekly, 28 August 2009) 18). The UK-based Barclays bank is leading in the establishment of a new tax haven in Ghana, (The Guardian Weekly, 8 May 2009) 18), which undermines the UK government’s public commitment to reduce bank secrecy and, in then Prime Minister Gordon Brown’s words, ‘make further advances in the fight against harmful tax practices’ (N Mathiason, Brown backs new global assault on tax avoidance, OECD urged to relaunch campaign blocked by Bush, (The Observer: 5 April 2009).

242 Conference Board of Canada International Financial Policy Reform and Options for Canada, (Ottawa: Conference Board of Canada: February 2009). This report contains 11 specific recommendations for strengthened national regulation of financial capital markets but eschews raising these to the level of international agreement. The recommendations, in keeping with the generally pro-market stance of the Conference Board, calls for regulatory minimalism only ‘to correct market failures’ (32); and opposes any effort to enact a currency transaction tax. A contrary position is taken by Norway’s Policy Coherence Commission which notes that: ‘Large
be easier to pursue than regulatory agreements. Such codes nonetheless fail to overcome the free-rider problem unless other forms of diplomatic pressure are applied, although the absence of enforcement measures even where international regulations exist must also be noted. The present emphasis on financial markets in international diplomacy (the G8, G20 and other multilateral discussions on interventions into the global recession) is understandable in the short-term. At the same time, civil society organizations, health academics and some political leaders are pushing for a ‘Bretton Woods 2’ approach where larger issues of global governance are re-negotiated, including overdue (if haltingly initiated) reform of the World Bank and International Monetary Fund; a re-examination of trade rules in light of development and human rights goals or obligations; and greater emphasis on global development, including improving global health equity, rather than growth *per se* as the metric against which to judge economic policy.

The UK *Health is Global* policy is alone in referencing ‘global financial turbulence’, for which it calls for non-specific reforms of the IMF. Given that it is the most recently released statement on global health policy, the silence attests to the general lack of national regulatory oversight paid to the sub-prime and toxic debt problems until a rapid collapse ensued. Norway’s Policy Coherence Commission is more explicit on the nature of reforms to the international financial institutions:

> The majority of the Commission recommend a democratisation of the international financial institutions whereby developing countries are given a greater voting weight and the scheme where the USA and EU appoint the institutions’ leaders is phased out. Economic conditionalities that entail requirements for privatisation and liberalisation should not be utilized by either the IMF or the World Bank.

In 2007 Norway withheld roughly 25 percent of its planned financial support to the World Bank’s International Development Association (IDA) which makes grants or concessional loans to low-income countries, to protest continuing financial stipulations attached to such grants or loans.

While there is more consistency in the approach taken to global financial stability, statements on the need for a rules-based multilateral trade system are in greater dispute. The *Oslo Declaration*, for example, equivocates. On the one hand it states that ‘A universal, rule-based, open, non-discriminatory, and multilateral trade system, including trade liberalisation, can support global health security, such as enabling the implementation of the International Health Regulations;’ while in the same textual breath it argues the need to ensure ‘equal and universal access to essential medicines [as] one example with major relevance for global public health.’ Yet the issue of IPRs remains highly problematic within trade treaties (discussed below), and even within virus-sharing arrangements managed by WHO. The UK policy also refers to ‘stronger, freer and fairer trade’, though others would hold this triad of adjectives to be in self-contradiction since freer trade is not necessarily fairer. Nor has the imprecation of freer trade been followed by high-income countries; as the Swedish report on global public goods commented:

> The [global trade] system has permitted greater protectionism in products of significant export interest for developing countries. The provisions allowing for special and differential treatment for these countries, cash flows can also have a destabilising effect on financial markets in developing countries. Non-regulated capital flow enables speculation and large, short-term movements of capital in and out of the individual economies. In the worst case scenario, this can trigger financial crises that can have major economic and political bearing on vulnerable developing countries. This problem also has a democratic dimension; democratically elected Governments can restrict or defer political changes out of fear of reactions in the financial markets’ (PCC 59). This last point was documented in the *Final Report of the Globalization Knowledge Network* for the WHO Commission on Social Determinants of Health, see R Labonté et al 2008. The Policy Coherence Commission recommends imposition of a currency transaction tax to curb short-term speculative flows and to finance global development.

243 DoH Annex 49.
244 Warnings, albeit weakened by assurances of low risk, had been made by several national and international watchdog groups as early as 2006. See Conference Board of Canada (February 2009).
245 PCC 18. The Norwegian government has already adopted this position, unless such requirements are essential to anti-poverty and anti-corruption measures.
247 Oslo Declaration 1373-1378.
248 DoH Annex 58.
and the trade preferences granted by developed countries do not compensate in any meaningful way for the trading opportunities missed as a consequence of the remaining protectionism. Objectively, the system is unbalanced against the interests of developing countries.249

The Oslo Declaration's description of the trade system is taken directly from MDG 8’s Target 12. At issue is whether a non-discriminatory trading system can be fair. There is little disagreement in discussions of global trade on the need for a rules-based system, but considerable dissensions on what should be rules, for whose benefits, with what health considerations and under what power relations in their negotiation.

The Norwegian Policy Coherence Commission is surprisingly straightforward on the issue of unequal global power relations, not simply in relation to trade but in the use or protection of global public goods more generally:

Power is systematically unevenly distributed between countries, and makes some countries dependent on framework conditions set by others. The latitude for action afforded to developing countries is, therefore, often extremely limited... Governments in poor countries... are powerless when it is rich countries’ interests or policies that block their access to the public goods. Since Norway and other countries are part of a global system in which power and possibilities are systematically unevenly distributed, aid and good intentions are not the only things needed to make a positive contribution to development. Acknowledgement that conflicts of interest exist between rich and poor countries is required, as is a willingness to consider aspects other than Norwegian interests, and to give up privileges that rich countries currently have in a number of areas. Such changes can be painful to carry through in policy areas that apply to national interests that are regarded as vital and are therefore often difficult to achieve. Nevertheless, there is no excuse for not changing a policy that thwarts development in poor countries.250

Power differentials between the world’s countries, and their peoples, is a topic on which global health policy texts are largely silent.

**Health and Trade**

The issue of power differentials is perhaps most acutely apparent where global health intersects with global trade. It is also where differences between the countries with or espousing global health policy begin to show more starkly. This was already encountered in virus-sharing and intellectual property rights. Of all health and trade issues, that of IPRs has generated the greatest controversy and most global health diplomacy.

**Intellectual Property Rights**

The argument from high-income countries where IPRs have greater economic importance emphasizes a balance between ensuring access to medicines in low- and middle-income countries and maintaining sufficient pharmaceutical profitability, profitability generally defended as essential to stimulate new research. The Swiss health policy is most explicit on this, noting that ‘Switzerland, with its major pharmaceutical industry and long humanitarian tradition, is committed both to adequate protection of intellectual property as well as access to essential drugs for the world’s poorest countries.’251 It further cautions that ‘Switzerland must ...represent the interests of the pharmaceutical industry, which is a major player in its economy, and safeguard the industry’s base here.’252 It reconciles the conflict by arguing that ‘appropriate protection for intellectual property [is] an essential incentive for research into, and development of new drugs and vaccines.’253 The same argument is found in the UK policy statement, which calls for ‘a robust system of intellectual property rights, used innovatively and flexibly to promote access to medicines.’254 It goes on to affirm government support of ‘the right of developing countries to use the flexibilities built into the Trade-
Related Intellectual Property Rights (TRIPS) Agreement, such as the judicious use of compulsory licensing in order to improve access to medicines. But this should not be at the expense of damaging incentives to invest in research and development.\textsuperscript{255}

The 2001 Doha Declaration on TRIPS and Public Health to which the UK policy refers, however, makes no mention of ‘judicious’ use of its provisions. While recognizing that ‘intellectual property protection is important for the development of new medicines’ (Article 3)\textsuperscript{266} it makes no reference to balancing use of TRIPS flexibilities against possible dampening of research and development incentives. The UK’s policy statement imply a tougher stance on IPRs than what been agreed to multilaterally during the Doha meeting. That it took negotiators of that Declaration two years to agree on what was simply an affirmation of existing treaty rights further indicates that ‘these…flexibilities were rejected by some of the holders of intellectual property rights\textsuperscript{257},’ a rejection that does not appear to be in abatement. Even the provisions on parallel importing finally agreed upon are so onerous that there remains doubt that ‘the solution can be effectively implemented,’ but that any greater flexibility would fuel ‘bilateral trade agreements’ that offer ‘a cheap alternative to eroding the WTO solution.’\textsuperscript{258}

Much of the current argument now surrounds precisely that outcome: the proliferation of ‘TRIPS+’ provisions in bilateral or regional trade treaties instigated by the USA and European countries. In 2003, Sri Lanka agreed to a TRIPS+ agreement with the USA under which compulsory licensing and parallel importing were prohibited, in clear violation of the Doha Declaration. Legal challenges by civil society activists eventually forced a promise to revise the bill to permit these flexibilities.\textsuperscript{259} Efforts to create a free trade agreement between Thailand and the USA similarly stumbled over TRIPS+ provisions. Evidence that these provisions could add between USD 152 – 723 million to Thailand’s public health spending on pharmaceuticals, equal to over 5 percent of all public health spending, along with intense pressure from civil society groups and health ministry arguments, led to a collapse in negotiations.\textsuperscript{260} While this was seen as ‘a triumph of human rights over profiteering’ it also led to Thailand being placed on the US trade representative’s priority watch list, signalling a potential loss in US foreign investment.\textsuperscript{261} Neither Colombia nor Peru fared as well in limiting TRIPS+ provisions, sacrificing the ‘low politics’ of public health to the ‘high politics’ of (presumed) economic growth.

The USA is often singled out as one of the worst promoters of TRIPS+ provisions in its bilateral agreements, although in 2007 it announced intentions to bring some of these provisions into greater compliance with TRIPS. Nor is it alone in pressing for greater IPRs in bilateral negotiations. The Norwegian Policy Coherence Commission, noting that the country’s ‘official policy’ is ‘not to force more stringent controls on developing countries than provided for in the TRIPS agreement,’ nonetheless found that five of six agreements to which it is party under the European Free Trade Association are ‘TRIPS+.’\textsuperscript{262} The reason for this lay partly in the absence of European trade treaty details being forwarded to Norway’s parliament (the Storting). The Commission puts some of the blame for TRIPS+ provisions on Switzerland, ‘which has strong interests within the pharmaceutical industry, has been an active driving force for extensive international copyright protection and wants more stringent patent protection in bilateral agreements as well.’\textsuperscript{263}

\begin{itemize}
\item\textsuperscript{255} DoH Annex 28.
\item\textsuperscript{257} P Messerlin Trade, drugs and health services, (The Lancet: 2005 365) 1199.
\item\textsuperscript{258} P Messerlin 1199.
\item\textsuperscript{259} C Blouin et al forthcoming.
\item\textsuperscript{260} Cost estimates are from the Third World Network, Developing countries warned against WTO-plus issues and rules in FTAs, (South North Development Monitor: 31 August 2005.) Equivalence to public health spending: author’s calculations using upper range estimate and 2005 data from WHO Core Health Indicators, http://www.who.int/whosis/database/core/core_select.cfm.
\item\textsuperscript{262} PCC 132.
\item\textsuperscript{263} PCC 132.
\end{itemize}
Norway’s government policy is to promote a renegotiation of the TRIPS agreement ‘with a view to introducing greater exceptions and national adaptation for developing countries;’ the Policy Coherence Commission argues further that it should ‘strive towards a general exemption in copyrights based on considerations for development, poverty reduction, farmer’s rights and the fight against diseases.’ Its argument is claimed to be evidence-based:

There is no research basis for claiming that more stringent copyright legislation would contribute to technological development in poor countries. On the contrary, legislation can help to prevent technological development in the least developed countries.

While this observation is generic to IPRs (and not to medicines per se), the claim that expanded IPRs are needed to stimulate new drug research and development, particularly for neglected diseases, has been questioned empirically.

A more positive development has been India’s announcement in February 2009 that it has ‘effectively licensed 200,000 local treatments as public property,’ in an effort to shut down what has been called ‘bio-piracy’ or ‘bio-prospecting’ of traditional medicines by multinational drug firms. This move will cast doubt on the legitimacy of some 5,000 patents on Indian remedies so far filed, and prevent costly lawsuits India has had to wage to challenge (successfully) past monopoly patents issued on some of its traditional remedies. In contrast to its ambivalence regarding its own pharmaceutical discoveries, Switzerland has supported moves to ensure protections of traditional medicines are written into the TRIPS agreement as part of the Doha round of negotiations.

Even when countries avoid bilateral agreements enhancing IPRs, they face domestic challenges in efforts to use existing TRIPS flexibilities. Malaysia’s health ministry recommendation to import generic ARVs under these flexibilities was initially opposed by the national cabinet, fearing reprisals from foreign investors threatened by the American Chamber of Commerce, other industry groups and the two affected patent holders (GSK and Bristol Meyers Squib). Similar conflicts were noted in Thailand in 2008 when Sanofi-Aventis questioned which branch of Thai government had the authority to issue compulsory licenses, the health ministry or the department responsible for intellectual property. Still unresolved, the controversy highlighted two diverging perspectives:

One side firmly adheres to the principle of human rights and wants to ensure wider access to life-saving medicines for the poor whereas the other side does not wish to bear the brunt of retaliation from its trading partners, arguing that the government could afford the patented medicines without resorting to the use of CL [compulsory licensing].

Two highly publicized events in late 2008 and early 2009 show that these controversies are far from resolved. In December 2008 a shipment of a generic cardiovascular medicine bound for Brazil was held for several weeks at the request of Merck, the patent holder before being returned to the manufacturing country (India) rather than being allowed forward transit to Brazil. A few months later, a shipment of ARVs...
bound for Nigeria was also seized following complaints from the patent holder, GlaxoSmithKline. Both events, two of fourteen reported over a one year period, involved the Dutch government. Both contradicted rules under TRIPS (neither Brazil/Nigeria nor India had granted a patent on the drugs in question) but were imposed under European Community legislation designed to protect IPRs and to prevent transit of counterfeit medications. Trade in counterfeit medicines is posing increasing health risks in low-income countries to which they are most often destined, notably in sub-Saharan Africa where 'the dismantling of the health-care system in most African countries has created the vacuum into which counterfeiters have been able to slip.' But observers of these recent generic drug seizures believe they have more to do with protecting IPRs than with protecting poor peoples' health. The risk of counterfeit drugs itself may be linked to the cost of essential medicines in many low-income countries remaining unaffordable to public health systems.

Despite the well-documented pressures on TRIPS flexibilities exerted by drug companies, recent decisions by major pharmaceutical firms to improve drug access for the poor have also been welcomed. A key initiative was GlaxoSmithKline’s February 2009 announcement to share proprietary information in patent pools for neglected diseases, reduce prices for its patented drugs in least developed countries and put 20 percent of its profits on sales in those countries towards more research on neglected diseases. GSK, however, excluded patented ARVs from this policy, has sales of only USD 42 million in least developed countries and, even with the price reduction, will still have a profit margin equal to almost half its sales value. There is concern that GSK’s call for a patent pool could compete with UNITAID’s development of a similar pool that would be controlled by drug purchasers rather than by drug suppliers; and efforts to establish prize funds linked to the UNITAID pool that would create ‘a new business model for drug development’ by de-coupling research incentives from monopoly rights.

Developing alternatives to patent protection to stimulate research into neglected diseases that lack profitable markets have been a focus of considerable health diplomacy ever since the TRIPS agreement came into force. WHO became involved in these efforts in 1998 when a World Health Assembly debated a resolution calling for public health, rather than commercial, primacy in pharmaceutical policy. It created a Commission on Intellectual Property Rights, Innovation and Public Health in 2003 but, three years later, the Commission failed to reach consensus on many of its recommendations and was unable to formulate any clear action plan. An Intergovernmental Working Group was subsequently established with the aim ‘to promote new thinking on innovation and access to medicines’, including development of new research incentives from monopoly rights.

274 Koivusalo and Mackintosh argue that negotiations around an anti-counterfeiting treaty are being used by pharmaceutical companies precisely for that purpose: to strengthen enforcement of IPRs. The large gap between costs of production and price acts as an incentive in the counterfeit trade. See: M Koivusalo and M Mackintosh, IKD – Innovation, Knowledge and Development: Working Paper 4 (The Open University: February 2009). http://www.open.ac.uk/ikd/documents/working-papers/ikd-working-paper-45.pdf. Accessed 24 March 2009. It is important to note that ‘counterfeiter’ under TRIPS, EU legislation and the Anti-Counterfeiting Trade Agreement still in negotiation (until early 2010, secret negotiations that only leaked texts made more public) refers to infringements on copyright or patents. In the case of medicines, this could apply to generic drugs, and not only to falsified or illegally represented treatments.
275 A corollary problem is the controversy surrounding increased assistance for the private provision of health care in these countries discussed earlier. Much of this private provision exists in unregulated sales of drugs through small shops or open markets, where the counterfeit medicines are most likely to be found.
funding options. Its detailed action plan was adopted by all WHO Member States in May 2008 and is seen as a useful tool, but one that still fails to bring conclusive resolution to the frisson between public health and commercial interests. As a recent essay on the negotiating process concluded:

Sufficient articulation and understanding of relationships between IPR and health may not be merely a problem for developing countries. The lack of capacity - or interest - to address health policy concerns in health-related IPR matters, for example, was found also in the IGWG process within developed countries, where the capacities to put forward trade and industrial policy interests were far stronger than the capacity to represent health-related interests in IPR-issues.280

Trade in Health Services

Health services are also tradable commodities under WTO and other regional and bilateral agreements. Few of the global health policies refer to this aspect of health and trade apart from the UK, which states its economic interests in such trade albeit couched in mutual benefit:

Trade in health services, drugs and medical devices contributes significantly to the UK and global economies. The marketplace for these commodities means that the UK and other economies can benefit from the opportunities that come through freer and fairer global trade in health services and commodities.281

It goes on to say that it will work to enhance ‘the UK as a market leader in well-being, health services and medical products’282 targeting specifically ‘the health sector in India, China and Brazil’.283 This appears to vaunt the UK into a globally competitive market for private health services, either as direct providers, contractors or technical consultants. While medical products need to be traded in order to meet health needs in other countries, does the same apply to health services? If reducing the burden of disease in developing countries is a policy goal for whatever reason (national security, global health security, normative commitments under the MDGs, long term economic development goals), is global trade in health services a good means to achieve it?

There is little consensus on an answer to these questions; the role of private sector involvement in health services remains theoretically and ideologically contested in global policy debates. The Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health, following its review of the evidence, concluded that market failures in more privatized health systems inevitably lead to inequities in access. Its policy advice to low- and middle-income governments is to increase risk-pooling efforts, build towards a universal system under public regulation, restrict or carefully regulate private provision within such a system and confine private insurance to top-ups for wealthy individuals.284 At the same time, the World Bank’s commercial lending arm, the International Finance Corporation, is providing up to USD 1 billion in loans and debt guarantees to encourage private sector investment in health care in Africa.285 The rationale is that the private sector is there, it dominates much health care provision in developing countries and public services are woefully under-resourced and under-staffed.286 But measures to better regulate

280 M Koivusalo and M Mackintosh 29.
282 DoH Annex 10.
283 DoH Annex 29.
286 World Bank, World Development Report 2004: Making Services Work for the Poor, (Washington: World Bank: 2004.) The basic argument is that private health should be there for people who can pay, and the state should contract for-profit or not-for-profit providers for the poor who cannot. The counterargument, provided in the World Health Report 2000 is that this undermines cross-subsidizing equity principles in health care access in which the rich subsidize the poor and the healthy subsidize the sick. That the benefits of public services in low- and middle-income countries are often (though not always) disproportionately captured by better off groups has also been argued as a reason to restrict public funding to poorer groups only. But such capture is not the case in high-income countries, indicating this is an issue of improving regulation and not of segmenting markets.
an existing private sector are quite different from those intended to promote its growth. The rationale for growth measures is that increased private financing and provision for those who can afford it frees up public revenue for more effective and targeted provision to the poor. The weight of evidence, however, finds the opposite: commercialization in health services or insurance creates inequities in access, and also in health outcomes. The 2008 World Health Report was forceful on this point:

Unregulated commercialized health systems are highly inefficient and costly; they exacerbate inequality; provide poor quality, and they provide poor quality and, at times, dangerous care that is bad for health...Thus, commercialization of health care is an important contributor to the erosion of trust in health services and in the ability of health authorities to protect the public.

The UK commitment to increase trade in health services is thus somewhat concerning from a global health equity vantage, although it is not clear exactly what this commitment means. The policy states:

We want to promote the best in British healthcare because we believe we can make an effective contribution to health systems in other countries. We also recognise that there are significant benefits for the UK economy.

This appears at odds with earlier policy statements concerning the depth of medical poverty created by private health care and lack of public health access in many developing countries; and the UK commitment to strengthen through its health development assistance public health systems in poorer countries. Its commercial claim is somewhat nuanced by the statement that ‘where we promote UK services and products (including pharmaceutical and medical devices) overseas, we will make sure that our approach fits with the country’s strategy and that it neither increases health inequalities nor becomes an obstacle to poverty eradication and the achievement of the MDGs.’ At present, none of its health care export activities include products, and appear restricted to the use of UK private sector health consulting firms to run training programs. Yet, as with Switzerland’s equivocation about IPRs and essential medicines, this signals a potential conflict or lack of coherence in the UK strategy.

A similar situation exists in Thailand, where the health ministry has responsibility for ensuring universal access to health services, while also promoting trade in such services. Thailand is expanding its role as a destination for ‘health tourism,’ a growing global industry that can bring economic growth benefits to low- and middle-income countries promoting it while potentially reducing the emigration of health workers (notably physicians). But health tourism can also worsen access to public health services for national citizens by incentivizing movement of health workers from rural to urban settings, and from public to private health care facilities catering to foreign consumers.

This does not imply that some trade in some forms of health services may not offer some health equity benefits. At issue is the extent to which such international commercial exchange becomes written into binding trade treaties such as the General Agreement on Trade in Services (GATS) that preclude governments


289 DoH Annex 67.

290 DoH Annex 67.

291 C Blouin et al forthcoming

292 CA Pachanee and S Wibulpolprasert, Incoherent policies on universal coverage of health insurance and promotion of international trade in health services in Thailand, (Health Policy and Planning: 2006 21) 310-318.
from changing their minds in the future, at least in any cost-free way. Three recommendations from a 2006

text on trade in health services bear repeating:

- Countries may wish to experiment through autonomous liberalization of certain aspects of health
  services, and only make commitments after a careful assessment of the effects of these.293

- [Countries should] subject all requests for, and offers of, liberalization of trade in health services to a
  thorough assessment of their health policy implications.

- The status of health as a human right should inform and guide proposals to liberalize trade in health
  services.294

Public consultations with civil society groups and strengthened health ministry/research participation in
trade negotiations can increase the political strength that may be required to maintain such negotiating
positions.295

The requirement of progressive liberalization in services in GATS (which could eventually put pressure to
open trade in health services, since governments presently have discretion over which sectors to liberal-
ize and under what conditions) may conflict with obligations for the progressive realization of the right to
health under human rights treaties, to the extent that international commercialized trade leads to reduced
or inequitable forms of health care access.296 This possibility led the Norway Policy Coherence Commission
to conclude less cautiously ‘that water, health and education should not be sectors that are subject to the
GATS regulations, but be protected with a view to future generations’ possibilities for regulating these basic
services for the good of the population’.297 The level of commitment under GATS in health services remains
fairly low298, although developing countries made a disproportionate share of GATS commitments in 1995
and often included fewer limitations than those specified by high-income countries.

There are also political and ethical considerations associated with GATS, underscored by the South African
experience. One of the last acts of that country’s apartheid regime was to commit to fully liberalize trade
in health services. The post-apartheid government subsequently passed national legislation guaranteeing
certain health rights by requiring inter alia needs-testing before service providers can set up shop in differ-
ent parts of the country. Intended to improve equity in access, this provision violates its GATS commitments,
leaving the country vulnerable to costly disputes.299 No trade challenge has yet been made and may not,
since political choices influence when and why a trade challenge might be notified. The possibility of such
a challenge, however, has lead some health and trade observers to call for cancelling all existing GATS

293 Or, as Smith et al expressed this point: ‘countries should sample before committing.’ R Smith, R Chanda and V
Tangcharoensathien, Trade in health-related services, (The Lancet: 14 February 2009 373) 599. The WHO Commission on Social
Determinants of Health was more forceful: ‘Until governments have demonstrated their ability to effectively regulate private invest-
ment and provision in health services in ways that enhance health equity, they should avoid making any health services commit-
tments in binding trade treaties that affect their capacities to exercise domestic regulatory control. It is not clear that any government,
anywhere in the world, has met this test’. (World Health Organization Commission on the Social Determinants of Health: 2008) 129.

240-241. A new and detailed list of questions that should be answered before making any health services trade commitments can be
found in: C Blouin et al forthcoming.

295 Such consultations are credited with Pakistan ‘carving out’ health services provided in public facilities from its GATS commit-
tments. At the same time, these were insufficient to prevent Peru from signing on to a TRIPS-plus bilateral treaty with the USA. See
C Blouin et al forthcoming.

296 R Labonté 467-482.

297 PCC 54.

298 R Adlung and A Carzaniga, Update on GATS Commitments and Negotiations, in International Trade in Health Services and

299 S Sinclair, The GATS and South Africa’s National Health Act: A Cautionary Tale, (Ottawa: Canadian Centre for Policy
commitments on health services and removing health and other essential health-related services from the scope of subsequent negotiations, echoing the Norwegian Policy Coherence Commission’s advice.

**Trade and Development**

An important though less prominent trade and health argument follows a standard economic logic: trade liberalization increases growth and development, which reduces poverty, which leads to improved health that in turn improves growth. Evidence for this reasoning derives mainly from World Bank studies that found that during the 1980s and 1990s ‘globalizers’ (those countries whose trade/GDP ratio increased since 1977) grew faster than ‘non-globalizers’ (those countries whose ratio did not). However, countries held up as model high-performing globalisers (China, India, Malaysia, Thailand and Viet Nam) actually started out (and even ended up) as more closed economies than those whose growth stalled or declined during this period, most of which were in Africa and Latin America. The non-globalizers were already more open economies and also traded globally as much, if not more, than the globalizer group. They stalled for reasons other than lack of global market integration, with some arguing that it resulted from their premature and ill-conceived integration into the global economy, largely a result of the developing world debt crisis and the liberalization conditionalities of subsequent structural adjustment programs managed by the international financial institutions. While most econometric studies find that trade liberalization on average is associated with growth, this positive relationship ‘is neither automatically guaranteed nor universally observable.’ Neither is poverty reduction, at least on a scale associated with growth that would also be environmentally sustainable.

This does not mean that trade is bad for health; there is some evidence suggesting the opposite. A panel study of trade openness (measured by the value of imports and exports/GDP and an index of trade openness policies) from 1960 to 1995 found that openness was associated with improvements in infant mortality and life expectancy at birth, lending some support to the standard economic argument of liberalization’s trickle-down health benefits. Causality is difficult to prove in such studies, however, even when outcome variables are lagged; and health improvements associated with trade openness held for developing but not developed countries. Moreover, and echoing an earlier study that found that global diffusion of health technologies contributed more than economic growth to worldwide health gains in the past half-century, the authors concluded that the better explanation for their results did not lay in the dominant economic growth story but in (1) the greater exchange of health technologies, public health knowledge and foreign aid between high- and low-income trading countries; and (2) the likelihood (though still speculative) that more open countries adopted domestic economic policies associated with better health outcomes. There are two important caveats to this otherwise positive finding: national level health data, such as that used in this study, tell us nothing about the distribution of health gains within a country; and the period of study pre-dates the establishment of the World Trade Organization (WTO) and the growth of regional and bilateral trade treaties that constrain some of the policy options that governments might use to promote gains in health equity.

There are several health-negative risks associated with trade liberalization, especially for low- and middle-income countries. There is general empirical consensus that liberalization leads to inequalities in labour markets, as wages for highly skilled workers in globally competitive industries rise and those for lesser

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303 D Woodward and A Sims 2006.


305 A Deaton 2006.
skilled workers in relative abundance fall. The World Bank in 2007 predicted that globalization’s labour market effects would continue to increase economic inequality in much of the developing world leaving lesser skilled workers even further behind, as well increase overall economic insecurity. These assessments predate the present global recession, which will intensify such insecurity. While trade openness is associated with fewer violations of core labour rights, calling into question the ‘race to the bottom’ argument criticizing trade liberalization’s labour impacts, having a right is not the same as having the power to exercise it. As the authors of these studies acknowledge that, despite the legal existence of these rights, ‘it is quite likely, that globalisation boosts the bargaining power of capital at the expense of labour, which would put downward pressure on outcome-related labour standards such as wages, working times and other employment conditions.’

Social protection measures can partially compensate for the inequality effects of liberalization. But financing these may be difficult for many low- and some middle-income countries whose tariffs were reduced either through conditionailities on loans or grants from the international financial institutions, or through trade negotiations. In theory, liberalization is supposed to lead to growth that allows for more forms of taxable revenue to compensate for tariffs losses. In reality, low-income countries ‘have recovered, at best, no more than about 30 cents of each lost dollar’ of tariff revenue; another study found that only six of 28 low-income countries that lost tariff revenues were able to replace any of these losses from other sources. Given that many of these countries still rely on tariffs for 20 to 40 percent of their public revenue (owing partly to underdeveloped tax systems and a large informal labour market) this erosion of revenue-raising ability almost certainly compromises public investment in social protection spending or labour market adjustments. Sub-Saharan African countries are particularly weak in tax infrastructure and in tax/GDP ratios, especially when compared to middle-income Asian countries. Having followed earlier advice from the international financial institutions to lower tax rates on foreign investment and open tax-free export processing zones, more than two-thirds of SSA countries provide tax holidays yet still suffer declining rates of investment. IMF policy advice is now to end such practices. High tariffs in low- and middle-income countries can damage trade amongst them and prevent the import of goods useful to their own development, while the rents they accrue can be captured by corrupt politicians or officials. But unless and until stronger and more accountable forms of taxation are developed, pressures for tariffs reductions, especially for countries facing ‘poverty traps,’ can undermine both health and development.

Negative aspects of health- and development-related trade liberalization will vary from country to country. Their potential does not imply protectionist policies, but rather a careful sequencing of liberalization such that health is improved, or at least not compromised. This, in turn, demands careful consideration of pre-existing economic, labour, education and policy conditions, as well as a country’s factor endowments and development needs and potential. Cross-national aggregate data on liberalization’s effects on growth

309 E Neumayer and I De Soysa 2005a.
313 R Labonté et al 2008.
offer little useful information for how the effects of trade openness might be experienced within a particular country, or amongst different population groups within that country.

Some of these trade and development concerns are reflected in global health policy statements. The UK policy, in committing to ‘fair and open trade’ notes that ‘any trade reform needs to be spaced, designed and sequenced in a way that is appropriate for the particular circumstances of poor countries;’ and that ‘the economic partnership agreements that the EU is signing with the poorest African, Pacific and Caribbean countries [must] give these countries a good trade deal.’ There are strong reasons to suspect this has not been, nor will be, the case.

For years European countries had special trading relations with countries in the African, Caribbean and Pacific (ACP) regions, generally their former colonies. These were subsequently deemed illegal under WTO rules and the EU had until the end of 2007 to negotiate new deals (‘Economic Partnership Agreements’ or EPAs) with the ACP countries. While most ACP countries have signed interim EPAs dealing with goods, few have signed full EPAs that (controversially and at the EU’s instigation) also cover services, investments and other trade-related policies. Observers of the negotiating process with the UK Overseas Development Institute complain that ‘the EU is behaving like the proverbial bull in a china shop, destabilising a delicate balancing of national interests.’ They cite as one example an arrangement between a small country with a fragile arable sector and its larger neighbour that bans cereal imports during harvest months. This regional accord, ‘a good trade deal’ for the countries involved, is illegal under the new EPA. There is also concern that ACP countries will lose important policy space for human security purposes, including (with some regional exceptions) the ability to ban food exports to fight domestic shortages and, through stronger IPRs in the agreements, the ability to save and share seeds.

ACP countries will experience some economic gains by the EPA elimination of tariffs and quantitative restrictions on their exports to the EU. This applies particularly to non-least developed countries, since least developed countries already enjoy relatively free access to European markets under the ‘Everything But Arms’ policy. Using 2006 data, the estimated EPA annual gain to all ACP countries would be €12.7 million and possibly more once barriers to sugar imports are removed. These market access gains are modest. Importantly, the EPAs require that ACP countries for the first time provide reciprocation by progressively abolishing tariffs and other policy barriers to imports from the EU. The argument for reciprocity is that import liberalization will stimulate competition within ACP economies, which will act as an incentive to local and foreign investment leading to increased growth. The evidence for this classical argument, as noted earlier, is in some dispute. The loss of tariffs revenue under conditions of weak institutional tax capacity and full liberalization may also be substantial. Estimates of this loss exceed €550 million annually, which some trade and development economists analysts argue should be compensated through specific ‘aid for trade’ schemes or increased development assistance transfers. The EU has promised increased levels of ‘aid

314 DoH Annex 62.
315 C Stevens and M Meyn, Economic Partnership Agreements (EPAs) – will a new broom sweep cleaner? http://blogs.odi.org.uk/blogs/main/archive/2008/10/30/5681.aspx. Accessed 12 January 2009. Detailed examples of pressure applied to ACP countries by EU negotiators, and comments on these by ACP negotiators, are documented in C Stevens et al, The new EPAs: comparative analysis of their content and the challenges for 2008, Final Report (31 March 2008) http://www.odi.org.uk/ged/publications/The%20New%20EPAs%20-%20Final%20Report%2031-03-08.pdf. Accessed 21 March 2009. A further analysis is offered by M Meyn, Economic Partnership Agreements: A ‘Historic Step’ Towards a ‘Partnership of Equals’? (Development Policy Review: 2008 26(5)) 515-520, which argues that asymmetric power relations between the EU and ACP countries led to hasty liberalization commitments that failed to consider fully the national and regional development implications. The ODI concluded its detailed analysis of the EPAs by arguing that if they are to have development, rather than trade, as the central goal, negotiations on final texts should not be rushed; should reflect common interests of all members of a region; and should allow individual countries to opt out of an EPA and participate in a different WTO-permissible trade regime such as the Generalized System of Preferences +.
316 C Stevens et al xiv.
318 C Stevens et al.
319 C Stevens et al. The hypothetical revenue loss, based on 2006 data, was given as USD 685 million and converted based on 2006 exchange rates.
for trade;’ in 2006 it allocated USD 3.1 billion for this purpose, and ‘aid for trade’ now accounts for 33 percent of all donor assistance.321 ACP countries, sceptical of such commitments given the historical gap between pledges and disbursements, have requested that ‘aid for trade’ promises be written into the binding texts of the EPAs. This has not occurred. The UK policy statement on this issue, as one example, is itself qualified: it ‘expects to’ (but not necessarily will) ‘increase spending on ‘aid for trade’ by 50% to US$750 million a year by 2010.’322

The skewing of costs and benefits has been noted even more strongly with WTO negotiations. A review of recent economic modeling of different Doha Development round outcomes found a range of estimates, with the World Bank’s ‘most realistic scenario’ projecting worldwide welfare gains by 2015 of USD 96 billion (around 0.25 percent of global gross domestic product).323 This calls into question repeated claims, also from the World Bank, that ‘a successful Doha Round is one of the most important steps nations, acting collectively, could take to enhance inclusive and sustainable growth’324 – sustainable here not being used in any environmental sense. Nor would it be terribly inclusive: developed economies are estimated to receive USD 80 billion of the net gain while developing economies would benefit by a scant USD 16 billion, equivalent to a penny or two a day for those presently living below the ethical poverty line. The authors of the review article, one of whom is Assistant Secretary General for Economic Development with the UN Department of Economic and Social Affairs, comment that:

Whatever the right assumptions are, all the different models come to essentially the same conclusion: Global gains of a Doha trade agreement are miniscule relative to world GDP and mostly accrue to large and more developed countries.325

WTO negotiations include seeking new agreement on ‘non-agricultural market access’ (NAMA), which, like EPAs, would lower developing country tariffs on imports from high-income nations. Under tariffs-reduction proposals tabled by high-income countries, developed countries would lose USD 38 billion in border taxes, but developing country losses would exceed USD 63 billion.326

These trade and development inequities led the Norway Policy Coherence Commission to examine carefully that country’s performance with respect to its trade policies in light of agreed upon global development goals. The political context differs little from that of EU/ACP negotiations, or the UK’s simultaneous need to promote its economic interests while also favouring developing country growth. On the one hand:

One of the Government’s key priorities is to strengthen the international competitiveness of Norwegian goods and service producers by ensuring that the business environment remains conducive to innovation, investment and growth.

On the other:

…economic policies, including trade policy, must ensure that the benefits of trade and economic growth are distributed in an equitable way, both nationally and globally.327

322 DoH Annex 62.
323 J Sundaram and R Arnim 212.
324 World Bank 2008 118.
325 J Sundaram and R Arnim 212.
326 K Gallagher, The Political Economy of the Doha Round: Shrinking Benefits and Real Costs for Developing Countries, in (International Studies Association 48th Annual Convention: 2007a); and K Gallagher, Measuring the cost of lost policy space at the WTO, (IRC Americas: 2007b). Trade restrictions on environmentally friendly technologies, which remain higher in low-income than in high-income countries, however, can be considered damaging to health equity (as might be tariffs on essential health goods such as bed nets) and should be regarded as important health exceptions to an otherwise general policy of not coercing premature tariffs reductions in developing countries.
Norway claims coherence in trade by virtue of granting duty- and quota-free market access for all imports from 64 low-income countries, including all 50 least developed countries. The Washington-based Centre for Global Development, which produces a *Commitment to Development Index* (CDI), however, rates Norway poorly in this respect, due mainly to the low value of imports from these countries and the high tariffs still levied on imports from other developing nations, notably agricultural products. This does not imply that an opening of northern markets to agricultural exports from low-income countries will be the development panacea some have claimed; estimates of gains from the removal of import barriers and decrease in produce subsidies have, over time, tracked downwards, with an emerging consensus that ‘the supposed gains from agricultural trade liberalization are likely to bring greater benefits to a few rich agriculture-exporting countries, rather than to most of the developing world, let alone the bulk of the poor.’

More pointedly, Norway ‘has an expressed policy to support developing countries’ requirements and help preserve their policy space;’ a position that conflicts with its ‘offensive interests in the NAMA negotiations’ with respect to increasing market access for Norwegian fish and fish products. This one market access requirement, if realized, would be accompanied by similar rates of tariffs reductions by developing countries in all other manufacturing sectors. The Policy Coherence Commission urges Norway to reduce its market access demands in the NAMA negotiations and to support developing country efforts for various exemptions that would positively discriminate in their favour. It similarly cautions against Mode 3 liberalization under GATS (commercial presence), ‘since this puts restrictions on a country’s potential to use political instruments’ such as ‘requirements for local labour or local input factors’ both of which ‘can contribute to long-term development.’ It further argues that a coherent trade and development policy demands ‘asymmetrical agreements’ disproportionately benefitting developing countries. These are more readily negotiated bilaterally or regionally, although the present direction of bilateral treaties is ‘WTO+,’ exacting greater developing country concessions rejected in multilateral WTO negotiations due to the stronger bargaining position of more powerful, high-income countries.

Helping to challenge the differences in negotiating power between countries was cited as a particular example of effective global health diplomacy by Brazil: ‘The Brazilian Government led to the creation of a block of developing nations – the G20 – to thwart US and European hegemony in global trade talks.’ Thailand makes a similar point, albeit phrased more diplomatically: ‘Trade objectives do not always coincide with public health needs; in fact they are often shown to be in conflict.’

As was seen with Thailand’s contrasting perspective in intellectual property rights to that of Switzerland’s, developing countries have quite different health interests in trade, whether framed around access to medicines or development more generally. It remains to be seen if the essential mercantilism of most countries engaged in trade negotiations can be nuanced by a stronger presence of health arguments. A recently developed framework, posing over 120 detailed questions that should be addressed ‘to ensure that trade contributes to improving population health and health systems,’ can at least assist health diplomats in making those arguments.

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328 D Roodman 24. The methodology used in developing this index remains controversial; its finding on Norway’s trade barriers, however, is not.

329 In 2004 estimates of annual losses to developing countries due to continuing agricultural subsidies in high-income nations ranged from USD 20 to 60 billion (ICTSD, WTO Agriculture Week: No Negotiating Breakthrough Expected, *Bridges Weekly Trade News Digest* 2004 8(11)). In 2007 a revised estimate of fully liberalized agricultural trade put annual developing country gains at only USD 9 billion (KP Gallagher, *Measuring the cost of lost policy space at the WTO*, (IRC Americas: 2007)).

330 J Sundaram and R Arnim 212.

331 PCC 47.

332 PCC 54. While performance requirements on foreign investors can, and has, led to ‘crony capitalism’ benefiting corrupt leaders and their families or supporters, it has also led to more equitable forms of growth and development.


335 C Blouin et al forthcoming.
The Global Financial Crisis and ‘Murky Protectionism’

Cautions with regard to trade liberalization, development and health are not the same as arguments favouring protectionist policies; ‘using tariffs to switch given aggregate demand from others to your own goods is to use a policy that simply switches employment from others to us, but does not increase world employment.’

Gains in increasing current levels of liberalization following completion of the Doha round may be somewhat marginal and dis-equalizing, and past trade-related economic and development gains have not been equitable across developing countries. At the same time, the depth of global production chains means that the collapse of international trade in manufactured goods (‘sudden, severe, and synchronised’) is rippling across supply chains in low- and middle-income countries worldwide with health-negative implications via increased unemployment and poverty and decreased public revenues for social investment. Substantial trade-related job losses have been reported in Indonesia (electronics), Cambodia (textiles) and Zambia (mining) since 2008, three of ten countries being closely monitored by the UK’s Overseas Development Institute.

It is estimated that, as of January 2009, almost 80 ‘murky protectionist’ measures worldwide have been enacted, most by middle- and high-income countries engaged in counter-cyclical spending. Their ‘murky’ quality resides in them being permissible under existing trade treaties, but liable to spark equally permissible retaliatory measures.

One example is the ‘Buy American’ government procurement policy adopted by the USA which, by a last minute stipulation that the policy be consistent with that country’s international agreements, avoided violating trade rules. Since government procurement remains a plurilateral treaty under the WTO, only firms in those countries that signed it (40 in total) and those with bilateral free trade agreements with the US will be unaffected by its provisions. It is plausibly arguable that, in a deepening recession, public funds should support workers in the country collecting and disbursing the tax revenues or committing citizens to repaying debt-financed spending. However, the depth of global market integration achieved in the past 30 years of liberalization policies, and the existence of considerable room under existing trade rules for countries to raise tariffs in retaliation to what is seen as protectionist behaviour, could lead to counterintuitive effects.

By one estimate, stipulating that the US government should buy its steel only from American providers would save 1,000 jobs but could prompt retaliatory measures from its major export markets that would ‘in an extreme case’ produce a net job loss of 65,000. Not all analysts agree, positing that some protectionist policies, albeit within the legal terms of existing trade treaties, are unlikely to provoke severe retaliatory measures and may be a ‘second-best’ short-run approach to economic stimulus.

The issue remains that this is primarily a prerogative of wealthier countries and of China and other Asian nations holding large US Treasury Bill assets in their currency reserves.

Arguments that Depression-era protectionist policies and a rapid decline in global trade led directly to the political turmoil leading up to World War Two may be overstated; global trade loss is less the cause of such turmoil than a result of episodic crises in capitalist overproduction. Many analysts point to a huge

340  GC Hufbauer, and J Schott, Buy American: Bad for Jobs, Worse for Reputation, (Peterson Institute for International Economics Policy Brief: February 2009). http://www.petersoninstitute.org/publications/pb/pb09-2.pdf. Accessed 22 March 2009. The extreme case is based on 10 percent of the export market being targeted for retaliation. A more plausible number may be 1 percent, or 6,500 jobs. Other economists question both the extent of tariffs flexibility amongst US major export markets, and the likelihood of it being used. The point that global markets are now so highly entwined that protectionist policies can have opposite effects on employment still stands.
excess of production over consumption in China and other Asian countries coupled with a huge excess of consumption over production in the USA and other high-income countries. The former (a ‘sterilization’ of export earnings through accumulation of US Treasury Bills) was a rational response to earlier predations of financial market liberalization in which runs against these countries’ currencies precipitated major crises in the 1990s with devastating domestic effects. The latter, fuelled by what has been called ‘a perverse fetishisation of home and SUV ownership,’ led to debt-financed consumption through asset bubbles (housing and stocks) that inevitably collapsed. Rapidly falling rates of global trade should be seen as symptomatic, not causal. The potential for social conflict arising from a slowdown or reversal of growth and development in densely populated emerging economies (the so-called BRICs: Brazil, Russia, India and China) and its regional spill-over, however, is regarded as high. Policies promoting domestic consumption rather than export growth could buffer some of these threats, and is being pursued aggressively by China.

It has further been argued that public funding for environmental technologies and a ‘greener’ economy should not be restricted to domestic researchers, companies or suppliers. ‘Green’ protectionism could undermine efforts to achieve a post-Kyoto climate change protocol which climate scientists now say is urgently required. Such policies could also impede development of much needed new technologies, or their global diffusion, thus proving incoherent with stated policies to assist developing countries in preventing or mitigating the health-negative effects of climate change.

The global financial crisis both complicates and heightens the responsibilities for health-based arguments in trade negotiations – whether to avoid a protectionist spiral of uncertain environmental, social and economic consequences, or to ensure that efforts to complete the Doha Development round (now seen by some as a priority to avoid prolonging the global recession) is much more heavily influenced by health equity concerns and development outcomes aligned better to the Millennium Development Goals.

To summarize, there are three main arguments emanating from health and trade, all of them equivocal. First, the rationale that extended IPRs are essential to finance research and development for new drugs, especially for neglected diseases, is weak, especially given the potential of alternative financing models. Second, the growth in health services trade (e.g. private provision, private financing and health tourism) can bring economic benefits to certain sectors of the economy, but leads to inequities in access to both providers and services. Flanking policies may be able to minimize these inequities, but until these have been demonstrated as doing so, committing trade in health services (and possibly other important health-determining services) in trade treaties can have long-term negative health impacts. Third, trade liberalization more generally may be associated with greater growth and poverty reduction, thus improving health; but the relationship is dependent on pre-existing development conditions and public policies that vary by country. Increases in economic insecurity and labour market losses that result from liberalization may be offset by increased social protection measures, but such measures are less affordable if countries reduce tariffs before developing broader and more equitable forms of capturing tax revenues. Countries’ economic interests in trade are often in conflict with health interests. If health and development are to be more central to the outcomes of trade, wealthier and more powerful countries need to accord greater trade policy flexibilities to poorer developing nations.

344 See R Labonté et al 2008.
346 YP Woo, First to find bottom, first out of it, (Globe and Mail: 24 February 2009). Other analysts, however, point out that much of China’s USD 600 billion is being spent on infrastructure to sustain its urban development and export-orientation and not on more equitable domestic consumption or sufficient levels of social protection. See ‘We are humans before we are consumers’, Tu Wenwen, (Focus on Trade 145: April 2009).
347 S Evenett and J Whalley, Resist green protectionism – or pay the price at Copenhagen, in R Baldwin and S Evenett 2009.
The essential rationale is that, as Norway’s Policy Coherence Commission expressed, ‘trade is an instrument, not a goal in itself.’

**Health as a Human Right**

What possibility do arguments from human rights hold in positioning health more firmly in trade talks, or in global health diplomacy more generally? With respect to trade, some maintain that health ‘has a much stronger profile in international trade law than the protection of human rights, which is not an objective trade treaties recognize as a legitimate reason for restricting trade.’

This is not for lack of efforts to position both health and human rights more strongly in trade debates. The former UN Special Rapporteur on the Right to Health, Paul Hunt, issued several reports noting potential conflicts between trade and health rights, including *a priori* advice against agreeing to TRIPS+ provisions in bilateral treaties in light of human rights obligations to ensure access to essential medicines. Several UN Special Rapporteurs have detailed how trade liberalization, as generally negotiated, can undermine states’ capacities for the progressive realization of a number of human rights. In 1999, the UN Committee on Economic, Social and Cultural Rights expressed concerns that the underlying drivers of trade liberalization and the ensuing ‘wave of economic and corporate restructurings undertaken to respond to an increasingly competitive global market and the widespread dismantling of social security systems have resulted in unemployment, work insecurity and worsening labour conditions giving rise to violations of core economic and social rights set forth in articles 6 to 9 of the Covenant.’ It went on to specify that ‘global governance reform,’ of which the WTO is part:

…must be driven by a concern for the individual and not by purely macroeconomic considerations alone. Human rights norms must shape the process of international economic policy formulation so that the benefits for human development of the evolving international trading regime will be shared equitably.

Yet human rights, much less health rights, have been largely absent in trade treaty negotiations and missing completely in rulings on trade disputes.

One of the suggestions to bridge the trade/human rights gap, mooted by the World Commission on the Social Dimensions of Globalization and recommended more forcefully by the Final Report of the Globalization Knowledge Network of the WHO Commission on Social Determinants of Health, is to refer trade disputes based on developing countries’ development goals or human rights obligations to a panel of development and human rights experts to determine if the abrogation of trade treaty rules was necessary to achieve the stated purpose. Whether this became a parallel process within WTO dispute resolution procedures or remained a distinct and merely informing activity is a matter of debate. A less demanding reform would make *amicus curiae* briefs from health, human rights and/or development experts compulsory in such instances and a requirement on the part of dispute panel to state publicly any disagreements with these experts’ findings.

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349 PCC 45.
350 C Blouin et al forthcoming.
357 R Labonté et al 2008.
The Primacy of Human Rights

Few analysts deny the potential conflict between trade and human rights. The reforms suggested above constitute potentially ‘winnable’ global health policies that might help resolve such conflicts. A strong argument supporting these reforms as a minimal intervention lies in international law. While the relationship of human rights covenants to other treaties, such as trade agreements, is still a central debate in international law, the primacy of human rights is supported by a number of legal and scholarly texts. These include:

- Section 103 of the Charter of the United Nations, which states that in conflicts between Charter obligations and those under other international treaties, Charter obligations will prevail. The Charter specifically places human rights obligations on states in Articles 55 and 56.

- The Vienna Declaration and Program of Action (1993), which is widely regarded as a state consensus on the moral primacy of human rights over other public interests. One hundred and seventy one states proclaimed the protection and promotion of human rights and fundamental freedoms as the first responsibility of governments.358

The Vienna Declaration sits somewhat uncomfortably with the high politics of national security and economic interests. It is possible to shoe-horn both security and economics into several human rights treaty obligations; but it has also been argued that international law ‘presupposes that there is a minimum substantive normativity inherent in the international legal order, a kind of foundation or floor, grounding the aspirations and efforts of the international legal system’, and that the preservation of human life and health can be understood to comprise that floor.359 Human security, or the security of the person, is not the same as national security. It implies a different set of policy priorities and diplomacy approaches than arguments from national security alone.

References to the importance of human rights pepper many of the global health policy statements. The Oslo Declaration accepts that ‘health is a fundamental right of every human being’ and, in line with legal scholarship, that ‘life is the most fundamental of human rights, and that life and health are the most precious assets.’360 France cites its support of EU policies on ‘health as a fundamental human right’ and gives as an example its efforts with UNAIDS to eliminate travel or entry restrictions on persons who are HIV-positive.361

The UK Health is Global policy commits to including health as a section in its government’s annual human rights report362, claims to champion the rights of women with particular reference to HIV treatment and services access363 and sexual/reproductive rights364, and cautions that unfair or unethical trade can deprive workers of their ‘rights to security of employment and compensation.’365 How strongly this last sentiment motivates UK diplomacy in negotiations on the EPAs, however, remains open to debate. Thailand claims that the right to health (Article 12 of the International Covenant on Economic, Social and Cultural Rights) was the driving force behind its global health diplomacy efforts, and that this right was entrenched in Thai National Health Act of 2007.366 Brazil finds that having the right to health in its federal constitution provides a strong base for arguing health in foreign policy agendas. The Swiss Health Foreign Policy states that ‘one of its main objectives is to strengthen the global partnership for development, security and human rights

360 Oslo Declaration 1373-1378.
363 DoH Annex 28.
364 DoH Annex 42.
365 DoH Annex 60.
that has been agreed upon and implemented in the context of the UN\textsuperscript{367}, although its position on IPRs is contrary to that espoused by human rights experts.

Sweden’s 2003 legislated \textit{Policy for Global Development} is less ambivalent:

It is proposed that two perspectives permeate all parts of the policy: a rights perspective based on international human rights conventions; and the perspectives of the poor.\textsuperscript{368}

Its entire policy document references specific rights issues throughout. Similarly Norway’s Policy Coherence Commission devotes considerable attention to a human rights framing of its foreign policy. The government’s official position regarding IPRs is that access to medicines ‘must be regarded in a human rights perspective.’\textsuperscript{369} It further argues the importance of related rights to water and to food, ‘one of the most important human rights,’ chiding the international trading system and the financial institutions for emphasizing growth through agricultural export without due attention to domestic food security. Since ‘many of the poorest countries have now become net importers of food,’ the Commission points out, ‘it is time to adapt the theory to reality’ and for ‘Norway [to] support poor countries’ rights to develop food security for their own population.’\textsuperscript{370} Unlike other policy statements, it also specifically cites the right to development in relation to greenhouse gas emissions and the financing of climate initiatives, stating that these ‘must be based on countries’ historical responsibility and financial capacity, and safeguard the right to development for poor countries.’\textsuperscript{371}

This entails poor countries being given latitude to increase their emissions and rich countries financing emission reductions in developing countries.\textsuperscript{372}

\textbf{Collective Health Rights}

While these statements imply strong support for social rights under the ICESCR, it is curious to find that the speech by Norway’s foreign minister on the 60\textsuperscript{th} Anniversary of the UN Universal Declaration on Human Rights references entirely individual civil and political rights.\textsuperscript{373} These ‘negative’ rights that require freedom from state interference routinely receive media and political attention, while ‘positive’ rights that oblige states to provide for citizens are often dismissed as ‘serving no useful purpose.’\textsuperscript{374} Human rights are nominally indivisible, leading to tensions between negative and positive rights. One of Norway’s Policy Coherence Commissioners, associated with a market libertarian political party, for example, disagreed with the report’s final recommendations and insisted that:

Norway cannot… support initiatives that are aimed at strengthening the political authorities’ policy space where this has negative consequences on the individual citizen’s economic space. Norway should therefore, in a human rights perspective, support economic policy reforms and initiatives that make it easier for the poor to make use of their economic freedom, such as deregulation, debureaucratisation,  

\begin{itemize}
  \item \textsuperscript{367} FoPH 12.
  \item \textsuperscript{368} Government of Sweden 1.
  \item \textsuperscript{369} PCC 133.
  \item \textsuperscript{370} PCC 44.
  \item \textsuperscript{371} PCC 18.
  \item \textsuperscript{372} PCC 115.
  \item \textsuperscript{373} JG Støre, The 60th anniversary of the UN Universal Declaration of Human Rights: \textit{What are the dilemmas for foreign policy?} (Norway: University of Bergen: 11 November 2008). \url{http://www.norveska.ba/policy/humanitarian/9%C3%B8rne+speech.htm}. Accessed 25 March 2009.
  \item \textsuperscript{374} This claim is taken from an Editorial in the May 2007 \textit{Economist} which also and incorrectly stated that ‘social and economic rights’ were new, and that they diluted traditional civil and political rights (cited by AE Yamin, \textit{Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care.} \textit{(Health and Human Rights: 2008 10(1)) 45-63, 53}. The distinction between negative and positive rights is no longer taken seriously in international rights analysis, nor is the criticism that positive rights place undue financial obligations on states. Civil and political rights require expensive publicly funded legal systems; while economic, social and cultural rights protect individuals from state actions such as unjustifiable evictions or land appropriations.
\end{itemize}
tax reductions, strengthening of the private right of ownership regime and establishing a financial infrastructure.\textsuperscript{375}

These policy positions that the Commissioner argues do not, in fact, flow from any legal texts on human rights\textsuperscript{376}, but they do indicate how individual rights claims can be used to undermine collective rights inherent in the ICESCR. More critically, such conflicts are instantiated in human rights treaties themselves, with several instances of clear contradictions, e.g. rights of minorities to self-determination obligations of states to meet core economic, social and cultural obligations; right to free expression/prohibitions against national, racial or religious hatred; rights of minorities to enjoy their own culture/ rights of women against patriarchal cultural norms.\textsuperscript{377} More specific to health: Does the right to security of person (as one example) require a government to allow private health systems to compete with public ones so that those with the ability to pay can avoid wait-times for public care that could pose a risk to life?\textsuperscript{378}

The right to health (technically, the Right to the Highest Attainable Standard of Physical and Mental Health) has received most attention in global health diplomacy. Article 12 of the International Covenant on Economic, Social and Cultural Rights places obligations on states to ensure equitable access to a minimum set of resources required for the progressive realization of the right to health. General Comment 14 elaborates some of these resources which extend beyond basic health care services to such key underlying health determinants as ‘safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and health-related education and information, including on sexual and reproductive health.’\textsuperscript{379} These determinants also fall into a category of public goods, since their provision avoids widespread public bads. General Comment 14 further states that ‘collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.’\textsuperscript{380} While this infers there are collective rights that must be balanced within the individual entitlements, there is no clear guidance on when an individual health right claim might compromise a collective health right claim.\textsuperscript{381}

There are particular concerns about such a compromise with respect to access to costly patent drug treatments. Right to health arguments were important in Brazil’s policy to supply ARVs, issue compulsory licenses and finance the costs (for a time) through a financial transaction tax. But more recent studies conclude that civil society mobilization around the right to health in that country is less about collective rights and access than ‘a strategy of the pharmaceutical industry, to take advantage of the large number of judicial decisions granting individuals a right to receive expensive medicines this industry produces.’\textsuperscript{382} Pharmaceutical companies in Brazil were found to be paying lawyers to get patients to use that country’s right to health

\begin{itemize}
\item \textsuperscript{375} PCC 62.
\item \textsuperscript{376} Indeed, General Comment 3 on the \textit{International Covenant on Economic, Social and Cultural Rights} specifically states that ‘in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laisser-faire economy, or upon any other particular approach,’ \url{http://www. unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3. En?OpenDocument}. Accessed 25 March 2009. Classical libertarian argument holds that a distribution of goods is just if it is brought about by freely made exchanges between individuals starting from positions of equality. Any subsequent inequalities do not merit state intervention (i.e. ‘the political authorities’ policy space’) to redistribute towards greater equity. One key problem with the libertarian argument is that there is no initial starting place of equality under which exchanges can be freely made.
\item \textsuperscript{377} A Chapman, The Divisibility of Indivisible Human Rights, (University of Connecticut School of Medicine: 2008). (mimeo).
\item \textsuperscript{378} The case sometimes cited in this regard is the 2005 Canadian Supreme Court ruling that restrictions on private health care violated the right to security under one province’s (Quebec’s) constitution. The flaw in the judgement, however, did not lie in placing one individual’s right over that of the larger policy, but in accepting arguments that the existence of a parallel private system did not in any way imperil access for others in the public system.
\item \textsuperscript{379} UN Economic and Social Council, The right to the highest attainable standard of health (General Comment No. 14, E/C.12/2000/4, paragraph 11). \url{http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En}. Accessed 24 March 2009. The Comment, however, does not have the same legal force of Article 12 itself, and some countries do not accept its expanded scope.
\item \textsuperscript{380} UN Economic and Social Council paragraph 30.
\item \textsuperscript{381} S Mathews, Discursive alibis: Human rights, millennium development goals and poverty reduction strategy papers. (Development: 2007 50(2)) 76-82.
\end{itemize}
legislation to obtain high-cost medicines through the Brazilian health ministry. The cost of distributing these
drugs to Sao Paolo’s state health ministry alone (one of 26 such state ministries across Brazil) is USD 530
million annually. Pharmaceutical companies have also established so called ‘astroturf’ civil society organ-
izations in the names of different patient groups and diseases to create demands for patent drugs in other
jurisdictions, often using similarly rights-based claims.

An assessment of ‘judicial activism’ in Colombia highlights this dilemma. Since the early 1990s, Colombian
courts have ruled on ‘tens of thousands’ of health rights cases, culminating in a 2008 Constitutional Court
decision calling for a complete overhaul of the country’s mixed private/public system. On the one hand,
the preponderance of cases heard by courts concerned denial of access to services that had already been
guaranteed. The 2008 decision went further and ‘calls upon government to adopt deliberate measures to
progressively realize universal coverage by 2010’, a dramatic decision in a country characterized by en-
trenched neoliberal political ideology. On the other hand, many of the decisions, as with Brazil, were driven
by demands for access to high-cost drugs and the overall trend may ‘reinforce…1993 health reforms which
invested the majority of the health budget in individual insurance at the expense of public health promotion
and prevention.’ Cautions have also been raised that the costs of universal coverage could compromise
state obligations to progressively realize other human rights associated with important social determinants
of health, such as housing, education and prevention of gender or other forms of discrimination. This is
similar to findings from a comprehensive review of 71 right-to-health court cases in low- and middle-income
countries.

This has led some analysts to argue the right to health, based on individual claims, is a less useful tool
with respect to ensuring access to the resources that improve public health: ‘Configuring health services in
response to litigation may, ironically, give rise to further inequity, resulting in services based on the needs
of individuals or minority groups rather than populations’. In the Colombian case, while no de jure prejudice
towards higher-income individuals was found in decisions under right to health appeals, there was a de facto
inequity owing to higher-income individuals having greater resources to access judicial interventions.
The right to development is suggested as forming a more powerful logic for health rights arguments.

Health or Development/Health and Development
Adopted by the UN in 1986, the Declaration on the Right to Development defines it is a ‘comprehensive
economic, social, cultural and political process, which aims at the constant improvement of the well-being
of the entire population.’ The emphasis highlights the collective nature of this right. Several Articles imply
stringent obligations on states parties to ensure greater equality of opportunity and equity in outcome:

Article 2.3: States have the right and the duty to formulate appropriate national development
policies that aim at the constant improvement of the well-being of the entire population and of all individuals, on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting therefrom.

383  C Jurberg, Brazil probes pharmaceutical industry for building high-cost drug demand. (Intellectual Property Watch: 8 August
384  AE Yamin and O Parra-Verra, How do Courts set health policy? The case of the Colombian Constitutional Court. (PLoS
385  AE Yamin and O Parra-Verra 147-150. There is concern that the judicial decision may be undermined by an inadequate public
consultation (also ordered by the court) on the issue of financial sustainability of the health system and the need to determine cri-
teria for included and excluded services, leading to citizens returning to court orders (tutelas) to access care. See C Gianella-Malca,
O Parra-Vera, A Eli Yamin and M Torres-Tovar. Democratic deliberation or social marketing? The dilemmas of a public definitiaon of
health in the context of the implementation of Judgment T-760/08. (Health and Human Rights: 2009 11(1)).
386  AE Yamin and O Parra-Verra 147-150.
387  HV Hogerzeil, M Samson, JV Casanovas and L Rahmani-Ocora, Is access to essential medicines as part of the fulfilment of
the right to health enforceable through the courts? (Lancet: 2006 368(9532)) 305-311.
388  L D’Abmruoso, P Byass and SN Qomariyah. Can the right to health inform public health planning in developing countries? A
case study for maternal healthcare from Indonesia. (Global Health Action: 2008, DOI: 10.3402/gha.v1i0.1828).
Article 8: States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income. Effective measures should be undertaken to ensure that women have an active role in the development process. Appropriate economic and social reforms should be carried out with a view to eradicating all social injustices.\textsuperscript{389}

Some legal scholars believe that this right may actually entitle poorer countries (through their state) to make claims for assistance from higher-income nations.\textsuperscript{380} The legal status of this right remains in some doubt: Who is the claimant (individuals, groups, the state, or all three)? Is the right justiciable in law? As a Declaration rather than a Treaty, the right is non-binding on states. At the same time, the Declaration has become ‘a focal point of United Nations human rights activity concerning development and has been reaffirmed as a university human right by the international community.’\textsuperscript{391} It is considered to have more legal standing than other Declarations and has a Special Rapporteur attached to it. There have been efforts amongst health human rights lawyers to merge General Comment 14 with the right to development to create a stronger and justiciable right to public health\textsuperscript{392} or, at minimum, to advance arguments from both in interpretations of Article 12. The 2009 adoption of the Optional Protocol to the ICESCR, allowing individuals and groups to submit complaints on violations of rights under the ICESCR directly to the Committee on Economic, Social and Cultural Rights, is also thought to strengthen collective claims, particularly from ‘the most marginalized and disadvantaged, who are the most likely to see their rights violated.’\textsuperscript{393} At the same time, because the ’progressive realization’ of rights under ICESCR is acknowledged as subject to ‘resource constraints,’ this may limit the duties these rights impose on states and weaken their political utility by claimants. This charge, however, has been countered by reference to the minimum core obligations associated with such rights.\textsuperscript{394}

\textbf{International Obligations}

States are generally seen as duty-bearers in human rights treaties; and the state-centric nature of these treaties in a world in which non-state actors exert enormous policy influence has also come under criticism. However, human rights treaties attach three other duties to states parties: to respect, protect and fulfil the rights. \textit{Respect} requires that states do not actively deprive people of a guaranteed right partly achieved by ensuring that other international agreements they negotiate ‘do not adversely impact upon the right.’\textsuperscript{395} This appears to mandate a human rights impact assessment before all other foreign policy treaties or agreements, extending to the right to health. \textit{Protect} requires that states ensure that others within their jurisdiction (individuals, corporations) do not deprive people of their rights. While still state-centric, this extends obligations on non-state actors. \textit{Fulfil} requires the state to actively implement legislation, policy and programs, and create appropriate institutions, that meet the core obligations of specific rights and allow for their progressive realization. To overcome constraints on this realization due to resource limitations, especially in

\begin{itemize}
\item \textsuperscript{392} B Meier, Advancing health rights in a globalized world: Responding to globalization through a collective human right to public health, \textit{(Journal of Law, Medicine & Ethics: Winter 2007)} 545-555.
\item \textsuperscript{394} P Hunt and G Backman, Health systems and the right to the highest attainable standard of health, \textit{(Health and Human Rights: 2008} 10(1)) 81-92.
\end{itemize}
poorer countries, Article 2(1) of the ICESCR further mandates that each state party ‘take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources.’ Some legal scholars, including Paul Hunt, former UN Special Rapporteur on the Right to Health, argue that this obligates ‘developed States...to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries.’ Hunt cites international agreements on the MDGs as an affirmation of this responsibility, linking arguments from health and development to arguments from health and human rights. Hunt, amongst others, have also called for implementation of right-to-health-impact assessments of trade and other foreign policy initiatives; others have extended this by urging development of a right-to-health-and-development-impact assessment (RHDIA), bringing together key elements of the right to development, the right to health and normative commitments under the MDGs.

The use of health impact assessments as a tool in global health diplomacy is generally accepted and widely referenced in the UK’s global health policy statement, likely owing to that country’s experience with and high profile in promoting impact assessments as a ‘whole of government’ strategy. Extending this to an ‘RHDIA’ would not be difficult in theory. In practice, it could suffer from a lack of precision over boundaries or priorities. How far into the distal social determinants of health should a health impact assessment go, recognizing that the further one assesses the less precise become the causal data? With human rights, their stated indivisibility fails to address both intrinsic conflicts between certain rights and which ones, given finite resources, should be given priority by states. To be useful as a health guide in foreign policy decision-making, some reasonable ranking system is needed.

With respect to HIAs, the screening test for a HIA in England can be usefully applied to foreign policy prioritization:

- Are the potential positive and/or negative health and well-being impacts likely to affect specific subgroups disproportionately, compared to the whole population?
- This question introduces an important equity consideration.
- Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates?

This question applies to the whole population, and ‘care services’ can be extended essential health-promoting services as identified in the right to health.

Are there likely to be public or community concerns about potential health impacts of this policy change?

This question incorporates some obligation of participation by people in the policy process, without which a determination of concern cannot be made.

But rights-based arguments are not simply about health or health-care; they extend to well-being and to individual capabilities that form a base for individual and group enjoyment of health that, in turn, forms a base for the fuller enjoyment of all human rights.

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399 DoH Annex 2.
400 The claim of the indivisibility of human rights was made for political reasons in the 1960s when economic, social and cultural rights were not regarded as ‘real’ or as important civil and political rights. The intent of the claim was to emphasize the equal standing of rights under the ICESCR.
Audrey Chapman, an ethicist and human rights scholar, draws on two moral philosophers to argue the priority of some rights over others. Citing Henry Shue and his Cold War era defence of human rights in foreign policy, she identifies certain basic rights that must be met in order for other rights (no less important but temporally sequential) to be realized:

- a right to full physical security (which implies access to health resources)
- a right to subsistence (or minimal economic security) and
- a right to liberty (including the right to participate in decisions affecting one’s life).

Shue, like his mentor, John Rawls, emphasizes minimal obligations. Where that minimum level should be drawn is harder to establish, but there is an appealing clarity to the three basic categories of rights.

Martha Nussbaum, who with Amartya Sen developed a moral philosophy based on the concept of human capabilities, offers a base from which to extend Shue’s list. While Sen argues effectively for the obligations states have to provide a minimum basket of resources allowing people to develop their capabilities (and hence their health), Nussbaum attempts to identify the contents of that basket:

1. Life: being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living.
2. Bodily health: being able to have good health, including reproductive health, to be adequately nourished; to have adequate shelter.
3. Bodily integrity: being able to move freely from place to place; being able to be secure against assault, including sexual assault, having opportunities for sexual satisfaction and for choice in matters of reproduction.
4. Senses, imagination, and thought: being able to use the senses, to imagine, think, and reason – and to do these things in a way informed and cultivated by an adequate education, including but not limited to literacy and basic mathematical and scientific training. Being able to use one’s mind in ways protected by guarantees by freedom of expression with respect to both political and artistic speech. Being able to search for ultimate meaning of life in one’s own way.
5. Emotion: being able to have attachments to things and people outside ourselves.
6. Practical reason: being able to form a conception of the good and to engage in critical reflection about planning one’s life; Nussbaum recognizes that this entails protection for the liberty of conscience and religious observance.
7. Affiliation: being able to live with and toward others; to engage in various forms of social interaction; having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being including protection against discrimination on the basis of race, sex, sexual orientation, religion, case, ethnicity, or national origin.
8. Other species: being able to live with concern for and in relationship to the world of nature.
9. Play: being able to laugh, or play, to enjoy recreational activities.
10. Control over one’s environment both politically and materially, including having the right to political participation and having property rights on an equal basis with others, having the right to seek employment on an equal basis with others.

405 M Nussbaum 77-80.
Her list is extensive and imprecise. But, drawing from the International Covenant on Civil and Political Rights (ICCPR), as well as the ICESCR, Chapman maps these capabilities against what could be considered basic human rights for human capabilities:

1. The inherent right to life (ICCPR, art. 6.1);
2. Components of the right to the highest attainable standard of physical and mental health (ICESCR, art. 12);
3. Parts of the right to adequate education (ICESCR, art. 13);
4. The right to freedom of thought, conscience, and religion (ICCPR, art. 18).
5. The rights to peaceful assembly (ICCPR, art. 21), freedom of association with others (ICCPR, art. 22), and the right to take part in the conduct of public affairs and to vote (ICCPR, art. 25).
6. Equality before the law and the prohibition of discrimination (ICCPR, art. 26).

One could consider this a short list against which any foreign policy decision should be interrogated before being agreed upon; and which should inform global health diplomacy efforts that incorporate both health and its key social determinants.

With respect to the components of Article 12, Hunt in a separate analysis re-iterated the importance of such core obligations as ‘freedom from discrimination, the preparation of a comprehensive national health strategy, integrated primary health care (as set out in the Alma-Ata Declaration), and access to basic sanitation.’ He also underscored ‘the principle of “non-retrogression”,’ meaning that resources for health should only improve and never worsen. For purposes of assessment, he suggests four simple questions:

- What is the policy under consideration?
- What are our key international human rights treaty obligations?
  (Chapman’s list of the basic 6 above could suffice)
- What are our key national human rights laws?
- Does this policy have any potential right-to-health impacts?

The assessment should include consideration of policy modification or mitigating measures should any health rights obligations be negatively affected; a preliminary check-list of key questions can guide such a determination.

Chapman’s arguments for some form of ‘divisible’ prioritization of rights, together with Hunt’s core content and check-list, provide reasonable grounds for why and how ‘basic’ health and health-related human rights can be integrated within foreign policy assessment, evaluation and negotiation.

**Health and Ethical/Moral Reasoning**

Human rights codify into binding obligations what moral or ethical reasoning has posited as essential responsibilities people have to one another, imperfectly mediated through state systems. They have been called ‘the most globalized political value of our times.’ But the legalistic language and problematic individual nature of these rights has some legal and philosophical scholars claiming that without a more explicit

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408 W Austin, Using the Human Rights Paradigm in Health Ethics: The Problems and the Possibilities, *(Nursing Ethics: 2001 8(3))*, 183-95.
set of ethical principles against which decisions can be appraised, the high politics of foreign policy might always override the low politics of global health.

Arguments from values or ethics (or calling on arguments to specify moral or ethical reasoning) are not common in policy discourse.409 Values may be perceived as vague or not universal (cultural relativism) and, ever since Machiavelli's 16th century defence of power over jurisprudence in the governance of states, there is a truism that moral argument, to the extent it is invoked, is used to justify the exercise of power rather than to constrain or modify it. However, states, the people who govern them and the institutions they create (all of which constitute the actors and contexts of global health diplomacy) are moral actors. Whether or not they behave as such does not remove their capacity for, and necessity of, ethical justification for their actions.

Explicit reference to values or ethical norms is not common in global health or other policy statements, but neither is it absent. The 2008 UK National Security Strategy claims that:

Our approach to national security is clearly grounded in a set of core values. They include human rights, the rule of law, legitimate and accountable government, justice, freedom, tolerance, and opportunity for all. Those values define who we are and what we do. They form the basis of our security, as well as our well-being and our prosperity. We will protect and respect them at home, and we will promote them consistently in our foreign policy.410

Sweden’s 2003 policy describes ‘the firm conviction that everybody has a right to a life in dignity’ as ‘the basis of the solidarity with poor, oppressed and vulnerable people that has been an important element of Sweden’s domestic and foreign policies for many years.’411 The concept of human dignity is considered axiomatic in all Western (and some have posited universal) systems of moral philosophy. It also underpins the Millennium Development Goals, in that the Millennium Declaration (of which the MDGs are only one part) expresses an explicit core value of ‘collective responsibility to uphold the principles of human dignity, equality and equity at the global level,’ requiring of political leaders (those who ultimately sign off on diplomatic efforts) ‘a duty...to all the world’s people, especially the most vulnerable’ (Article 2)412.

Human rights scholars, in turn, argue that a concern for the ‘equal dignity of the human person’ forms the base of all human rights, and represents a core moral value.413 Feminist philosophers have displaced somewhat the notion of the individual human person with the concept of, at minimum, dyadic or larger familial

410 Cabinet Office 6.
411 Government of Sweden 19.

Freedom. Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice. Democratic and participatory governance based on the will of the people best assures these rights.

Equality. No individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.

Solidarity. Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.

Tolerance. Human beings must respect one another, in all their diversity of belief, culture and language. Differences within and between societies should be neither feared nor repressed, but cherished as a precious asset of humanity. A culture of peace and dialogue among all civilizations should be actively promoted.

Respect for nature. Prudence must be shown in the management of all living species and natural resources, in accordance with the precepts of sustainable development. Only in this way can the immeasurable riches provided to us by nature be preserved and passed on to our descendants. The current unsustainable patterns of production and consumption must be changed in the interest of our future welfare and that of our descendants.

Shared responsibility. Responsibility for managing worldwide economic and social development, as well as threats to international peace and security, must be shared among the nations of the world and should be exercised multilaterally. As the most universal and most representative organization in the world, the United Nations must play the central role.

413 AE Yamin, Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care. (Health and Human Rights: 2008 10(1)) 45-63.
and social relations. Dignity and the security of the person cannot be removed from the web of relationships in which persons exist and obtain both meaning and capabilities.

Health, in turn, is argued as having special importance to an individual’s experience of security or dignity. The reasoning for this lies, first, in health as basic to peoples’ enjoyment of other rights or capabilities; second, in the role health plays in the social and communicative rituals of most cultures (in greetings, toasts, celebrations), hence in sustaining social cohesion; and third, in provision of resources for health being prone to market failures thus requiring collective forms of intervention. These instrumental arguments are accompanied by an ‘ethical principle of human flourishing or human capability’ with roots in Aristotelian political theory and Sen’s and Nussbaum’s capabilities approach; health is both ‘intrinsically and instrumentally valuable.’

Defining ‘health’, however, is always contentious, not made any easier by the WHO’s troubling addition of ‘complete’ in its somewhat circular reference to health as ‘complete physical, mental and social well-being.’ Various studies of health definitions agree that the term incorporates physical, psychological and social characteristics (some now urge the inclusion of a spiritual dimension); and that these can be measured both subjectively (individual perception) and objectively (consensually agreed upon metrics or deviations from accepted norms of functioning). The scope of the potential meanings of health makes consensus on its ‘positive’ expression, apart from self-reported health, elusive. Its absence is usually easier to gauge than its presence, although disease and disability (the usual measures of its absence) do not preclude people from experiencing health (especially its psychosocial qualities). Nonetheless:

The important elements of the concept of health that we might take from [its many] definitions are: (1) perception and meaning (health is as much what is experienced as what can be measured), (2) social relations (health is embedded in human networks and interactions), (3) capacities/capabilities (health is a product of many intrinsic and extrinsic resources) and (4) physical functioning (health is embodied and not simply imagined).

These elements of positive health are similar to four principles argued by a health promotion philosopher, David Seedhouse, as the foundation for an ethically sound model of health:

- A core respect for the autonomy of individuals;
- A focus on the central conditions in people’s lives that support such autonomy;
- Prevention of disease, illness, injury and disability;
- Prevention of obstacles in the way of achieving the previous three conditions.

The first principle maps easily against traditional biomedical ethics. The latter three extend biomedical ethics to, respectively, social conditions (the determinants of health), socially desirable outcomes (the ‘special importance’ of health in people’s lives) and social obligations. As a group they resonate with Sen’s and Nussbaum’s arguments in support of capabilities and the importance of ‘freedom of choice’ to live a valued life; and with human rights obligations with respect to removal of constraints on the achievement of such capabilities, including the provision of core resources for their expression.

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418 Biomedical ethics are generally founded on the following principles: beneficence (a practitioner should act in the best interest of the person); non-maleficence (‘first, do no harm’); autonomy (the person has the right to refuse or choose their treatment); justice (equity in the distribution of scarce health resources); dignity (the person and practitioner both have to the right to be treated with dignity); and truthfulness and honesty (informed consent). Their limitation is that they deal with dyadic (practitioner/patient) relationships and ignore social inequities in access to health and to the remediation of disease.
Arguments from Social Justice Theory

As soon as the issue of resources arises, so do matters of social justice in how fairly resources are allocated amongst peoples and (from a global health diplomacy perspective) countries. Social justice theory is generally associated with Western societies, and particularly with struggles surrounding the industrial revolution and the emergence of socialist, social democratic or other models of redistributive welfare states: ‘Social justice is not possible without strong and coherent redistributive policies conceived and implemented by public agencies.’419 Social justice theory is essentially concerned with equity, or fairness. On this basis, it is argued that social justice (equity) is a universal concern, since all social arrangements, to be legitimate and to function at all, must have attend to issues of equality.420

But there are subtleties to how equity is conceived with two main dimensions: equality of opportunity, achieved through procedural justice or ‘horizontal equity’ in which equals are treated the same; and equality of outcome, achieved through substantive justice or ‘vertical equity’ in which people are treated differently according to their initial endowments, resources, privileges or rights. Both equalities (opportunity, outcome) are ideal types; neither exists in ‘true’ form, or is likely ever to exist.421 They represent aspirational ideals of what societies strive to create for their members (fairness in outcomes) and how they believe this should be accomplished (fairness in opportunity). Both equalities offer an analytical lens by which foreign policies, and their health impacts, can be assessed.

There is a political, as well as philosophical, difference in these two broad argumentative streams. In the first instance, recent decades of global market integration and the collapse of socialism have truncated social justice to economic justice. In turn, proponents of more open markets and conventional approaches to growth and development emphasize equality of opportunity, with only a residual nod towards equality of outcome. This was the position taken by the 2006 World Development Report, which was less supportive of post-market income redistribution to achieve greater equality, instead favouring greater individual equality of opportunity through inter alia ‘equality before the law, equal enforcement of personal and property rights, non-discriminatory institutions, and equal access to public services and infrastructure.’422 The slight nod to a concern with outcomes was reference to avoidance of absolute deprivation.

Moral arguments underpinning a superordinance of procedural over substantive justice have strong root in Western theories of liberal individualism; but not without some tempering. Adam Smith, in his Wealth of Nations, famously argued for some form of state intervention to moderate the market’s ‘invisible hand,’ extending beyond the World Bank’s welfare minimalism:

By necessaries I understand not only the commodities which are indispensably necessary for the support of life, but whatever the custom of the country renders it indecent for creditable people, even of the lowest order, to be without.423

For Smith’s time and place, this meant a linen shirt for even the poorest worker. While often invoked in defense of free markets (and minimal state intervention), Smith was ‘deeply concerned about the inequality and poverty that might survive in an otherwise successful market economy’ and ‘the strong need for actions based on values that go well beyond profit seeking.’424

While he wrote that ‘prudence’ was ‘of all the virtues that which is most useful to the individual … humanity, justice, generosity, and public spirit, are the qualities most useful to others.’425

419 IFSD 6.
421 Equality of opportunity, based on procedural justice, can be argued as easier to accomplish since it is not subject to individual choice or biological differences that, with respect to health, would make ‘true’ equality of outcome impossible.
425 A Sen, Capitalism Beyond the Crisis, (2009).
Moral defense for some mitigation of social inequalities is a recurrent theme in much contemporary Western philosophy. Singer, in a utilitarian vein, posits ‘a Greater Moral Evil Principle:’ it is both just and of collective benefit to act to relieve poverty and deprivation if, in doing so, we do not sacrifice something of comparable moral significance.428 Around the same time Rawls published his highly influential Theory of Justice. Standing behind a ‘veil of ignorance’ as to their social standing at birth, people would choose a justice that guaranteed a minimum of primary goods that any rational person would choose as basic to their needs. This justice theory then builds upon two principles: The first principle is the ‘priority of the equal’ (basic liberties), which roughly equates with negative civil and political rights; the second principle is based on legal equality of opportunity, which roughly equates with positive economic, cultural and social rights. But the second principle also demands the ‘difference principle:’ inequalities in social and economic goods (‘primary goods’) are allowable only to the extent that they improve the lot of the least advantaged, compared to what their lives would have been like without such inequalities. The difference principle obliges a degree of state interventions of redistribution and regulation, although Rawls did not believe that the extreme differences in wealth and power that markets create was of moral concern provided the conditions of the least advantaged also improved.427 Rawls also emphasized the centrality of better procedural justice. The difference principle did not demand excessive forms of state involvement for substantive justice, if social rules were designed to ensure some degree of vertical equity, such that social spending is greater for those with more need or fewer ‘native endowments.’428

Rawls’ justice theory is located within the ‘social contract’ school, which views states as the primary actors in international relations, consistent with dominant international relations theories and the classic hierarchy of foreign policy goals. It elides with a particularist justice perspective in which communities (or nation-states) with shared meanings and practices set the political boundaries for moral arguments: there are no universal moral principles of justice; only those relative to particular peoples and places.429 Pogge challenges this by drawing on cosmopolitan arguments and the existence of human rights treaties.430 Cosmopolitanists (which include Singer, Sen and Nussbaum) hold that ‘the ultimate units of moral concern are individual people, not states or other particular forms of human association.’431 Rather than reduce moral concerns to one of immediate-others (and a devolution of political decision-making to the most decentralized level possible), Held, another cosmopolitanist, argues that the existence of national or local decision-making having trans-local effects requires ‘political institutions [to] not only be locally based but...have a wider scope and framework in order to respect the inclusion and agency of ‘people who are significantly affected by a political issue in the...transcommunity public...sphere’432. Pogge weds this argument to a claim that human rights

427 This is similar to arguments that a ‘pro-poor’ policy is one that decreases poverty by any degree, even if it dramatically increased inequality. Instrumentally, there is evidence that the efficiency of growth decreases with rises in income inequality, and that growth itself may slow; although growth also slows when incomes become too equal (see G Cornia and J Court, Inequality, Growth and Poverty in the Age of Liberalization and Globalisation, Policy Brief 4. Helsinki : United Nations University WIDER: 2001). Whether growth should be the metric by which health equitable development is measured remains a separate and debatable issue. Morally, and by reference to the importance of human agency that is fundamental in most justice theories, to the extent that inequalities beyond a certain degree preclude least advantaged groups from functioning with perceived and actual capabilities, they become ethically indefensible. Rawls’ indifference to matters of escalating inequalities is one source of criticism of his moral philosophy, as was his initial exclusion of health care (and by extension other resources for health) as primary goods and his inability to propound upon patriarchal injustices reproduced within familial relations.
428 DL Schaefer, Procedural versus substantive justice; Rawls and Nozick. (Social Philosophy and Policy; 2006 24)164-186. Schaefer’s choice of these two moral philosophers is intentional, since Rawls is associated with arguments for state intervention to ease the conditions of the least advantaged, hence substantive justice; while Nozick is associated with arguments based only on procedural justice in which distributive differences between individuals are morally irrelevant if the means by which they were achieved were fair (equality of opportunity). Schaefer contends that Nozick’s ‘entitlement’ theory of justice is undermined by his acknowledgment that unfairness in initial conditions experienced by people (created by a lack of procedural justice in the past) demands ‘the principle of rectification,’ requiring the use of Rawls’ difference principle to warrant some form of state intervention for redistribution.
432 Held 471.
constitute a universal moral standard for all individuals. In doing so, he extends Rawls' basic justice theory to a global level, contending that there are not simply 'positive duties' to assist (setting aside debates as to the level to which such assistance should rise), but moral obligations (negative duties) to prevent harm. Pogge's theory of relational justice is based on three lines of argument:

1. The radical inequalities observed between peoples and nations today are partly an effect of a violent history in which some gained at the expense of others. While we individually cannot be held responsible for the actions of our forebears in this 'conquest,' as moral persons we can be held accountable for rectifying the vast disparities in initial conditions that this history has created.

2. Not only does procedural justice by itself fail to account for these vast disparities in initial conditions; it is impossible to conceive of these disparities existing on the scale that they do without 'an organized state of civilization' to uphold them. Both procedural and substantive injustices thus endure.

3. There is evidence that economic institutions operating on an international scale (the 'organized state of civilization') have been complicit in upholding these injustices. There are also feasible alternatives to these economic institutions that would reduce the 'radical inequality' of persisting poverty. Persons involved in upholding these institutions are thus implicated in creating subsequent ill health, even though they may be half-way around the world.

Pogge concludes that: 'we are harming the global poor if and insofar as we collaborate in imposing an unjust global institutional order on them;' and proceeds to offer an evidence-informed argument to establish that present global institutional rules and procedures are unjust. The moral implication is one of immediately engaging in 'rectification' through strengthened human rights and more progressive systems of global resource redistribution; but also an obligation to change the rules by which the very rules of economic governance is established in order to overcome the historic and radical inequalities in initial conditions.

**Ethical Process and Global Health Diplomacy**

If our moral concerns with radical and health-compromising global inequalities in resource and power begin with differences in peoples' initial conditions, the distinctions between equality of opportunity (procedural justice) and equality of outcome (substantive justice) begin to lessen. Equality of opportunity, to be just, requires vertical equity: a disproportionate provision of public goods and capability resources for those whom history's conquests, and today's political institutions, place in highly unequal initial conditions. Departing from the redistributive minimalism of the World Bank's 2006 World Development Report, a later report of the Bank's Latin American Development Forum argues that:

A better understanding of the importance of inequality of opportunity in the determination of inequality of outcomes may change attitudes towards redistribution. People dislike and consider unfair inequalities associated with differences in circumstances, which many argue should be compensated for by society. By highlighting that component of inequality attributable to circumstances, this type of analysis...
can help build a social and political consensus on both the necessity of the best means for addressing inequality of opportunity.437

What becomes morally important in a conception of global health equity is that all people have ‘equal realization of their health potential,’438 a sentiment essentially similar to the ‘right to highest attainable standard of physical and mental health.’ But what remains at issue is the extent of moral (or legal) obligation for amelioration of gross inequalities in initial conditions that create ‘shortfall inequalities in central health capabilities.’439 Is there an ethically defensible scale of rectification?

There is no answer to this question, apart from the imperative to seek an answer. In this quest, norms of procedural justice become important. Boggio, in an argument for why international organizations and those within them have an ethical obligation to act to redress systematic health inequalities, addresses how such policy decisions can be made in a just manner. He identifies three basic principles for an ‘ethically-informed deliberative process’: publicity (transparency in process, a comprehensible rationale, and public argument and evidence); relevance (trust in actors/institutions by recipients, opportunity for wide participation, and interventions based on recipients’ needs, values and aspirations); and revisability (policies and programs can be challenged over time and improved, and individuals and institutions can be held accountable to purpose).440 Several of these conditions are similar to principles of good governance widely held by governments and multilateral organizations; that is, they can be considered as having a broad normative base.441

Citing Daniels, Boggio concludes that ‘ethics require “that there is a space for deliberation in which reasonable people will disagree about what is ethically required, either from a human rights perspective or from other ethical conceptions”.’442 These procedural elements of ethical decision-making, developed to apply to international institutions, could apply equally to negotiations encountered in global health diplomacy. These procedural elements, however, do not and should not reduce to communitarianism, in which the distributive norms and values of a community or society are taken as absolute regardless of their form, as long as there has been some deliberative space for sharing of differing conceptions of the ‘good life’ and ‘justice’ in their historic development. Such relativism would deny the powerful and evidence-informed justice arguments brought forward by Sen, Nussbaum and Pogge, amongst others.

Conclusion

Global health is an increasingly prominent challenge to foreign policy deliberations. How should this challenge be framed? The assumption underlying this paper’s examination of differing global health discourses is that each one sets the boundaries of problem-definition and intervention. In that sense, each global health discourse examined has limitations but all have something strategic to offer. To summarize:

- **Security** gives global health interventions greater traction across a range of political classes than a rights-based argument alone. To the extent that this strengthens a base of public health expansion, securitisation of health may be a prerequisite to its eventual de-securitization. But vigilance is needed to avoid national security from trumping human security.

- **Development** remains the invitation to global governance debates. It provides a seat at the table. Risks inherent in its ‘investing in health’ instrumentalism can be tempered by continuously reminding decision makers to distinguish which one is the objective (human development) and which one the tool (economic growth). The accountability advocacy of international NGOs continues to pressure

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437 RP De Barros, FHG Ferreira, JRM Vega and JS Chanduvi, *Measuring Inequalities of Opportunities in Latin America and the Caribbean*, (Washington: The World Bank: 2009) 50. Ameliorating inequalities of opportunity through ‘universal provision of basic opportunities,’ which the report argues is ‘a valid and realistic social goal’ (3) requires taxes and transfers that amount to a redistribution of income and resources. and not merely a guarantee of procedural justice.

438 JP Ruger 431.

439 JP Ruger 431.


rich nations to move beyond the inadequate patchwork of broken aid promises to a global system of taxation and redistribution.

- **Global public goods** provides a language by which economists of one market persuasion can convince economists of another that there is a sound rationale for a system of shared global financing and regulation.

- **Trade** can improve health through global market integration, economic growth and positive health externalities. However, present trade rules skew benefits towards more economically and politically powerful countries; and evidence of negative health externalities demands careful *a priori* assessments of trade treaties for their health, development and human rights implications.

- **Human rights**, though weak in global enforcement, has advocacy traction and legal potential within national boundaries. Such rights do not resolve embedded tensions between the individual and the collective, an issue to which human rights experts are now attending.

- **Moral/ethical reasoning** is suggested as a necessary addendum to the legalistic nature of human rights treaties. This need, in turn, has created scholarly momentum to articulate more rigorous argument for a global health ethic based on moral reasoning. Competitors for such an ethic range from a liberal theory of assistive duties based on ‘burdened societies’ in need, to an emphasis on minimum capabilities needed for people to lead valued lives, to more recent arguments for a new ethic of relational justice.

A moral language, while requisite, is insufficient in itself as a global health discourse. Legal language is also needed and remains best provided in human rights covenants. Neither moral nor legal discourse (in the absence of enforcement mechanisms) is necessarily compelling as an economic or political rationale. Economically, both the global public goods and development discourses have some utility in policy debates, but only if they are located beneath a penumbra of ethical reasoning and legal obligation. Otherwise the risk exists that these discourses will lead to a triaging of foreign policy or global governance decisions that reflect the interests of wealthier nations. Politically, the security and trade framings are the most potent but remain the most problematic.

None of the countries examined fully meet the implicit or explicit intentions of their policy statements or commitments. That should not be surprising; policy reach always exceeds *realpolitik* grasp. The UK offers perhaps the most detailed policy arguments, as well as the most robust evidence-base against which to appraise them, the latter a testament to degrees of public service openness and a strong civil society and academic network keeping it so. In terms of examination of coherence in light of development (and via development, global health) equity, Norway and Sweden offer the most detailed accounts. While behavior has not always followed analysis, as with the UK there is openness in critique and review. The positions adopted by Brazil and Thailand, while less fulsomely developed in text, appear most consistent with policies that would promote global health equity. That global health equity empirically demands degrees of economic and trade-related special and differential treatment towards these, and other developing, countries aligns domestic policy interests with foreign policy objectives more closely than with economically advanced high-income countries.

While these differing policy frames offer multiple rationales for positioning health higher in foreign policy debates, what are the prospects that ‘global health diplomats’ will succeed in capturing more of the foreign policy turf? In partial answer, Fidler offers three conceptualizations to clarify global health’s recent rise in foreign policy prominence: revolution, remediation and regression443.

*Revolution* argues that health’s increasing role in foreign policy is transformative of the health-foreign policy nexus. Health collapses the traditional distinction between high and low politics and provides new political space in which health is an overriding normative value and the ultimate goal of foreign policy. This conceptualization is consistent with health as a human right informed by moral/ethical reasoning.

Remediation asserts that health’s rise as a foreign policy issue reflects the continued reality of the traditional hierarchy of foreign policy functions. Health has become another issue that needs to be addressed through traditional approaches. It does not transform thinking and is not an overriding norm, and has risen as a foreign policy issue only because it threatens the high politics of national security and material interest. This conceptualization resonates most with health as security and, to some extent, health as development and as tradable commodity.

Regression views health’s integration into foreign policy as an indicator that health problems are getting worse. The increasing attention paid to health across the functions of foreign policy signifies the failure of public health efforts and a short-term need for some improvement to simply ‘stay the course.’

This paper’s review of existing policy and practice presented in this article largely concurs with the remediation conceptualization, consistent with the realist theory that states act in their own interests in the international arena. Self-interest, however, cannot entirely account for foreign policy practices and certainly not for several of the global health policy claims. There is a disjunction between policy and practice in many instances, and inconsistencies within some of the policies themselves; but there is also argument offered that cautions against such lack of coherence. To the extent that discursive framings create an enlarged space for policy debate, an opening exists for global health equity to become more central in foreign policy deliberations. But, while there may be an implicit revolution in the rhetoric of global health, follow-up practice remains too constrained to claim that health has achieved status as a super-ordinate global norm. There is also risk that the global financial crisis of 2008, and the public debt-financed bailouts and countercyclical spending of high-income countries, will reduce these nations’ appetites for foreign policy goals apart from retaining a modicum of conventional economic stability.

There nonetheless remains some cause for optimism that global health will retain its prominence in foreign policy. Spain has announced that its EU presidency in the first half of 2010 will focus on issues of global health equity, coherence and knowledge; the WHO continues to emphasize the health risks of unregulated global financial markets; and the transition from the G8 to the G20 (while still fraught with issues of economic elitism in global governance) incorporates some countries with stronger histories of rights-based approaches to health. Global health is well-positioned to influence how globalization re-emerges from its present economic crisis; but how well it accomplishes this will partly be determined by the capacities and skills of its health diplomats, and the policy framing arguments they choose to emphasize.
Appendix: Checklist of Key Questions, Rationales, Overlaps and Conflicts in Global Health Diplomacy

Arguments from Security

Unchecked disease can lead to economic decline, failed states and domestic/ regional conflict, posing national security risks and economic costs (or loss of future gain) with knock-on health effects in countries not directly affected by the disease.

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<tr>
<td>What is the likelihood that unchecked disease in a foreign country/region will lead to economic decline, failed states and domestic or regional conflict?</td>
<td>Such costs come at the expense of domestic expenditures protecting health.</td>
<td>Development arguments</td>
<td></td>
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<td>What are military and financial implications of such conflict in peacekeeping or other possible intervention costs?</td>
<td>Economic benefits, especially if equitably distributed, improve population health and future economic performance.</td>
<td>Trade arguments</td>
<td>Development arguments based on health need and international development commitments.</td>
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<tr>
<td>What are the economic implications of such conflict in trade losses (whether as an export market for domestic goods or as a source of imports of benefit to domestic consumers)?</td>
<td>Where convergence of interests can be found, cross-government support for global foreign health is more likely.</td>
<td>Trade arguments</td>
<td>Development arguments based on health need and international development commitments.</td>
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<tr>
<td>What is the strategic importance of the country/ region to other foreign policy interests?</td>
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<td>Trade arguments</td>
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Global health security requires response to disasters and conflicts based upon scale and urgency, which may not always cohere with media accounts or with other foreign policy strategic interests.

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<tr>
<td>What is the scale and urgency of the health crisis arising from disaster?</td>
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<td>Is attention on the disaster region driven more by media than by scale and urgency?</td>
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<td>Is attention on the disaster region driven more by other foreign policy strategic interests than by scale and urgency?</td>
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<tr>
<td>What is the scale and urgency of the health crisis arising from conflict?</td>
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<tr>
<td>Is attention on the conflict region driven more by media than by scale and urgency?</td>
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Is attention on the conflict region driven more by other foreign policy strategic interests than by scale and urgency?

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<tr>
<td>How will the foreign policy under consideration affect the risk of pandemic disease through: the movement of people or goods an increase in the risk of MDR-XDR forms of disease anywhere in the world changes in the climate increasing the risk and range of infectious disease and/or a decrease in the capacity of nations, and especially those at high-risk of being source points for a pandemic, to prepare through effective monitoring, reporting, emergency responsiveness and access to essential medicines?</td>
<td>National health security now requires global health security which, in turn, is only as strong as its weakest link. The implication is a national self-interest to strengthen weak links.</td>
<td>Human rights arguments</td>
<td>Trade policies with respect to trade in weapons, especially small arms.</td>
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Similar to those respecting unchecked disease but also: obligations “to... ensure respect for these Conventions under all circumstances” (Article 1 of the 1949 Geneva Convention) and “in situations of serious violations … to act, jointly or individually, in co-operation with the United Nations and in conformity with the United Nations' Charter” (Article 89 of the 1977 Additional Protocol I). Both Articles imply consideration of non-forceful intervention to prevent, amongst other violations, attacks on things essential for the survival of the population, including health care facilities, food supplies, drinking water installations and irrigation works.

Global health security requires global interventions to reduce the risk of pandemic disease through increased movements of people and goods, changes in infectious disease range and increased capacity of probable point-source countries to confine outbreaks.
Global health negotiations, while usually topic-specific, should consider the impacts on both national and global health security of foreign policies that may be ‘off-topic’.

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<tr>
<td>What are the potential health risks of the foreign policies of other countries?</td>
<td>The foreign policies of countries with which one is negotiating for health purposes may pose health risks (however indirect) to one’s own country or countries of strategic or development importance. For purposes of greater policy coherence, these should be identified and potentially form part of the negotiation.</td>
<td>Human rights arguments, particularly with respect to whether such policies limit another country’s capacity for progressive realization of human rights entitlements; also development arguments, and a country’s abilities to meet or progress rapidly towards Millennium Development Goals and targets.</td>
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**Arguments from Development**

Global health security is premised on improving human security. Human security requires ensuring capacities to prevent or treat disease problems. Assistance for development should achieve a better balance between diseases of national security importance (e.g. pandemic influenza) and global burdens of disease affecting the world’s poorer populations.

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<tr>
<td>All foreign policy decisions should be scrutinized for the probable effect on another country’s ability to meet or make consistent and substantial progress towards the Millennium Development Goals.</td>
<td>The MDGs constitute a global compact amongst the world’s nations to lessen poverty and health-related barriers to development with defined goals and targets. While all MDGs have important bearing on health, several are regarded as health-specific. Progress on these health MDGs has lagged, with the goals and targets unlikely to be met by many countries. Donor assistance must be scaled-up and other foreign policy goals (related to security or trade) examined in relation to achievement of the MDGs.</td>
<td>Global public goods arguments, human rights arguments.</td>
<td>‘High politics’ foreign policy goal to protect the immediate security of one’s own citizens, followed by economic interests related to trade.</td>
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Increased health development assistance is required for prevention and intervention into chronic, non-communicable diseases if the global burden of disease facing poorer countries, and their economic and social costs, are to be reduced.

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<tr>
<td>How are foreign policy efforts aiding developing countries in increasing their chronic disease prevention efforts?</td>
<td>The MDGs and other global health initiatives focus primarily on infectious disease. Chronic disease is eclipsing infectious disease in many low-income countries creating additional burdens on development.</td>
<td>Economic interests related to trade in health-damaging products (including tobacco, alcohol, energy-dense low nutrient foods and hazardous goods)</td>
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Health development assistance can improve receiving countries’ economic performance creating trade-related economic benefits to donor countries.

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<tr>
<td>What are the historic and the anticipated trading relationships with countries in need of health development assistance?</td>
<td>Health aid improves a country’s overall economic and social development with potential positive economic externalities for donor countries.</td>
<td>National security, economic interests</td>
<td>Health aid as normative commitment (MDGs), human rights obligation and moral/ethical reasoning.</td>
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Health development assistance, to continue receiving public and political support, needs to show results; but such results must incorporate long-term health system strengthening and improvements in social determinants of health and not simply short-term disease-specific gains.

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<tr>
<td>What are the historic and the anticipated health gains in countries in need of health development assistance?</td>
<td>The ability to show results to sustain political and tax-payer support for development assistance may be necessary. This requires careful delineation of results and measures of health gains (which may be slow in showing improvements, particularly in least-developed or fragile-state countries) to avoid a triage of support by short-term results or more capable/less-needy nations.</td>
<td>Health assistance by burden of disease need, health aid as normative commitment (MDGs), human rights obligation and moral/ethical reasoning.</td>
<td>National security and economic interests.</td>
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Wealthier countries with private and public investment portfolios can improve health development in poorer countries if such investments are managed to balance better profit needs of investors with health promotion needs of recipient countries.

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<tr>
<td>How does a country’s foreign investment policy affect the health and development potential of least developed, low- and middle-income countries?</td>
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### How can public supports to foreign investors promote health improvements through equitable and environmentally sustainable economic growth in developing countries?

Aid flows constitute a small portion of global financial flows. Though other financial flows (notably foreign direct investment) are likely to slow down due to the global credit crunch, such investment (properly regulated and directed) can benefit a country’s economic development, growth and health.

### How can publicly managed investments (pension funds, sovereign wealth funds) promote health improvements through equitable and environmentally sustainable economic growth in developing countries?

Economic interests; these interests may already be part of regional and bilateral trade agreements which limit performance criteria on foreign investments and/or protect investor rights against future policies states may enact to improve the health, well-being and economic conditions of its citizens.

### Enabling migration to high-income countries of lesser-skilled persons from low-income countries can improve health and economic development in those countries through remittances and may meet labour market needs in high-income countries. The flow of highly skilled workers, notably health workers, has largely negative health effects for low-income countries.

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<td>How does migration policy affect global health development?</td>
<td>Increasing migration of lesser-skilled workers from low-income countries can aid health and development through remittances while meeting high-income labour needs. Migration policies biased towards highly skilled workers from low-income countries, particularly health workers, can undermine health and development in the source country despite the value of remittances.</td>
<td>Human rights arguments</td>
<td>For high-income countries: economic interests; health security of citizens (access to health care providers filled by émigré health workers); and gaining public support for policy favouring lesser-skilled migrants in times of higher unemployment. For low-income countries: economic interests (remittances) vs. health care access (loss of health workers).</td>
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### Arguments from Global Public Goods

Public goods in the form of public health interventions are important in reducing the burden of communicable disease, and are cost-effective.

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<td>What is the balance in donor assistance between health care and public health prevention? Should the balance be increased more towards public health prevention?</td>
<td>To the extent that this reduces the risk of cross-border disease transmission and improves the economies of developing countries, it also constitutes an arguable form of global public good. Yet funding for such goods lags considerably behind funding for specific disease interventions, or for health care. Some evidence for a 90/10 balance exists (i.e., at least 10 percent for public health programs providing public goods).</td>
<td>National security, development and human rights arguments.</td>
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Increase in the strength and reach of intellectual property rights compromises the ability of countries to cooperate in the supply of global public goods.

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<tr>
<td>What different reward mechanisms for new drug development based on global systems of virus- and other knowledge-sharing exist to avoid claims of intellectual property rights preventing the supply of a global public good?</td>
<td>The global risk of pandemic influenza is potentially very large. Its prevention demands international cooperation. That cooperation rests on mutual benefits which the use of IPRs can prevent.</td>
<td>National security, development and human rights arguments.</td>
<td>Economic interests, trade policies related to IPRs.</td>
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Too strong a commitment to evidence-based policies in global health can stall essential policy actions in areas of global public good importance (e.g. prevention of climate change) where a priori evidence is likely to be weak.

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<tr>
<td>How important a role should scientific health evidence play when available evidence is equivocal, but the global health risk is great?</td>
<td>The ability to provide evidence is an important asset health brings to global foreign policy. However, evidence is often equivocal or only available post hoc, requiring (a) agreements on how ‘weak’ evidence should be used in urgent cases (taking into account the precautionary principle) and (b) an understanding of when evidence-based arguments may not form the strongest rationale for health diplomacy.</td>
<td></td>
<td>Economic interests</td>
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Global health conventions remain ‘soft law’ though they have persuasive force within countries. The time and effort involved in creating such conventions may dissuade their future pursuit, despite their public good effect, unless there is public (civil society) support, strong evidence and a group of like-minded countries willing to initiate the process.

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<tr>
<td>How strong is the public, country and evidence momentum for initiating new rounds of global health conventions covering other global public goods?</td>
<td>Global trade and investment in alcohol and unhealthy foods are associated with increased burdens of disease related to alcohol abuse and poor dietary environments and choices. There are public health arguments for strengthening global efforts to reduce the health harms associated with these products. It is not clear if there is sufficient country, civil society and evidence support at this time; but this could change.</td>
<td></td>
<td>Economic interests, trade policy</td>
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### Arguments from Trade

*Diffusion of health technologies through global trade or exchange has contributed greatly to worldwide health improvements and, hence, global health and national security.* Trade in health goods and services can also have negative consequences with respect to equity in access.

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<tr>
<td>How will negotiations to improve a country’s economic interests in health services trade affect access to those services in trade partner countries?</td>
<td>Evidence suggests that equity in health service access improves with the breadth and depth of risk-pooling and extent of public regulation. Private financing is best left to ‘top-ups’ for wealthy individuals, and private provision (profit or not-for-profit) should be carefully regulated under public contracts. The growth of unregulated commercialization of health services, partly aided through trade, has been costly, ineffective and worsened inequalities. Experimentation in trade in services may be desired, but committing to liberalize such services in trade treaties without a full assessment of its long-term health equity effects should be avoided. Public consultations with civil society organizations can strengthen the negotiation position to ‘carve out’ such services from trade treaty commitments.</td>
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<td>Economic interests</td>
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<tr>
<td>How will efforts to promote trade in health services affect access to those services in one’s own country?</td>
<td>‘Health tourism’ can promote economic growth and, potentially, reduce the migration of health workers in search of greater practice opportunity. But private health care provision to foreign consumers can also squeeze out providers in public systems to citizens, worsening access for national residents, especially poorer groups less able to afford private care.</td>
<td>National security, development and human rights arguments</td>
<td>Economic interests</td>
</tr>
<tr>
<td>How will efforts to promote trade in health and important health-determining services (such as water and education) affect country obligations under human rights treaties?</td>
<td>The progressive realization of several important human rights treaties (to health, to water, to food, to development) may be in conflict with progressive liberalization obligations under the General Agreement on Trade in Services. A full assessment of human rights obligations potentially affected by all trade treaty negotiations (not simply those covering services) should precede any commitments and guide new trade proposals.</td>
<td>Development and human rights arguments</td>
<td>Economic interests</td>
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*Increased imports of health-damaging products (e.g. tobacco, alcohol, unhealthy foods) are generally associated with increased health harms. Efforts to control such trade may conflict with trade treaty obligations.*

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<tr>
<td>How can regulatory efforts controlling the abuse of unhealthy products avoid conflicts with obligations under trade treaties?</td>
<td>Governments have an interest in protecting citizens from health hazards, including those associated with dangerous products or abuse of products causing health harm to self or others. Evidence shows that restricting access to such products via pricing and availability can reduce population health harms. But if such regulations restrict imports in ways that discriminate favourably towards domestic products (whether or not that was their intent) they are likely to be seen as protectionist under various trade rules. This demands careful efforts to ensure that regulatory restrictions are framed entirely as health protective measures, and demonstrate that they are least trade-restrictive.</td>
<td>Global public goods and development arguments; possibly domestic economic interests</td>
<td>Foreign (possibly also domestic) economic interests</td>
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How can trade treaty negotiations be undertaken to avoid regulatory conflicts in the future?

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<tr>
<td>How can trade treaties avoid health-negative consequences associated with liberalization?</td>
<td>Despite the potential benefits of liberalization, low- and middle-income countries in particular are vulnerable to two negative effects: increased economic insecurity through competitive pressures and labour market changes, and decreased public revenues through loss in tariffs. Enhanced social protection measures can buffer some of the economic insecurities associated with the closure of uncompetitive domestic industries, but the increased informalization of labour markets and loss of tariffs weakens many countries’ ability to do so. This demands careful consideration in all trade treaty negotiations of pre-existing economic, labour, education and policy conditions, as well as a country’s factor endowments and development needs and potential. This further implies far greater levels of ‘aid for trade’ and general development assistance transfers to compensate for such short- to medium-term losses.</td>
<td>National security (all countries) and economic arguments (low- and middle-income countries), development arguments and moral/ethical reasoning.</td>
<td>Economic interests, middle- and high-income countries seeking greater access to low- and middle-income country markets; also potentially development arguments as ‘aid for trade’ squeezes out humanitarian or other health-need related assistance.</td>
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Increases in global trade through liberalization (removal of border barriers to foreign goods and capital) have long been argued as essential means to improve growth, development and subsequent health in low- and middle-income countries. Evidence both for and against this general pattern can be found. While on average liberalization is associated with better growth, the relationship is not automatic and much depends on the careful sequencing of commitments and the retained policy space of governments to ensure that development proceeds in an equitable fashion.
How can a healthier balance be achieved between the growth and development potential of trade liberalization and the need for policy flexibility and public revenue generation in low- and middle-income countries?

Present multilateral trade negotiations include pressure on low- and middle-income countries to lock-in and reduce tariffs on imports of economic interest to high- and other middle-income countries. This can reduce the flexibilities they may need for development purposes and the revenues they require from tariffs. Evidence of health and development consequences of the potential gains/losses of differing approaches to tariffs reduction, with an emphasis on reducing both poverty and inequality, should be inform trade negotiation positions, rather than arguments from liberalization-related economic gains alone. Negotiating trade positions in greater coherence with health equity gains can be strengthened politically through public consultations with civil society organizations.

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<tr>
<th>Development and human rights arguments</th>
<th>Economic interests</th>
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<tr>
<td>Increase in the reach and strength of intellectual property rights can reduce the ability of developing countries to provide access to essential medicines. Various trade treaty negotiations and other legislative or policy means have been used to reduce existing flexibilities under the TRIPS agreement.</td>
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<tr>
<td>What different reward mechanisms for new drug development can enhance needed research without imposing cost constraints on access to new medicines?</td>
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<tr>
<td>What different reward mechanisms for new drug development can enhance needed research into neglected diseases lacking profitable markets?</td>
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<tr>
<td>What evidence exists that the economic gains of strengthened IPRs also improves health through more research investment that narrows the ‘10/90’ gap, and without creating financial barriers to access to new medicines?</td>
<td>Lack of profitable markets for medicines in low- and some middle-income countries is a disincentive to private-sector initiated research. Pressure on low- and middle-income countries to increase IPRs by removing flexibilities agreed to under multilateral negotiations can increase costs and decrease access to essential medicines in poorer countries. This can increase the risk of epidemic disease, costs associated with untreated chronic disease, growth in trade in counterfeit drugs and development of more drug-resistant strains of disease, all of which can pose global health security risks and loss of economic opportunities for all countries.</td>
<td>National security, aggregate economic interests, development and human rights arguments.</td>
<td>Selective economic interests</td>
</tr>
<tr>
<td>Are there strong civil society organizations (or CSOs that could be strengthened) holding decision-makers to account with respect to TRIPS flexibilities regarding access to medicines when external pressures are exerted to remove some of these flexibilities through other trade treaty or legislative means?</td>
<td>CSOs have played important roles in reducing the extension of IPRs in ways that threaten access to essential medicines. Given the potential for conflicting foreign policy agendas between health equity and trade-related IPRs such organizations can be effective public allies in swaying majority political opinion in favour of health equity.</td>
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**Arguments from Human Rights**

*Human rights treaties are widely regarded as having primacy over other international treaties when conflicts arise. The preservation of human life and health are at the base of such treaties and their obligations on states parties. This is supported by many existing global health policy statements. UN Special Rapporteurs on several of these rights, notably the right to health, have pointed to existing and potential sources of conflict between trade treaties and health rights.*

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<tr>
<td>What is the status of the right to health, and of other important health-related rights, in the countries involved in diplomatic negotiations?</td>
<td>Evidence suggests that the stronger the force of these rights in domestic legislation, the more persuasive they can be in foreign policy negotiations.</td>
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<td>How is the right to health being interpreted in legal decisions or national policy: as an individual right only, or as a collective right?</td>
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### How is the right to development informing foreign policy debates and decisions?

Individual rights to treatment have been used to force public payment of costly medicines with opportunity costs to other facets of public health access. International legal scholars argue that human rights emphasis should be placed on poorer and more vulnerable populations. This requires greater attention to collective rights. Collective rights are implied in General Comment 14 on the right to health, and are explicit in the Declaration on the Right to Development. Though the right to development is not a binding treaty, it is considered to have some standing in international human rights law and strong normative support through UN agencies and in the context of the Millennium Development Goals.

### What are the overall human rights implications of foreign policy decisions or international treaty negotiations?

### What human rights impact assessments have been carried out on foreign policy issues?

### How have interpretive (non-binding but authoritative) reports on human rights issued by UN Special Rapporteurs informed foreign policy discussions and international negotiations?

At minimum, states are obliged to several core obligations under different human rights. They are also obliged to ensure that their foreign policies, other international treaties into which they enter or negotiate, and non-state actors within their jurisdiction operating nationally or internationally do not infringe upon their own ability, or that of other states, to meet their obligations under human rights treaties. This implies the necessity of human rights impact analyses of all such foreign policies and international treaty negotiations.
How, specifically, will foreign policy decisions affect the right to health?

Health is considered a basic right, since it is foundational to the enjoyment of most other human rights. The foundational quality of health is reinforced in the normative prominence it receives in the Millennium Development Goals. A set of questions to guide a right-to-health impact assessment of foreign policies has been developed. At a minimum, states’ foreign policies should not lead to other states reducing in any way the present level of the realization of the right to health. (See: Question Check-List: Right to health Impact Assessment at end of document.)

Developing countries, even with enhanced development assistance from wealthier nations and under conditions of more favourable trade, may lack resources for rapid progression in the realization of all human rights. This requires prioritization in the protection of some rights over others.

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<tr>
<td>What are the basic human rights implications of foreign policy decisions or international treaty negotiations?</td>
<td>Though human rights are considered ‘indivisible,’ there are some rights that are foundational in the sense that they constitute a basic human capacity required to enjoy other rights: The inherent right to life. Components of the right to the highest attainable standard of physical and mental health. Parts of the right to adequate education. The right to freedom of thought, conscience, and religion. The rights to peaceful assembly, freedom of association with others, and the right to take part in the conduct of public affairs and to vote. Equality before the law and the prohibition of discrimination.</td>
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States, the institutions they create and the persons who function within them are moral actors. A key moral theme in Western societies, and possibly universal across societies, is human dignity. This moral axiom demands not only respect for the autonomy of individual, extends to the provision of core resources for the capabilities people require to live valued lives.

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<td>Do foreign policies embody (a) respect for the autonomy of individuals and their innate human dignity and (b) a focus on the conditions that ensure that their development of capabilities to live valued lives?</td>
<td>Respect for human dignity or human flourishing have long been accepted in many philosophical (ethical, moral) traditions. Basic to dignity is the autonomy of individuals, not simply as isolated rational agents but as persons whose identities and capabilities are embedded in social relations with others. Autonomy is usually presumed when people have freedom of choice; such freedom also requires conditions in which choices can not only be made, but also considered or conceived. Capabilities philosophers have identified core sets of capabilities, and human rights treaties have listed core obligations for the fair provision of resources required by individuals to develop them.</td>
<td>Human rights arguments</td>
<td>Economic interests</td>
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<tr>
<td>When conflicts between health and provision for other social goods or economic interests arise in foreign policy considerations, is health given 'special importance' rather than treated as simply another negotiable (hence tradable) item?</td>
<td>Health is considered to have 'special importance' in peoples' lives, and in their ability to enjoy both dignity and personal security. Capabilities for health are also perquisite to people being able to acquire other capabilities for human flourishing (e.g. education, meaningful work).</td>
<td>Development and human rights arguments</td>
<td>Economic interests</td>
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</table>
Social justice is the dominant ethical theory by which societal decisions about distributive and redistributive allocation of resources for health and other capabilities are made. Equity is at the core of social justice theory with two differing but non-exclusive conceptions: equality of opportunity (an emphasis on horizontal equity and procedural justice) and equality of outcome (an emphasis on vertical equity and substantive justice).

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<tr>
<td>What is the explicit or implicit theory of social justice in any given foreign policy or set of policy negotiations? What is the evidence that the policy will improve the conditions for capabilities of the least advantaged?</td>
<td>Moral philosophers have provided arguments supporting both equality principles. There is robust moral consensus emphasizing opportunity over outcome, and improving the situation of the least advantaged. Applied to health, substantive improvements in the health and the conditions for health (peoples’ capabilities to be healthy) would be a minimum consideration in any foreign policy. There is less moral consensus on acceptance of increasing inequalities even if they might lead to improving the situation of the least advantaged. While most social justice theorists focus on the nation state, others extend this to global political relations as well.</td>
<td>Development and human rights arguments</td>
<td>National security, trade and economic interests</td>
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<tr>
<td>How will the foreign policy provide for disproportionate capability resources for historically least advantaged?</td>
<td>In recent decades an overemphasis on equality of opportunity has been used to argue for minimal state interventions into market economies for redistributive (social welfare) spending. However, fairness in equality of opportunity requires that all persons have the same initial capabilities (horizontal equity: likes treated as likes). Since this is not the case with substantial inequalities between individuals and groups persisting and, in most instances, growing, fairness requires measures to ensure that disproportionately greater resources for capabilities are provided to historically least advantaged. Horizontal equity without vertical equity (procedural justice without substantive justice) is ethically questionable. This argument applies globally as well, with better off nations having achieved this status partly through the exploitation of poorer nations, and evidence of economic institutions (policies, practices, power) sustaining these historically created inequalities. As moral actors, better off states, and those governing them or upholding the global economic institutions sustaining inequalities, have obligations for rectification and for change in how such institutions and their policies function.</td>
<td>Development and human rights arguments</td>
<td>National security, trade and economic interests</td>
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<tr>
<td>Question</td>
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<td>How well do the processes of foreign policy-making (and global health diplomacy in particular) embody norms of procedural justice? How are non-elites and their claims incorporated within the policy-making process?</td>
<td>Individual choices can affect others directly and indirectly, which places some limits on what societies consider the acceptable range of freedoms. Morally, these limits are generally assumed best determined through deliberative and transparent means. Similarly, there is no formula for determining the scale of rectification for historic inequalities between people and nations, apart from the implications of increasingly scarce environmental resources and their disproportionate consumption by a few at the expense of the many. Ethically-informed deliberative processes to arrive at some meaningful outcome are argued as having three principle components: publicity (transparency in process, a comprehensive rationale, and public argument and evidence); relevance (trust in actors/institutions by recipients, opportunity for wide participation, and interventions based on recipients’ needs, values and aspirations); and revisability (policies and programs can be challenged over time and improved, and individuals and institutions can be held accountable to purpose).</td>
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<td>Final Argument</td>
<td>Experience suggests that global health concerns are more likely to be taken seriously in foreign policy discussions to the extent they have been publicly endorsed or promoted by government leaders, who are then held accountable to these endorsements by other political processes and civil society pressures.</td>
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### Question Check-List: Right to Health Impact Assessment

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<tr>
<th>AAAQ</th>
<th><strong>Health goods, facilities and services</strong></th>
<th><strong>Underlying determinants</strong></th>
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<tbody>
<tr>
<td>Availability</td>
<td>Is the proposed policy likely to enhance or jeopardize the availability of health goods, facilities and services in the State?</td>
<td>Is the proposed policy likely to enhance or jeopardize the availability of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Is the proposed policy likely to enhance or jeopardize the physical and economic accessibility of health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize the accessibility of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?</td>
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<tr>
<td>Acceptability</td>
<td>Is the proposed policy likely to enhance or jeopardize the ethical and/or cultural acceptability of health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize the acceptability of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?</td>
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<tr>
<td>Quality</td>
<td>Is the proposed policy likely to enhance or jeopardize the quality of health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize the quality of water, sanitation, housing, food and nutrition, education, employment conditions and/or the environment?</td>
</tr>
<tr>
<td>Progressive Realization</td>
<td>Is the proposed policy likely to enhance or jeopardize the progressive realization of the right to health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize the progressive realization of the rights to clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?</td>
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<tr>
<td>Core Obligation</td>
<td>Is the proposed policy likely to enhance or jeopardize the core obligation for the right to health care, including a national health strategy and plan of action and essential primary health care and medicines?</td>
<td>Is the proposed policy likely to enhance or jeopardize the core obligation for the underlying determinants of health, including a national health strategy and plan of action and minimum levels of water, food, housing and sanitation?</td>
</tr>
<tr>
<td>Equality and Non-Discrimination</td>
<td>Is the proposed policy likely to enhance or jeopardize equality and non-discrimination in provision of health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize equality and non-discrimination in provision of the underlying determinants of health, including clean water, adequate sanitation, safe housing, food, education, fair employment conditions and/or a healthy environment?</td>
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<tr>
<td>Participation</td>
<td>Is the proposed policy likely to enhance or jeopardize participation of the population in all decision-making related to health goods, facilities and services that affects them?</td>
<td>Is the proposed policy likely to enhance or jeopardize participation of the population in all decision-making related to the underlying determinants of health that affects them?</td>
</tr>
<tr>
<td>Information</td>
<td>Is the proposed policy likely to enhance or jeopardize government dissemination of information related to health goods, facilities and services and the rights to seek and impart such information?</td>
<td>Is the proposed policy likely to enhance or jeopardize government dissemination of information related to the underlying determinants of health and the rights to seek and impart such information?</td>
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<tr>
<td>Accountability</td>
<td>Is the proposed policy likely to enhance or jeopardize accountability for the right to health goods, facilities and services?</td>
<td>Is the proposed policy likely to enhance or jeopardize accountability for rights to the underlying determinants of health?</td>
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