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Global health in public policy: finding the right frame?

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One of health promotion's major contributions has been its discursive challenge to biomedical and even behavioural models of health and illness. The concept of social determinants of health is now widely accepted by health authorities in many parts of the world. When health promoters focus on these determinants, however, it is often at local or national scales. Contemporary globalisation demands a more critical appraisal of how many health problems have become inherently global in cause and consequence. In making such an appraisal, it is helpful to consider how global health is presently being framed to determine which arguments are most likely to be health-promoting for the greatest number. This article reviews five such frames: health as security, as development, as global public good, as commodity, and as human right. Most offer some useful argumentation to health promotion, although the rights-based frame, when supported by ethical reasoning (a moral voice), is the most consistent with health promotion's more empowering roots.

Keywords: Globalization; health promotion; public policy

Introduction

In 2005 the *Bangkok Charter for Health Promotion* stated that health promotion must become 'central to the global development agenda.' The Charter emphasised the health promotion impact of increased trade in health-damaging products and services, an important but limited view of the role played by contemporary globalisation in influencing health. None the less, the need to extend the environmental aphorism – think globally, act locally – to transnational health activism has begun to move from the periphery of social movements to the centre of foreign policy debates (Blouin et al. 2007, Donaldson 2007, Kickbusch et al. 2007). In doing so, multiple discourses around the issue of global health have emerged, each framing differing assumptions about the risks or opportunities for achieving greater health equity. Several are readily identifiable – health as security, development, global public good and human right – which comprise the dominant rationales for how and why the foreign policy roles and responsibilities of national governments should change. A fifth, health as commodity, clashes with all of these.

These global health discourses (a term used somewhat loosely in this article to convey a more general frame or rhetoric in which global health is constructed) represent different ways in which governments and multilateral institutions are responding to the increasing

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asymmetries and health risks posed by globalisation (for a detailed discussion of these asymmetries, and how they affect health equity, see Labonté and Schrecker 2007a–c, and Labonté et al. 2007). They also represent differing approaches to what many analysts consider globalisation's most critical challenge: a deficit in democratic (or accountable) global governance alongside an increase in the power of global economic actors (Lee 2002, Lee et al. 2007). Each discourse has its own extensive literature to which this article can only gloss. My purpose is not to present detailed theoretical or empirical examination of these discourses so much as to assess briefly the potential of each to generate state actions towards health equity, and how they might be used by activist health promoters to that end.

This article assumes the nation-state to be the important political actor in negotiating global policies or advancing international practices that improve health equity. This does not negate the role played by other actors (e.g. UN and other multilateral agencies, nation groupings such as the G8, multinational companies, global civil society groups), but these remain largely creations of or dependent upon nation-states for their existence. Nation-states have none the less entered into trade and financial market liberalisation treaties that directly or in path-dependent ways restrict their present and future policy power ('flexibilities'). To many analysts this portends a gradual decline in the political power of the nation-state and the eventual emergence of more forceful forms of global governance. Such governance, however, is still likely to be dominated by the interests of those nation-states presently most powerful; and there is nothing inevitable about if and what form(s) future global governance might take (Backer 2006).

Health as security

The most dominant discourse of recent years has been that of national security. At its extreme it finds such expression as the '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' (US National Intelligence Council 2002). Health as national security is consistent with nation-states' often explicit duties to protect their citizens from foreign risk by guarding their borders, whether the 'invaders' are pathogens or people. It has also, post-SARS, given long-neglected public health measures more political clout and fiscal resources, at least in many high-income countries. (Public health systems in many low-income countries continue to languish.) But it has also led to a distortion in global health risk and response and elides dangerously with repressive political measures in the 'war on terror'.

On the first: the securitisation of health, while now 'a permanent feature of public health governance in the 21st century' (Fidler 2007), disproportionately directs funding to those ills deemed politically to be security risks: HIV, twice addressed by the UN Security Council; and avian flu as the present exemplar of feared modern pandemics. Such designation is not based upon global risk, 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, to say nothing of the pandemic of chronic diseases sweeping developing nations alongside the globalisation of Western lifestyles, food products and consumption. Rather, and in ethically troubling ways, the securitisation of health privileges those diseases most likely to inconvenience 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’ (Thieren 2007).

On the second: health, in sharing national security with terrorism, may inadvertently lend credence to what UN human rights observers concluded is a national security that ‘is reductionist . . . essentially militaristic and manifestly retrogressive . . . with reliance placed on the superiority of military firepower and the curtailment of civil liberties’ (United Nations Economic and Social Council, Commission on Human Rights 2003). Fear of infection can morph into a fear of (bio)-terrorism, and then into a fear of the terrorist-Other itself. The continuous and heightened expression of possible risks routinised in airport screenings and building security checks, intersects with a saturated Western individualism to create a pervasive sense of helplessness. Helplessness without check becomes fear, transforming the possible into the probable (Durodié 2005). As public health historian Simon Szreter warns, this creates a base for, and apathy towards, political actions that abuse human rights and which can slip slowly towards fascism (Szreter 2003). Economic interests also underlie the security frame. Worry over avian flu created windfall profits for Roche, the patent holder of Tamiflu[®], in 2006 and 2007 (Cage 2007). The broader terrorist–security frame has created a massive ‘security industry’; in 2003, over US\$550 billion was estimated to have been spent on domestic (not military) security, 10 times the amount of total foreign aid that year (Labonté et al. 2004).

The *realpolitik* of international relations none the less assures durability to the security discourse. If the resource scarcities in such life basics as food and water anticipated by environmental researchers emerge as rapidly as some climatologists now caution, one can expect national security’s reductionism and militarism to deepen. This places activists concerned with global health equity in an awkward place. To dismiss security is to remove one from potentially useful policy engagements. To accept it risks a tacit strengthening of its worst forms.

A mitigating strategy exists in national security’s less commonly voiced sibling: human security. Human security, which has its own multilateral policy texts (Chen et al. 2004a, b), bases itself upon a person’s ‘physical safety, their economic and social well-being, respect for their dignity and worth as human beings, protection of their human rights and fundamental freedoms’ (Helsinki Process 2005). It emphasises attending to the needs of vulnerable peoples, representing an approach to security more consonant with the idealised principles of health promotion. It specifically stresses core capabilities, including income security, health care, housing, education, environmental security among other essentials for life. It also recognises that national security is no guarantee of human security within borders, and that the ‘core moral value of people’s security’ may actually be in potential conflict with it (Coupland 2007). Framing security in human, and not simply national, terms thus forces open debates on policy measures beyond rich country efforts to create a *cordon sanitaire* (whether for unwanted pathogens or unwanted aliens) to consideration of a larger set of international responsibilities. In doing so, it creates an argumentative path into other, potentially more empowering global health discourses.

Health as development

One of these – development – is perhaps the second most prominent in global health debate. Health has long been viewed as a desired outcome of development, most recently expressed in the Millennium Development Goals (MDGs) (Table 1). Agreed to by all the

Table 1. Millennium development goals and targets.

Goal 1: Eradicate extreme poverty and hunger

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Goal 2: Achieve universal primary education

Target 3: Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3: Promote gender equality and empower women

Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.

Goal 4: Reduce child mortality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5: Improve maternal health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7: Ensure environmental sustainability

Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Goal 8: Develop a global partnership for development

Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Target 13: Address the special needs of the least developed countries

Target 14: Address the special needs of landlocked countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)

Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make the debt sustainable in the long term

Target 16: In co-operation with developing countries, develop and implement strategies for decent and productive work for youth

Target 17: In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries

Target 18: In co-operation with the private sector, make available the benefits of new technologies, especially information and communications

world's nations in 2000, these 8 goals and 18 targets represent the most concentrated and collective global statement of development intent in human history. Most are directly or indirectly health goals. The MDGs, while galvanising global attention on issues of health and disparity, are not without trenchant criticism:

- (1) They lack equity stratifiers, meaning that countries can achieve them by improving the health of the better off while worsening that of the poor.
- (2) There are few reliable data available to track progress.
- (3) They are silent on the causes of the problems that they commit the 'global community' to address.
- (4) They are remarkably unambitious.

- (5) Goal 8's target of furthering an open trading and financial system may also be at odds with many of the other targets (Labonté et al. 2007).

The poverty goal, for example, is based on the narrowly defined World Bank \$1/day level, a measure critiqued on both methodological grounds (the relevance of the basket of goods on which it is based and the accuracy of reporting) and ethical grounds (achieving it would still leave almost half of the world's population consuming less than they would need to achieve a decent level of health). An 'ethical poverty line' of \$3–4/day has been suggested, based on estimates of the level of consumption required to achieve an average life expectancy of between 70 and 74 years (Edward 2006). The ethical poverty line triples the current estimate of world poverty from 1 billion to just over 3 billion persons. Even moving these three billion to this level would still leave them with life expectancies 10–15 years below those enjoyed in high-income countries.

That these criticisms are getting voice in global policy circles lends some utility to retaining the MDGs as global goalposts. At deeper issue is how the relation between health and development is seen. Until recently, development (invariably meaning economic growth) was viewed as preceding gains in health. This is true at very low levels of wealth and consumption, although as Lipson comments, 'A country need not be rich to be healthy, and countries can become wealthier without parallel gains in health' (Lipson 2001). The more recent health/development 'story' posits that investing in health yields substantial economic returns (Commission on Macroeconomics and Health 2001, Global Forum for Health Research 2004). Health is no longer seen simply as a consequence of economic growth, but as one of its engines. While politically compelling (health promotion has long attempted to monetise its value in order to gain the approval of finance ministers), this instrumental reasoning raises three concerns.

- (1) It silos health funding into vertical disease-based programmes with short-term achievable targets, not conducive to health promotion's concerns with underlying social determinants of health.
- (2) It disproportionately rewards those countries with the 'right' set of economic policies: the dominant if empirically dubious neo-liberal model of growth through market liberalisation and global integration.
- (3) It renders the causes and prevention of poverty and disease technical rather than political affairs.

Historically, aid has been a major form of capital transfer from rich to poor countries for health and development purposes. Aid levels plunged during the 1990s as neoliberal orthodoxy defeated older theories of endogenous development, and rhetoric of 'trade not aid' justified deep cuts to assistance levels among most donor countries – though not all: the Nordic countries for years have met or exceeded the benchmark contribution of 0.7% of Gross National Income, agreed to by donor nations 30 years ago.

The subsequent resurgence of global activism around the need for greater levels of aid spending 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 (Easterly 2006). The oft-cited exemplar is Africa, which received almost \$1 trillion in aid over the past 50 years but which, critics argue, failed to develop economically. This reasoning ignores the forced opening of its economies under structural adjustment, which fast-growing Asian countries did not experience. Africa also lost as much or more in capital flight over this same period due to corruption (often abetted by donor countries), profit repatriation (to corporations based in donor countries) and the recycling of aid funds back to the

donor countries for the purchase of their goods and services (Labonté et al. 2004, Bond 2006). There is finally considerable evidence that these problems are less now than in the past and that aid, administered transparently and in ways that builds local infrastructure and human capital (including health), improves economic growth (Labonté et al. 2007). There is also the patent inability of many poor African countries being able to raise through their own taxes sufficient revenues to fund even a fraction of the estimated minimum requirements for health remains decades away (Sachs 2007).

This does not mean that the political interests of donor nations have ceased to dominate aid transfers. There is also increasing overlap of aid with the national security discourse. Over 60% of aid increases between 2001 and 2004 went to Afghanistan, Iraq and mineral-rich conflict-riddled Democratic Republic of the Congo, which together account for less than 3% of the developing world's poor (World Bank 2006). Much trumpeted aid increases in 2005 came as debt reduction for Iraq and Nigeria, the latter an oil-rich nation of increasing interest to Western countries. Once removed, aid (in the form of new monies) actually decreased over the previous year (OECD-DAC 2006). That aid has still been found to have done some good globally given its misuse by donor and recipient country alike holds the possibility of much greater good as the political ties of its disbursements are increasingly severed.

However, aid levels remain remarkably ungenerous, especially given levels of global economic growth and private wealth accumulation during the 1990s and early 2000s. Yet simply calling for increased aid, one of the 'just globalisation' movement's mantra-like platform of 'more aid, fair trade, cancelled debt', fails to recognise that the very concept of aid legitimises historically paternalistic relationships between donor and recipient countries, many of which were former colonies. As one example: promises of future aid (or its withdrawal) have been used to pressurise poorer, recipient countries to agree to trade treaties favouring wealthier, donor nations (Jawara and Kwa 2003). More fundamentally, aid remains wedded to a development model that fails to question the sustainability of economic growth, rising population and increasing consumption; and which largely defines recipient countries as 'under-developed' due to unique contexts (geography, lack of infrastructure) that are severed from any linkage to the historic and continuing economic and political practices of rich world countries.

This is not to argue for a 'no growth' approach to poverty reduction in low-income countries, rather for a growth policy that specifically addresses the poor rather than the present 'trickle down' trust in neoliberal policies that have allowed most of growth's gains over the past two decades to be captured by a small number of elites. Also, and for sake of brevity, this article ignores the parallel issue of foreign debt and debt cancellation. Suffice to say that the causes of developing country debt are many and owe as much to the lending and monetary policies of the creditor nations as to the corruption and inefficiencies of the borrowing ones. Many of these debts are odious and should not be considered collectible under international law. Cancellation of debts owed to foreign (usually donor) governments are at the expense of new aid monies. Aid that is disbursed is often used to pay domestic creditors, as well foreign commercial creditors in donor countries who often pushed bad loans in the first place and who are becoming increasingly litigious in their efforts to collect them (IDA/IMF 2006).

As with security, health activists need not dismiss the value of the development discourse. When invoking it, however, they need to recast it in at least two ways. First, the concept of development must be centred on human potentials rather than market performance, a point long argued by progressive 'new internationalists'. This requires continued scrutiny and critique of the hegemony of economic rationalism that defines

neo-liberal globalisation. Second, in an increasingly interdependent economic world, the transfers now called 'aid' should not be seen as 'aid' at all but as redistributive obligations. Politically, redistribution on a global scale is no different than the financial transfers federated nations make between their component states, or that the European Union makes between its member nations: reallocating fiscal resources from its more populous or wealth-generating members to those states or nations that are less populous or poorer. Such transfers are usually made on the basis of strengthening social solidarity and maintaining social cohesion, the absence of which leads to a loss of faith in democratic governance, a rise in domestic disturbance and, ultimately, economic chaos. Even the World Bank in its 2007 *Global Economic Prospects* Report (World Bank 2007), while extolling the gains of increasingly globalised market capitalism, cautioned that the environmental damage and income inequalities that it was creating would lead increasingly to social unrest. This implies the need for solidarity-building mechanisms of global redistribution, albeit a conclusion that seems to elude the World Bank itself. One such mechanism already exists: a tax on airline fuel along with creation of a new organisation (UNITAID), also known as the International Drug Purchasing Facility, to finance essential medicines and health systems in poor countries. There is also a new 'Leading Group' of nations exploring other forms of 'solidarity levies for development'.

Health as global public good

The limitations of the development/aid discourse have none the less given rise to a third: that of global public good. Health promoters frequently invoke public or common good as shorthand to capture an ethic that places collective benefit above individual gain. In this use the term has the same evocative imprecision as 'community' (Labonté 2000). In economic theory, public good has a more exact meaning. 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.

A global public good is one whose benefits extend to all countries, people, and generations. A stable climate is an example. Efforts to correct its inverse 'global public bad' – greenhouse gas emissions – are also considered global public goods. Definitional boundaries remain vague, however, and identifying such goods remains more a matter of public policy, and hence politics, than of economic theory alone (Kaul et al. 2003, Woodward and Smith 2003). None the less, there are two axiomatic qualities of a *global* public good: its benefits are not confined to citizens of one nation; and, as with all public goods, it is under-provided in the market because its use by all engenders free riders – those who enjoy the good but pay nothing for it. Global public bads, in turn, are characteristically private or public decisions made in one country that have undesirable spill-over effects ('externalities') on people in other countries. Global public goods not only fill in for market failures in provision; they also correct for market 'successes' that create negative public externalities.

Health – or more precisely what creates it – is considered by some but not all to be a global public good. There is more agreement that what prevents the global public bad of disease fits better with the concept, specifically the production, dissemination and use of knowledge; effective and accessible health systems policy; and regulatory regimes to prevent disease (Woodward and Smith 2003). Examples of the first type include the growth of various global disease funds, notably The Global Fund (to fight AIDS, Tuberculosis

and Malaria). Despite their problems (short-term vertical programmes in the absence of equally or better-funded horizontal programmes to build public health systems) these funds begin to de-couple aid from the strategic interests of specific donor nations. Examples of the third type include the 2005 revision of the International Health Regulations, which requires WHO member states to strengthen core disease surveillance and response capacities and to report public health events to WHO; and the Framework Convention on Tobacco Control, which requires states parties to enact bans on tobacco advertising, marketing and promotion, implement warnings on packages and implement measures to protect exposure to second-hand smoke.

There are critics of the global public goods concept. Some argue that it is confusing and weaker in policy advocacy than human rights (Deneulin and Townsend 2006); others that it does not sufficiently address equity in health and fails to address *why* inequities have arisen in the first place (Mooney and Dzator 2003). A more serious limitation is its utilitarian approach to global cooperation. As with the security discourse, its underlying premise is that shared interests are the key rationale for collective action, a perspective that reflects a particular value system in contrast with needs-, capabilities- or justice-based rationales. At the same time, the underlying theoretical and empirical public good argument – that there exist profound market failures in key areas of human health and survival demanding new forms of global financial ‘risk pooling’ and regulation – is one that is likely to have greater traction with economists in treasury departments than any of the other global health discourses.

Health as commodity

Even so, the global public goods discourse must compete in treasury departments with the one outlier – health as tradable good. There is some pretence that such trade will lead to better outcomes, but the reality is that health is reduced to goods (such as drugs and new technologies) or services (private health insurance, facilities or providers), the increased cross-border flow of which is designed to maximise profit, not health.

The indirect effect on health of trade treaties is actually likely to have greater impact. Ongoing pressure on low- and middle-income countries to lock in and further lower their tariffs (border taxes) on high-income country imports, for example, will reduce available government revenues since most of these countries rely heavily on tariffs for taxes and presently lack the means to develop alternative systems (Baunsgaard and Keen 2005). Other treaties preclude governments giving preferential treatment to domestic producers or directing investment to particular sectors or regions. While prone to cronyism, such flexibilities are also important for domestic economic development and ensuring greater intra-country equity (Chang 2002, Labonté and Sanger 2006a, b). Finally, rich country promises to strengthen ‘special and differential treatment’ for poorer WTO members (essentially excusing them from full compliance with trade treaty obligations) have so far not been honoured (Labonté et al. 2009 forthcoming). The collapse of the so-called ‘Doha Development Round’ of WTO negotiations in 2008 over the issue of special safeguards developing countries could use to protect their domestic farmers against sudden surges of (still) subsidised imports from the EU and US further questions the intent of today’s wealthier nations to create trade rules based on reducing global poverty rather than self-interested mercantilism.

Those trade treaties attracting greatest global health attention are the ones with direct effects on health: TRIPS (Agreement on Trade-Related Intellectual Property Rights),

which extends patent protection that may limit poor countries' access to essential medicines; and GATS (General Agreement on Trade in Services), which locks in existing health care privatisation to the benefit of elites and private companies but to the detriment of those unable to pay the costs. Some progress on amending TRIPS to allow easier access to cheaper generic drugs was made in 2003. But the rules remain cumbersome and costly, and the US has since been pressurising its poorer trading partners to accept so-called 'TRIPS-plus' deals that take away the flexibilities they won at the WTO; although the 2006 Democrat majority in both US houses of government has led to modest shifts in that country's bilateral trade policy, essentially loosening some of the TRIPS-plus language in them so that they are more WTO-equivalent.

GATS is a more complex agreement combining bottom-up options and top-down requirements. The main concern is that the agreement could accelerate a global trend in health services privatisation in financing as well as provision. The argument that such provision, paid for by the wealthy, will remove pressure on public systems for the poor falters empirically (there is little evidence anywhere that this has transpired), politically (it erodes cross-class solidarity for publicly funded programmes) and ethically (it precludes the cross-subsidisation of broadly risk-pooled public financing in which the healthy or wealthy subsidise the sick or poor). GATS negotiations have ground to a halt as developing countries scrutinise more clearly its costs and benefits, since only a handful of the larger ones have service industries that might compete with those in the rich countries aggressively pushing GATS. None the less, 54 WTO members, most of them developing nations, made commitments to liberalise some health services before the full implications of GATS were understood, causing some analysts to argue for the removal of health services from its ambit altogether (Woodward 2005). That several countries, such as Canada, have declared their intent not (never?) to commit their health, education and social services to trade liberalisation supports such a claim.

Health can be commodified, but it is not a commodity. Public systems for health care arose in most developed countries because private systems proved inadequate and inequitable, a fact being rediscovered by most of the world's developing countries. For health activists, the stance on this particular discourse is clear: trade treaties, which are intended to promote private commercial interests, are no place to negotiate international rules for health, health care and other health determinants, such as education and water/sanitation.

Health as human right

Indeed, there are clear conflicts between the health/commodity discourse and that of human rights. All human rights covenants contain a provision for 'progressive realisation,' meaning that an individual country's compliance with rights obligations will vary according to its available resources to do so, but that it must, year by year, move progressively towards complete fulfilment. (The UN is shortly to release benchmarks for such progress.) This obligation jars against that of WTO membership which requires commitment to progressive liberalisation of trade. To the extent that such liberalisation disadvantages poorer countries in terms of their capacities to collect and disburse public revenues or ensure equitable access to essential health services it contradicts their obligations to progressively realise human rights. While human rights covenants are nominally superordinate to other multilateral treaties, their lack of enforcement also grates

against the WTO's enforceable dispute resolution system. No WTO dispute panel, comprised of trade experts, has yet considered a human rights treaty in its deliberations. One proposed solution is to create an oversight group of human rights and development experts who would determine if a country's abrogation of a trade rule was necessary to meet its human rights obligation. This would not change the WTO ruling, but would place the winning country in the position of explaining why it would allow a commercial trade treaty to overrule a human rights obligation.

One human right covenant gaining global health policy prominence is the right to health, technically known as 'the right to highest attainable standard of physical and mental health'. This right is embodied in a number of international declarations, covenants (treaties) and plans of action. Covenants are legally binding on countries that ratify them ('states parties'), but do not require states to guarantee that all people enjoy the same level of health. Rather, they obligate states to ensure that all people enjoy the same access to goods and services essential to enjoyment of this right. A key text on this right is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This Article, and its definitive 2000 'General Comment 14', read a little like the World Health Organisation's founding document and the *Ottawa Charter for Health Promotion* but with a trenchant difference: it specifically obligates states parties to ensure provision of a number of health care and public health services, as well as equitable and affordable access 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' (United Nations Committee on Economic, Social and Cultural Rights 2000). In doing so, it repeats many of those elements identified as essential for human security, creating another normative bulwark against the predominance of security's national iteration. Countries' performances in meeting these health right obligations are reviewed periodically by the UN Human Rights Committee that oversees this Covenant.

There are further international obligations. State parties must *respect* the right to health in other countries, partly by ensuring that any other international agreements they negotiate 'do not adversely impact upon the right' (United Nations Committee on Economic, Social and Cultural Rights 2000). This is where the potential conflict between free trade and human rights enters. States Parties to the covenant must *protect* against infringements of this right by third parties such as corporations, using their legal or political influences. They must also *fulfil* this right, which for rich countries means enhanced international assistance and cooperation to poorer countries to allow their progressive realisation of this right, thereby providing a normative base for a radical re-framing of aid.

The former UN Special Rapporteur on the Right to Health, Paul Hunt (who completed two 3-year terms in 2008 before being replaced by a new Rapporteur) issued several assessments on the real and potential conflicts between trade and health, focusing principally on extended intellectual property rights (and their denial of access to essential medicines) and health services trade (given that such trade invariably increased the private/public ratio of provision with equally invariable inequities in access). Hunt has also commented a priori on the human rights implications of bilateral trade agreements in negotiation (i.e. the 'TRIPS-plus' requirements of US-negotiated trade deals), usually at the invitation of the developing country partners (Hunt's written reports to the UN General Assembly and other multilateral agencies can be found at: http://www2.essex.ac.uk/human_rights_centre/rth/reports.shtm).

While the Special Rapporteur's advice is non-binding, it adds substantial leverage to civil society campaigns opposed to trade deals that limit access to health care and other essential goods or services. This includes a 2006 global right to health campaign by dozens of civil society organisations under the broad umbrella of the People's Health Movement, now active in 40 different countries. The focus of this campaign is a 'mobilisation of action from below' through training and capacity-building sessions, documenting violations of health rights and lobbying national governments (as primary duty bearers of the right to health) for policy change. Such popular mobilisations within countries have so far proved to be the only means of achieving policy change under the right to health. Apart from 'naming and shaming' at a global level, international human rights treaties lack enforcement courts. Scores of countries, however, have adopted all or parts of the Covenant and the right to health within their constitution. As such, the right becomes domestically judiciable, and has been used successfully in numerous campaigns, most concerning access to essential medicines.

Efforts to advance human rights as the guiding normative frame for twenty-first century global governance are growing. All UN bodies, for example, are obliged to apply a human rights-based approach, although how this should be done and what this means for each UN agency still remains unclear. Like any discourse advancing the possibility of global justice, rights-based arguments are easily dismissed by the realist ideology common to many governments and media commentators 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 are *individual* and not *collective* rights, for their lack of class analysis. This diverts energies away from a deeper critique of, and efforts to mobilise against, the appropriation of capital by global elites and the ongoing commodification of most aspects of life. Rights scholars themselves sometime express concern over potential competition between different rights: does the right to security of person, for 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 the could pose a risk to life? Given the slow global dominance of Western liberalism with its individualisation over the more communitarian ethos of many developing countries, this is a realistic concern. It is also leading some human rights activists to urge prioritisation amongst rights, giving more weight to those which, while still applied to individuals, obligates states to act in ways that benefit larger collectives (as in the right to health) or to meet the needs of the most disadvantaged and vulnerable. Others are urging the importance of building upon General Comment 14 to create a full-blown collective right to public health (Meier 2007).

Whether or not 'rights-talk' proves to be a sustainable countervailing discourse to our still dominating neo-liberal globalisation, as many scholars and activists view it, is unknown. At the same time, human rights are 'the most globalized political value of our times' (Austin 2001), representing the most widely shared language of opposition to devaluation of health that results from the globalisation-driven spread of markets.

Conclusion: towards an integrating global health discourse

Global health is the new challenge for a 20-year mature health promotion, and a just globalisation is its new prerequisite. How should this challenge and prerequisite be framed? The assumption underlying this article's brief 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, apart from commodity/trade, have something strategic to offer. (Not that global trade is inherently unhealthy, but trading health globally as a commodity is.) To summarise:

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-securitisation (Fidler 2007). 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)' (Global Forum for Health Research 2004). The accountability advocacy of international NGOs continues to pressure 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.

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.

This resolution requires firm ethical reasoning, presently lacking in the legalistic nature of human rights treaties (Ruger 2006). This need, in turn, has created scholarly momentum to articulate more rigorous argument for a *global health ethic*. Competitors for such an ethic range from Rawls' liberal theory of assistive duties based on 'burdened societies' in need (Rawls 1971) to Sen's and Nussbaum's emphases on minimum capabilities needed for people 'to lead lives they have reason to value' (Nussbaum 2000, Sen 2000), to Pogge's more recent arguments for a new ethic of 'relational justice' (Pogge 2002). The latter offers the most compelling moral case for what other analysts argue is the urgent necessity for a global entrenchment of rights, regulations and redistribution (Deacon et al. 2005). Pogge bases his reasoning on evidence that economic institutions operating on an international scale have been complicit in creating many of the conditions that lead to ill health, notably 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 (hence the 'relational' nature of justice) (Pogge 2004). Globalisation as we have come to know it is not a natural or inevitable fact but a series of deliberate decisions that disproportionately favour some over others. Alternatives to the global order – in the form of regulation, redistribution and the institutions required to manage them – are technically feasible and would allow human rights obligations and health equity to be better fulfilled. On this basis, the current global order is morally unjust and indefensible.

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 discourse is the most potent but remains the most problematic.

No integrating discourse as yet exists. There are some movements in that direction. One that holds potential is *global health diplomacy*, in which the ethical, rights-based, public goods, development and security arguments are all brought to bear on why improving global health equity should be a central plank in governments' foreign policy. In 2006, foreign ministers of the 'Leading Group on Solidarity Levies' mentioned earlier, comprised of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, met and declared the importance of new forms of global governance that, in the name of greater coherence, brought together foreign policies on development, equity, peace and security – all of which are amongst the basic prerequisites for health. The group continues to meet.

Whether this new initiative succeeds in developing a robust and universalised language that captures the idealism of health promotion, while attending to the constraints facing all international relations in an incompletely globalised world, is to be seen. That it is necessary to succeed there is little doubt.

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References

- Austin, W., 2001. Using the human rights paradigm in health ethics: the problems and the possibilities. *Nursing Ethics*, 8 (3), 183–195.
- Backer, L.C., 2006. Economic globalization and the crisis of the state: four perspectives on the emerging ideology of the state in the global order. *Berkley La Raza Law Journal*, 17 (1), 141–168.
- Baunsgaard, T. and Keen, M., 2005. *Tax revenue and (or?) trade liberalization*. (Working Paper WP/05/112.) Washington, DC: International Monetary Fund.
- Blouin, C., Heymann, J. and Drager, N., eds, 2007. *Trade and health: seeking common ground*. Montreal: McGill-Queen's University Press.
- Bond, P., 2006. The dispossession of African wealth at the cost of African health. *International Journal of Health Services*, 37 (1), 171–192.
- Cage S., 2007. Roche says Tamiflu® capacity outstrips demand. Reuters, 26 April. Available online: http://news.yahoo.com/s/nm/20070426/bs_nm/roche_tamiflu_dc_2;_ylt=AllFM9BpfF_2oRyjo3U7d2Tvyli. Accessed 3 May 2007.
- Chang, H.-J., 2002. *Kicking away the ladder: development strategy in historical perspective*. London: Anthem Press.
- Chen, L., Fukuda-Parr, S. and Seidenticker, E., eds, 2004a. *Human insecurity in a global world*. Boston: Harvard University Press.
- Chen, L., Leaning, J. and Narashimhan, V., eds, 2004b. *Global challenges for human security*. Boston: Harvard University Press.

- Commission on Macroeconomics & Health, 2001. *Macroeconomics and health: investing in health for economic development*. Geneva: World Health Organization.
- Coupland, R., 2007. Security, insecurity and health. *Bulletin of the World Health Organization*, 85 (3), 181–184.
- Deacon, B., et al., 2005. *Copenhagen social summit ten years on: the need for effective social policies nationally, regionally and globally*. Helsinki: Globalism and Social Policy Programme, STAKES, GASPP Policy Briefs.
- Deneulin, S. and Townsend, N., 2006. *Public goods, global public goods and the common good*. ESRC Research Group on Wellbeing in Developing Countries, University of Bath. Available online: <http://www.welldev.org.uk/research/workingpaperpdf/wed18.pdf>. Accessed 18 October 2006.
- Donaldson, L., 2007. *Health is global: proposals for a UK government-wide strategy*. London: Department of Health.
- Durodié, B., 2005. Inclusion versus experimentation. *Critical Review of International Social and Political Philosophy*, 8 (3), 359–362.
- Easterly, W., 2006. *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.
- Edward, P., 2006. The ethical poverty line: A moral quantification of absolute poverty. *Third World Quarterly*, 27 (2), 377–393.
- Fidler, D., 2007. A pathology of public health securitism: approaching pandemics as security threats. In: A.F. Cooper, et al., eds. *Governing global health: challenge, response, innovation*. Aldershot: Ashgate (Global Governance Series), 41–66.
- Global Forum for Health Research, 2004. *The 10/90 report on health research, 2003–2004*. Geneva: Global Forum for Health Research.
- Helsinki Process, 2005. *Empowering people at risk: human security priorities for the 21st century*. Available online: http://www.helsinkiprocess.fi/netcomm/ImgLib/53/164/hp_track3_report.pdf. Accessed 7 May 2007.
- International Development Association & International Monetary Fund, 2006. *Heavily indebted poor countries (HIPC) Initiative and multilateral debt relief initiative (MDRI) – status of implementation*. Washington, DC: International Development Agency and International Monetary Fund.
- Jawara, F. and Kwa, E., 2003. *Behind the scenes at the WTO: the real world of international trade negotiations*. London: Zed Books.
- Kaul, I., et al., eds, 2003. *Providing global public goods, managing globalization*. Oxford: Oxford University Press.
- Kickbusch, I., et al., 2007. Global health diplomacy: training across disciplines. *Bulletin of the World Health Organization*, 85 (12), 971–973. Available online: <http://www.who.int/bulletin/volumes/85/12/07-045856.pdf>. Accessed 7 December 2007.
- Labonté, R., 2000. Health promotion and the common good: towards a politics of practice. In: D. Callahan, ed. *Promoting healthy behaviour: how much freedom? whose responsibility?* Washington, DC: Georgetown University Press.
- Labonté, R., Blouin, C., and Forman, L., 2009 forthcoming. Trade and health. In: O.D. Williams and A. Kay, eds. *Global health governance: crisis, institutions and political economy*. London: Palgrave MacMillan.
- Labonté, R., Frank, J., and Di Ruggiero, E., 2007. Introduction to Part I. Unfair cases: social inequalities in health. In: J. Green and R. Labonté, eds. *Critical perspectives in public health*. London: Routledge, 14–24.
- Labonté, R. and Sanger, M., 2006a. A glossary of the World Trade Organization and public health: Part 1. *Journal of Epidemiology and Community Health*, 60, 655–661.
- Labonté, R. and Sanger, M., 2006b. A glossary of the World Trade Organization and public health: Part 2. *Journal of Epidemiology and Community Health*, 61, 738–744.
- Labonté, R., et al., 2004. *Fatal indifference: the G8 and global health*. Cape Town: University of Cape Town Press/IDRC Books.

- Labonté, R. and Schrecker, T., 2007a. Globalization and the social determinants of health: a diagnostic overview and agenda for innovation (part 1 of 3). *Globalization and Health*, 3 (5), 1–10.
- Labonté, R. and Schrecker, T., 2007b. Globalization and the social determinants of health: the role of the global marketplace (part 2 of 3). *Globalization and Health*, 3 (6), 1–17.
- Labonté, R. and Schrecker, T., 2007c. Globalization and the social determinants of health: promoting health equity in global governance (part 3 of 3). *Globalization and Health*, 3 (7), 1–15.
- Labonté, R. et al., 2007. Towards health-equitable globalization: rights, regulation and redistribution, globalization knowledge network final report to the Commission on Social Determinants of Health. Ottawa: Institute of Population Health, University of Ottawa. http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf
- Lee, M., 2002. The global divide: inequality in the world economy. *Behind the Numbers: Economic Facts, Figures and Analysis*, 4 (2), 8.
- Lee, K., et al., 2007. *Globalization, global governance and the social determinants of health: a review of the linkages and agenda for action*. Ottawa: Institute of Population Health, University of Ottawa. http://www.globalhealthequity.ca/projects/proj_WHO/pres_pub.shtml
- Lipson, D.J., 2001. *GATS and trade in health insurance services: background note for WHO commission on macroeconomics and health*. WG 4 (7), 1–10. Geneva: Commission on Macroeconomics and Health, CMH Working Paper Series.
- Meier, B., 2007. Advancing health rights in a globalized world: responding to globalization through a collective human right to public health. *Journal of Law, Medicine and Ethics*, 35, Winter, 545–555.
- Mooney, G. and Dzator, J.A., 2003. Global public goods for health: a flawed paradigm?. In: R. Smith, et al., eds. *Global public goods for health: health economic and public health perspectives*. Oxford: Oxford University Press, 233–245.
- Nussbaum, M., 2000. *Women and human development: the capabilities approach*. Cambridge: Cambridge University Press.
- OECD-DAC, 2006. *Development aid from OECD countries fell 5.1% in 2006*. Available online: http://www.oecd.org/document/17/0,2340,en_2649_34447_38341265_1_1_1_1,00.html. Accessed 6 May 2007.
- Pogge, T., 2002. *World poverty and human rights*. Cambridge: Polity Press.
- Pogge, T., 2004. Relational conceptions of justice: responsibilities for health outcomes, In: S. Anand, et al., eds. *Public health, ethics and equity*. Oxford: Clarendon Press.
- Rawls, J., 1971. *A theory of justice*. Cambridge: Harvard University Press.
- Ruger, J.P., 2006. Ethics and governance of global health inequalities. *Journal of Epidemiology and Community Health*, 60 (11), 998–1002.
- Sachs, J., 2007. Beware false tradeoffs. *Foreign Affairs*. Available online: http://www.foreignaffairs.org/special/global_health/sachs
- Sen, A., 2000. *Development as freedom*. New York: Knopf.
- Szreter, S., 2003. Health and security in historical perspective. In: L. Chen, et al., eds. *Global health challenges for human security*. Cambridge: Global Equity Initiative, Asia Center, Harvard University, 31–52.
- Thieren, M., 2007. Health and foreign policy in question: the case of humanitarian action. *Bulletin of the World Health Organization*, 85 (3), 218–224.
- United Nations Committee on Economic, Social and Cultural Rights, 2000. *International Covenant on Economic, Social and Cultural Rights, General Comment No. 14, Article 12*. Available online: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)
- United Nations Economic and Social Council, 2003. *Globalization and its impact on the full enjoyment of human rights*, E/CN.4/Sub.2/2003/12. Available online: <http://hei.unige.ch/~clapham/hrdoc/docs/globalizationsubcomfinalareport.pdf>. Accessed 7 May 2007.
- UN Millennium Project, 2005. *Investing in development: a practical plan to achieve the millennium development goals*. London: Earthscan.

- US National Intelligence Council, 2002. *The global infectious disease threat and its implications for the United States*. National Intelligence Estimate NIE99-17D Available online: <http://www.cia.gov/cia/publications/nie/report/nie99-17d.html>. Accessed 5 August 2002.
- Woodward, D., 2005. The GATS and trade in health services: implications for health care in developing countries. *Review of International Political Economy*, 12 (3), 511–534.
- Woodward, D. and Smith, R., 2003. Global public goods and health: concepts and issues. *In: R. Smith, et al., eds. Global public goods for health: health economic and public health perspectives*. Oxford: Oxford University Press, 3–29.
- World Bank, 2006. *Strengthening mutual accountability, aid, trade, and governance*. Washington, DC: World Bank.
- World Bank, 2007. *Global economic prospects 2007: managing the next wave of globalization*. Washington, DC: World Bank.