

Health in All (Foreign) Policy: challenges in achieving coherence

RONALD LABONTÉ*

Canada Research Chair, Globalization/Health Equity, Faculty of Medicine, Institute of Population Health, 1 Stewart Street, Ottawa, Ontario, Canada K1N 6N5

**Corresponding author. E-mail: rlabonte@uottawa.ca*

SUMMARY

Health in All Policies (HiAP) approach is generally perceived as an intersectoral approach to national or sub-national public policy development, such that health outcomes are given full consideration by non-health sectors. Globalization, however, has created numerous 'inherently global health issues' with cross-border causes and consequences, requiring new forms of global governance for health. Although such governance often includes both state and non-state (private, civil society) actors in agenda setting and influence, different actors have differing degrees of power and authority and, ultimately, it is states that ratify intergovernmental covenants or normative declarations that directly or indirectly affect health. This requires public health and health promotion practitioners working within countries to give increased attention to the foreign policies

of their national governments. These foreign policies include those governing national security, foreign aid, trade and investment as well as the traditional forms of diplomacy. A new term has been coined to describe how health is coming to be positioned in governments' foreign policies: global health diplomacy. To become adept at this nuanced diplomatic practice requires familiarity with the different policy frames by which health might be inserted into the foreign policy deliberations, and thence intergovernmental/global governance negotiations. This article discusses six such frames (security, trade, development, global public goods, human rights, ethical/moral reasoning) that have been analytically useful in assessing the potential for greater and more health-promoting foreign policy coherence: a 'Health in All (Foreign) Policies' approach.

Key words: policy development; global health; public policy; governance

HEALTH IN ALL (FOREIGN) POLICY: CHALLENGES IN ACHIEVING COHERENCE

As private economic actors move across borders with increasing ease and speed, developing international trade and investment rules that diminish governments' policy space for market regulation, what form of global governance should arise to re-balance the dynamic relationship between states, markets and civil society, and to ensure more equitable global health outcomes? These questions call for a Health in All Policies (HiAP) approach to foreign policy. Given the competing interests that dictate the landscape of international

relations, how can health find a strong place in a policy world dominated by concerns for national security and economic competitiveness?

FROM INTERNATIONAL TO GLOBAL HEALTH

It is first useful to distinguish *international* from *global* health, especially since much of what has recently been re-branded 'global' is simply old 'international' wine in new bottles. International health describes interventions to reduce the disproportionately greater burden of disease in low- and middle-income countries (LMICs). Much of

the past, and successful, international health effort consisted of transfers from richer to poorer countries of low-cost health technologies, health development assistance and technical cooperation, often delivered through non-governmental organizations (NGOs) which provided health services that cash-strapped governments were unable or unwilling to. International health remains the dominant model, exemplified by the massive increase in global financing for health arising out of the 2000 Millennium Development Goals (MDGs), the growth in global public-private partnerships for health and the scale and scope of international NGOs engaged in health development. While still important, international health has been criticized for a paternalistic *noblesse oblige* on the part of wealthier countries, and for remaining largely locked within biomedical, clinical and health systems frames of reference where access to health care, medical treatments and population prevention programs for specific diseases predominate.

Global health, in contrast, is concerned with ‘inherently global health issues’, those problems arising from heightened globalization-related interdependencies. In simple terms, it asks: *why* do some countries suffer disproportionately greater burdens of disease? What is it about our recent historical and contemporary global political and economic order that underpins these health inequities? Almost a decade ago, Labonté and colleagues developed a template of inherently global health issues organized into three clusters (environmental, socioeconomic and cross-cutting) (Figure 1) (Labonté and Spiegel, 2003; Labonté

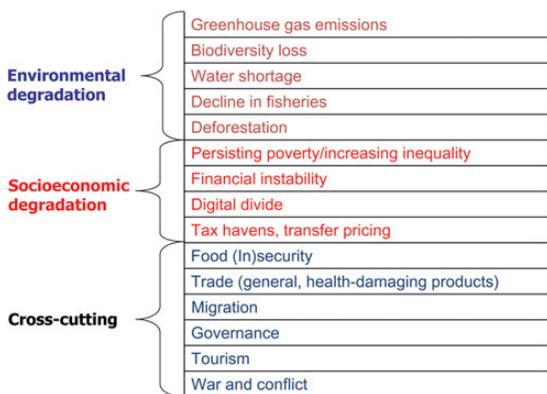


Fig. 1: Inherently global health issues. *Source:* Labonté and Spiegel (2003) and Labonté and Torgerson (2005).

and Torgerson, 2005). The two defining criteria of these issues are that their source is embedded within global economic and political policies and practices, and their impacts spill across borders. In one sense, this is nothing new: there have been critics of colonialism and the exploitation of poorer nations by richer ones for decades, if not centuries; and disease spread has long followed trade routes, migration, military campaigns and religious pilgrimages. What is new is that contemporary (post-1980 neoliberal) globalization is undermining regulatory powers of the post-Westphalia nation state while freeing capital from territorial restraint. This has increased both civil society and (some) government attention on the need for new forms of global governance, generally, and for health, specifically.

FROM GLOBAL HEALTH GOVERNANCE TO GLOBAL GOVERNANCE FOR HEALTH

Here, it is helpful again to distinguish between two closely related terms: global health governance (where health is the focal sector and tries to get buy in from other sectors, mostly around diseases and health care) and global governance for health (where sectors affecting determinants of health—, e.g. trade, investment, macroeconomic policy, environment, labour and migration—are the focal points and health attempts to influence decision-making such that health concerns are given fuller consideration). Both approaches are variations on HiAP, although global governance for health comes closer to embodying HiAP’s ambitions by immediately drawing attention to the plurality of venues in which multilateral negotiations and norms-setting occur around issues that are not explicitly health-focused.

Global governance is usually regarded as processes that involve state and non-state actors in managing ‘inherently global’ issues, whether through the ‘hard law’ of trade and investment treaties (which carry monetary penalties for breaking the rules), the ‘soft law’ of international human rights (characterized by an absence of enforcement measures) or compliance with the normative commitments contained in multiple international declarations (which relies more on domestic civil society pressure than international censure) (Lee *et al.*, 2009). Although global governance is frequently seen as a collaborative undertaking, power politics prevail in agenda

setting and states continue to hold final decision-making authority. This renders states' foreign policy priorities and practices central to how health is advanced during multilateral negotiations or norms-setting processes. A new term has been coined to capture this dynamic: global health diplomacy (GHD), broadly defining two ways in which health and foreign policy are entwined (Lee and Smith, 2011). The first use, more akin to 'international health', is using health as a means to enhance other foreign policy goals (e.g. using economic costs of excess disease burdens to strengthen commitments to climate change targets, or increasing health aid to reduce the risk of conflict in strategically important countries or regions). The second use, aligned more closely with global health, is using other foreign policy goals to advance health (e.g. adapting trade policy to positively discriminate in favour of healthy foods, or imposing financial transaction taxes to reduce de-stabilizing short-term capital flows and finance health development in poorer countries).

GHD has generated substantial academic interest in theoretical and empirical study (Fidler, 2005; Fidler and Drager, 2009; Smith *et al.*, 2010; Lee and Smith, 2011; Kickbusch *et al.*, 2013), which can be distilled to three basic questions:

- (1) How does health become an issue in foreign policy?
- (2) How is health negotiated in bilateral, international and multilateral forums?
- (3) How do these supra-national treaties/conventions and norms affect national policy-making?

Drawing from our own recent work on GHD (Labonté, 2010; Labonté and Gagnon, 2010; Labonté *et al.*, 2011, 2012), the rest of this article focuses on the first question by identifying six health framings in foreign policy, and examining these for how they position health as a foreign policy concern. If public health and health promotion workers want to influence foreign policy, it is helpful to know the arguments residing in these different framings, and how and when they might be used. Although it is unlikely that the elusive HiAP goal of health policy coherence across all sectors will be achieved in foreign policy, the inherent conflicts or incoherence between competing foreign policy goals can at least be better managed to maximize positive and minimize negative health externalities.

FRAMING HEALTH IN FOREIGN POLICY

Health frames describe the rationale for consideration of health as a foreign policy issue. The six that we discuss—health as security, trade, development, global public good, human rights and ethical/moral imperative—are neither exclusive (other global health policy documents use similar framings) nor exhaustive. They nonetheless reasonably capture the different ways in which a case for health as a foreign policy priority can be advanced.

Health as security

The security frame is the most common one encountered in foreign policy statements and multilateral negotiations. There are three variations on this framing:

- (1) National security: border protections against the rapid spread of infectious disease such as influenza pandemics, or of drug-resistant disease strains through migrations, travel or citizens returning from surgical procedures obtained in other countries ('medical tourism').
- (2) Economic security: high disease burdens in LMICs can suppress growth and disposable incomes in those nations.
- (3) Human security: a cosmopolitan, people-centred (rather than state-centred) concept in which foreign policy has a duty to ensure the 'capacities' (including health) of all the world's population, notably those in vulnerable circumstances.

The first two correspond to international relations theory that posits national security and economic interests as the two 'high politics' of foreign affairs (Fidler, 2009). Health's alignment with national security is already well accepted; as is the argument that national health security (framed as pandemic preparedness) requires global health security in the form of intergovernmental cooperation (Ministers of Foreign Affairs, 2007). The economic argument (or 'business case') for health as a security issue is less prominent but rests on some evidence that in low-income countries unchecked disease can lead to economic decline, failed states and domestic/regional conflict (Labonté, 2010). This can lead to costs associated with peace-keeping or military interventions and post-conflict reconstruction, and to a loss in trade- or investment-related economic opportunities in disease-burdened countries.

Human security is the outlier in the list, speaking to the ‘low politics’ of humanitarian assistance and human development. It dropped from prominence in development and international relations discourse after a brief flurry of attention in the 1990s, although arguably persists in the MDGs, discussed below.

The *coherence* concerns with the security framing are that it is fundamentally utilitarian and leads to a triage of short-term ‘high politics’ policy choices based on national (and even electoral) self-interests rather than global health need. Efforts to align health more closely with security (as in the US ‘smart global health’ in which occupying troops help to set up health clinics or run immunization programs, thereby winning local support for its military interventions) reverses earlier international health interventions based (at least in part) on humanitarian motives. The securitization of certain diseases, notably HIV and pandemic influenza, both recognized as security threats by the United Nations, has led to collective health financing vastly disproportionate to their actual burdens or potential risk. Thus, although aligning health in foreign policy with national security and economic interests is appealing and likely to gain political traction in countries with strong conservative or neoliberal parties in power, it should be used with caution and not without reference to other health frames as supplementary arguments.

Health as development

The second most encountered health frame is well-known and was substantively accelerated in the post-MDG era. Health has long been a pre-occupation in international development. It was first seen as a positive externality of economic development (‘trickle-down’ health), and often came with the caution, especially during the era of structural adjustment loans in the 1980s and 1990s, that too much public health spending could dampen economic growth. Since the late 1990s, buttressed by influential reports from the World Bank (World Bank, 1993) and the World Health Organization (Commission on Macroeconomics and Health, 2000), health has been recast as a necessary investment in development that can yield impressive returns in economic growth, especially when accompanied by improvements in sanitation, potable water and education. Once again, there are strong ‘business cases’ to be made for development financing as a foreign policy

priority, with health financing near the top of the list:

- (1) Health improvements in aid recipient countries can increase productivity, growth and greater health, contributing to global economic growth.
- (2) Health gains can improve aid recipient countries’ economic performance, creating trade-related economic benefits for donor countries.
- (3) Improvements in health can decrease security threats to donor countries by reducing disease-based risks of conflict within or among recipient countries.

Apart from these self-interested (‘high politics’) rationales, the 2000 MDGs gave high normative priority to reducing several disease burdens (HIV, malaria and tuberculosis; maternal and child deaths) as well as extreme poverty and hunger, the two leading risk conditions for preventable disease. In 2011, 133 member nations of the UN issued a political declaration on non-communicable diseases, which is now also seen as imperilling growth and development. Although such non-binding declarations have persuasive power, their voluntary commitments lack both the carrots and the sticks with which countries might be prodded to comply. As well, the 2008 financial crisis and subsequent global recession (Labonté, 2012; Ruckert and Labonté, 2012, 2013) has slowed growth in health development assistance and may be dampening international enthusiasm for new global health goals as countries (rich and poorer alike) turn inwards to their sluggish domestic economies.

There are also long-standing *coherence* concerns with the development frame itself. Although health aid in the main has been shown to yield positive health improvements and some economic benefit (Labonté *et al.*, 2009), development financing continues to be allocated more by donor country geopolitical interests than by global health or recipient country need. Vertical funding predominates, and there are problems of aid-dependency, lack of harmonization among donor nations or agencies, lack of predictability or stability in aid transfers and high transaction costs. This has led some critics to argue against ‘Dead Aid’ (Moyo, 2009), demonstrating aid ineffectiveness by noting that after almost USD \$1 trillion in foreign assistance over the past 40 years, Africa still lags on most economic and social measures. Such criticisms have some merit, and the development frame clearly presents as an ‘international’ rather than ‘global’ health approach

to HiAP. But the criticisms also ignore that, returning to Africa over the same 40-year period, the continent lost almost twice what it received in aid in capital flight, most of it illicit and much of it the result of transnational corporate tax evasion aided by the existence of offshore financial centres (Ndikumana and Boyce, 2011). Most of these 'tax havens' are located within or operate under the protection of high-income donor countries—one of the grander cases of foreign policy incoherence.

In arguing health as a development priority, a HiAP approach would thus recognize the importance of providing aid for recipient countries to develop more progressive and transparent tax systems, and urge donor countries to work with their recipient partners to increase the royalties charged on the extractive or 'land-grabbing' industries owned or financed by foreign investors. The greater coherence challenge is that promoting and financing long-term equitable global development may conflict with the political ideologies of some governments and with the interests of economic elites within both donor and aid-recipient countries. The best stance in such a situation is to invoke the benefits of helping to build revenue self-sufficiency in recipient countries (rather than ongoing costs of continued aid financing), the health risks of cross-border disease spread in failing to do so and the long-term economic benefits for all nations that a stable, healthier world can provide.

Health as global public good

Global public goods have been advanced as another important health frame. The concept arises from economics to describe goods that are accessible to all, and for which use by one does not preclude use by another. Road traffic signals, potable municipal water systems and air quality are localized examples. Drawing definitional boundaries around *global* public goods has proved challenging, but such goods include peace, prevention of pandemics, financial stability, human rights, free access to knowledge and a stable climate (Labonté and Gagnon, 2010). Because public goods are non-exclusive and non-exhaustible, they are undersupplied by markets; there is no economic benefit in creating or sustaining them and individuals can 'free-ride' by enjoying the good without having to pay for it. The same applies to global public goods, which Kickbusch (Kickbusch, 2013) suggests are becoming less economically and more politically defined along three axes: 'rules that apply across

borders, institutions that supervise and enforce these rules, and the benefits that accrue without distinction between countries' (p. 5). Whether economically or politically argued, the provision of such goods falls within governmental systems of collective financing and regulation or, in the case of global public goods, intergovernmental agreements. Not all economists agree that health is a public good; some view it primarily as a private good. But many of the determinants of health fall within the ambit of public goods; and globally such goods include international health, environmental, labour and other social conventions that regulate their provision. Efforts to stem cross border disease risks or the globalization of unhealthy products through, respectively, the World Health Organization's recently revised International Health Regulations and its Framework Convention on Tobacco Control (FCTC) are specific examples.

The strength of the global public good frame is that it is based on economic concepts that can provide an argumentative bridge between persons working in health, environment and other 'public good' domains nationally with those in finance or treasury and foreign affairs ministries. There is also an extensive literature on the concept providing the economic rationales for why national governments should be financing such goods. There are overlaps with the other health frames, in that intergovernmental and global governance arrangements to finance and manage global public goods improve both national health security and economic growth. Just as health as development went through a shift from being seen as a cost to regarded as an investment, a 'business case' for global public goods can be made, whereby collective financing for such goods is seen as an investment in preventing global public 'bads' such as climate change or unchecked pandemics, thereby reducing the downstream costs of their remediation.

But there are *coherence* issues with the concept. No consensus exists on the boundaries demarcating a 'global' public good from a regional or national public good. More problematic is that despite the economic appeal of the concept, funding for such goods is not keeping pace with the need for their provision; and financing for climate change prevention or mitigation conflicts with those countries whose economies continue to be driven by fossil fuel extraction or use. Governance for such goods requires intergovernmental agreement on new conventions, with the

long negotiating time for conventions creating less government appetite for their engagement. Global public goods remain a potentially useful HiAP frame, with some evidence of its use in such WHO treaties as the FCTC and the International Health Regulations, but one that presently lacks traction in health and foreign policy discourse (Labonté and Gagnon, 2010).

Health as trade

There are two broad ways in which health and trade have been framed as mutually positive. The first views health as a commodity or sector in which trade and investment should occur. Private investors, insurers and health services providers, when protected by liberalization treaties, are better able to move across borders to markets where public health care is underfunded or under-developed. Although primarily serving higher-income groups able to afford the cost, such privately provided services are argued to relieve pressure on the public health system, allowing it to devote more resources to poorer populations. There is economic interest on the part of exporting countries, with some estimates of the global health market (both public and private) exceeding USD \$6.5 trillion annually (Emergo Group, 2012). Developing countries are also argued to benefit from health services trade, with two frequently cited examples being the remittances sent home by émigré health workers and ‘medical tourism’ that attracts foreign, fee-paying patients to medical facilities offering prompt care and lower costs. Much of this trade (health workers out, foreign patients in) currently takes place outside of liberalization treaty rules, but trade negotiators continue to push for more health services commitments in regional and bilateral treaties. Finally, although protectionist rather than liberalizing, the inclusion of strong intellectual property rights in such treaties has been justified as essential to finance the development of new drugs. The second views the relationship more broadly, with increases in global trade and foreign direct investment through liberalization argued to improve economic growth and development in LMICs, with subsequent ‘trickle-down’ health (Labonté *et al.*, 2010).

These arguments, although frequently encountered, are also contentious. The ‘trickle-down’ health argument is weakened by evidence that trade treaties to date have disproportionately benefited wealthier nations, often at the expense

of poorer ones (Polaski, 2006; Sundaram and Arnim, 2009). Even if all countries grow, even if at similar rates, the absolute income differential between countries becomes larger. Reductions in border taxes (tariffs) often lead to lower public revenue capture in LMICs, notably in sub-Saharan Africa, which lack effective taxation systems to replace the losses (Keen and Mansour, 2009). Many émigré health workers are unable to find employment in high-income ‘destination’ countries’ health systems, and their remittances are private welfare transfers that do not necessarily compensate for the losses in their ‘source’ country’s health systems (Packer *et al.*, 2009). Medical tourism and foreign investment in health care can increase inequities in the private/public mix of services, and crowd out health care access for poorer populations (Alsharif *et al.*, 2011). Evidence that strengthened IPRs (extended patent protection) are needed to finance new drug research is questionable, at best (Correa, 2008). There is also robust empirical consensus that trade liberalization leads to inequalities in labour markets, as wages for highly skilled workers in globally competitive industries rise and those for lesser skilled workers in relative abundance fall, increasing destabilizing income inequalities within countries (Ravallion, 2006). Finally, liberalized and deregulated capital markets have led a new ‘financialized’ economy based on highly leveraged, short-term speculative gambling, which eventually brought us the Great Financial Crisis of 2008, and the Great Recession and Austerity Agenda in its wake (Labonté, 2012; Ruckert and Labonté, 2012, 2013; Stuckler and Basu, 2013).

Indeed, the trade framing of health presents the greatest *coherence* challenges. Trade and investment liberalization can undo many of the health gains or protections achieved through global health financing (the development frame) or even pandemic preparedness (the security frame). As ‘hard law’ for the economic penalties such treaties have for enforcement, it is important that HiAP advocates understand the nuances of trade and investment policy in order to ensure better health protection during new treaty negotiations, and to make full use of flexibilities in existing trade treaties through carefully crafted domestic public health regulations. It is possible for trade treaties to contribute to global public health goals such as those related to NCD control, if they are used to dispute agricultural subsidies for obesogenic foods while permitting subsidies for the production, marketing and

export of healthier foods (although the complex issue of national food security/sovereignty would remain). There is also growing acceptance of public health concerns in trade treaty disputes under the multilateral World Trade Organization (WTO) agreements, provided public health regulations do not discriminate against foreign goods, that is, all goods must be treated the same regardless of country of origin. The proliferation of WTO+ bilateral and regional trade treaties, however, is undermining this flexibility (Friel *et al.*, 2013). The provision of greatest concern is the ongoing push to liberalize all forms of capital flows (largely driven by the USA), and to incorporate ‘investor-state dispute settlement’ (ISDS) chapters, allowing foreign corporations and investors to sue governments for regulations that they think dampen their anticipated return on investments. ISDS rules could also lead to foreign investors engaged in rapid inflows/outflows of ‘hot money’ suing governments for the very financial chaos their cross-border arbitrage creates. Such ISDS provisions, along with IPR protections within the WTO and other bilateral or regional treaties, are also being used to challenge public health regulations that comply with ‘best practice’ recommendations of the FCTC (tobacco control), and are likely to be used to undermine globally agreed upon efforts to reduce the growing burden of diet- or alcohol-related NCDs.

The most powerful arguments for ensuring that trade and investment treaties ‘first, do no harm’ are those similar to the ‘business case’ for both security and development: If trade and investment treaties increase wealth and income inequalities within and between nations, they risk future security costs, lost future trade and investment opportunities and potential and costly damages to peoples’ health. Prospectively, a HiAP approach would initiate health impact assessments of current and proposed trade treaties, at least to the extent that the provisions of new treaties under increasingly ‘secret’ negotiation are leaked publicly and available for analysis. A defensive measure would also be to advocate with government trade negotiators for inclusion in all new treaties of a requirement that dispute panels incorporate specific reference to all international public health ‘soft law’ (such as the FCTC and the International Health Regulations) and normative agreements (such as World Health Assembly approved global action plans on various health issues) in their decision-making.

Health as human right

Human rights are frequently invoked for political purposes by heads of state and foreign affairs officials, but rarely do foreign policy statements make explicit reference to countries’ obligations under international human rights law (Bustreo and Doebbler, 2010). This does not remove their legal or normative requirement to do so. Section 103 of the Charter of the United Nations, for example, states that in conflicts between Charter obligations and those under other international treaties, Charter obligations will prevail, and specifically places human rights obligations on states in Articles 55 and 56. The Vienna Declaration and Program of Action (The Vienna Declaration and Program of Action, 1993) is widely regarded as a state consensus on the moral primacy of human rights over other public interests. The 171 states that signed this Declaration effectively proclaim that the protection and promotion of human rights and fundamental freedoms (and not national security or economic competitiveness) are the first responsibilities of governments.

The most cited human rights law with bearing on health and foreign policy is the right to health, technically known as the Right to the Highest Attainable Standard of Physical and Mental Health. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) obligates states to ensure equitable access to a minimum set of health services, while General Comment 14 (GC 14) on this Article identifies a broader range of actions covering many of the social determinants of health that are required for the progressive realization of this right. The right to health can also be found in other human rights conventions (such as the Convention on the Rights of the Child), meaning that almost all of the world’s countries have ratified this right and are bound by its obligations. Although international human rights law is seen as primarily a matter of national jurisprudence (what states are obliged to guarantee for their citizens), it has foreign policy implications. Article 2.1 of the ICESCR mandates each state party in fulfilling their obligations to ‘take steps individually and *through international assistance and cooperation*, especially economic and technical, to the maximum of available resources’ (emphasis added); while Paul Hunt, former UN Special Rapporteur on the right to health, has argued 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', a normative affirmation of which exists in the MDGs. The ICESCR further requires state parties 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, methods for which have been developed with specific reference to the right to health and IPRs (Forman, 2012), as well as more generically (Labonté, 2013). It also provides leverage for advocates of a HiAP approach to foreign policy.

The greatest *coherence* challenge to the human rights frame exists in the conflicts between several provisions of trade and investment treaties (hard law) and obligations under human rights covenants (soft law). While there has been no shortage of efforts to position both health and human rights more strongly in trade debates, the protection of human rights is not an objective trade treaties presently recognize as a legitimate reason for restricting trade. This has led to several calls for *ex ante* right to health impact assessments (similar to health impact assessments) and for inclusion of a human rights impact analysis in the trade dispute settlement process.

Although compelling, 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 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 (Austin, 2001). Their specific obligations on states can and should be used by HiAP

advocates to advance global health equity arguments within foreign policy deliberations. This requires close collaboration with international human rights experts.

Health as ethical/moral imperative

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 (security and economics) will always override the low politics of global health (development, public goods, human rights). Arguing from an ethical vantage will be the most challenging for a HiAP approach to foreign policy; since Machiavelli's sixteenth 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. At the same time, 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 (Sen, 2004; Yamin, 2008), 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 foreign policy discourse (IFSD, 2006), although reference to social justice as an overarching ethic is frequently encountered and Article 19 of the UN Millennium Declaration announced its core value as a 'collective responsibility to uphold the principles of human dignity, equality and equity at the global level', requiring of political leaders 'a duty . . . to all the world's people, especially the most vulnerable' (Article 2, [General Assembly Resolution, 2000](#)).

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 cannot only be made, but also be considered or conceived as real possibilities. Capabilities philosophers have identified core sets of capabilities (Sen, 1999; Nussbaum, 2000), and human rights treaties have listed core obligations for the fair provision of resources required by individuals to develop them (Chapman, 2009). A HiAP approach would involve appraising foreign policy choices against these capabilities and human rights obligations. Health is also generally considered to have ‘special importance’ in peoples’ lives, and in their ability to enjoy both dignity and personal security (Ruger, 2008); and capabilities for health are also prerequisite to people being able to acquire other capabilities for human flourishing (e.g. education, meaningful work).

These moral (capability) arguments immediately surfaces questions of social justice in how fairly (equitably) resources are allocated among peoples and countries. 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). Although often seen as competing, these two norms are more complementary than exclusive. 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 inequalities between individuals and groups persisting and, in many instances, growing, fairness requires measures to ensure disproportionately greater capability resources for those historically disadvantaged by social, economic and political systems of oppression or exclusion (Schaefer, 2006). The most developed argument for such rectification at a global scale is Pogge’s theory of relational justice, which is based on three lines of argument: (1) today’s inequalities are an effect of a violent history of exploitation of some by others; (2) these disparities persist through the practices of nation states and economic actors; and (3) economic institutions operating on an international scale have been complicit in upholding these injustices (Pogge, 2004). The moral implication is one of strengthening human rights and engaging in 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.

The *coherence* challenge in arguing for HiAP from a moral or ethical frame is that there are no universally accepted metrics (or rationales) for the obligation actors and states have to ameliorate gross inequalities in peoples’ initial conditions that create ‘shortfall inequalities in central health capabilities’ (Ruger, 2008). Even international human rights covenants are silent on the question of redistributive scale. It is possible that a ‘business case’ for a HiAP approach to foreign affairs and global governance can be made that does not conflict with the social justice premises of moral reasoning, similar to the arguments presented in the development frame. Fundamentally, however, ethics are an attempt to transcend utilitarianism by invoking universal precepts for human social behaviour. To that extent, HiAP advocates should never feel constrained in making well-developed moral arguments; even as they should never rest their entire effort to advance health in foreign policy priorities on ethical reasoning alone.

CONCLUSION

Several countries over the past decade have adopted policy frameworks for engaging in health as a global issue, and global health continues to figure prominently in international/intergovernmental policies and debate. Much of the existing discourse, however, is consistent with the realist theory of international relations that states act in their own interests in the international arena; yet self-interest does not define all of the practices or policies of states. This has created more space for public health and health promotion practitioners to become ‘policy entrepreneurs’ for positioning health higher up in the foreign policy agenda of their national governments. The premise of this brief review of global health frames is that each of them sets boundaries around problem-definition and resolution: they function in an agenda-setting way and as such offer different strategic entries for a HiAP foreign policy practice. As we concluded in an earlier review of these frames:

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 and global health aid decisions that reflect the interests of wealthier nations. Politically, the security and trade framings are the most potent but remain the most problematic. Both privilege existing relations of political, military and economic power over human rights, need or moral reasoning. The securitization of health, even in its human rather than national or economic rendering, remains premised in a conception of the individual made capable to function as a market actor; that is, it supports, rather than challenges, the social and economic assumptions that have driven the past three decades of neoliberal globalization (Labonté and Gagnon, 2010).

There are differing analyses of how effectively health can retain or expand its position in foreign policy debate. There is concern that the post-2008 financial crisis is driving countries into a more inward, economic and mercantilist set of policies, arguably inimical to global health equity; or that their foreign policies are increasingly dominated by trade and investment treaties and resource extractions that prioritize wealth generation (and for whom?) over health protection. Others are more sanguine about the future, as Kickbusch concludes in her review of a ‘game change in global health’:

We are witnessing a convergence on a set of key principles that form a global health ethics in a challenging narrative of rights and justice which is beginning to be reflected in the debates on post-2015 [development goals]. The next era of global health will be judged by its political capacity to ensure global health security, build universal health coverage, address the commercial determinants of health and reduce global health inequalities (p.15) (Kickbusch, 2013).

FUNDING

No funding was received for this specific article. Earlier publications on this topic, however, were supported by research contracts and grants. Information on these are available if needed.

CONFLICT OF INTEREST

None to declare.

REFERENCES

- Alsharif, M. J., Labonté, R. and Zuxun, L. (2011) Medical tourism: an exploratory study of patient experiences in four countries. *Global Social Policy*, **10**, 315–335.
- Austin, W. (2001) Using the human rights paradigm in health ethics: the problems and possibilities. *Nursing Ethics*, **8**, 183–195.
- Bustreo, F. and Doebbler, C. (2010) Making health an imperative of foreign policy: the value of a human rights approach. *Health and Human Rights: An International Journal*, **12**, 47–59.
- Chapman, A. (2009) Globalization, human rights and the social determinants of health. *Bioethics*, **23**, 97–111.
- Commission on Macroeconomics and Health. (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. World Health Organization, Geneva.
- Correa, C. (2008) *Intellectual Property Rights and Inequalities in Health Outcomes*. Globalization Knowledge Network, World Health Organization Commission on the Social Determinants of Health. Available at: http://www.globalhealthequity.ca/projects/proj_WHO/index.shtml.
- Emergo Group. (2012) Worldwide spending on healthcare. Emergo Group, marketing department. Available at: <http://www.emergogroup.com/resources/worldwide-health-expenditures>.
- Fidler, D. (2005) *Health and Foreign Policy: A Conceptual Overview*. The Nuffield Trust, London.
- Fidler, D. (2009) After the revolution: global health politics in a time of economic crisis and threatening future trends. *Global Health Governance*, **2**, 1–21.
- Fidler, D. and Drager, N. (2009) *Global Health and Foreign Policy-Strategic Opportunities and Challenges: Background Paper for the Secretary-General's Report on Global Health and Foreign Policy*. World Health Organization, Geneva.
- Forman, L. (2012) From TRIPS-Plus to Rights-Plus? Exploring right to health impact assessment of trade-related intellectual property rights through the Thai experience. *Asian Journal of WTO and International Health Law and Policy*, **7**, 347–375.
- Friel, S., Gleeson, D., Thow, A-M., Labonté, R., Stuckler, D., Kay, A. and Snowdown, W. (2013) A new generation of trade policy: potential risks to diet-related health from the trans-Pacific partnership agreement. *Globalization and Health*, **9**, 1–7.
- International Forum for Social Development (IFSD). (2006) Social justice in an open world: the role of the United Nations. *Economic and Social Affairs*. Available at: <http://www.un.org/esa/socdev/documents/ifsd/SocialJustice.pdf>.
- Keen, M. and Mansour, M. (2009) Resource mobilization in Sub-Saharan Africa: challenges from globalization. IMF Working Paper, Fiscal Affairs Department.
- Kickbusch, I. (2013) A game change in global health: the best is yet to come. *Public Health Review*, **35**, 1–20.
- Kickbusch, I., Lister, G., Told, M. and Drager, N. (eds) (2013) *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases*. Springer Books.
- Labonté, R. (2010) Global health policy: exploring the rationale for health in foreign policy. Globalization and Health Equity Working Papers, Ottawa. Available at: <http://tinyurl.com/6kmal9f>.
- Labonté, R. (2012) The austerity agenda: how did we get there and where do we go next? *Critical Public Health*, **22**, 257–265.
- Labonté, R. (2013) Human rights and equity: the value base for global health diplomacy. In Kickbusch, I. et al. (eds), *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases*. Springer Books.

- Labonté, R. and Gagnon, M. L. (2010) Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health*, **6**, 1–19.
- Labonté, R. and Spiegel, J. (2003) Setting global health research priorities. *British Medical Journal*, **326**, 722–723.
- Labonté, R. and Torgerson, R. (2005) Interrogating globalization, health and development: towards a comprehensive framework for research, policy and political action. *Critical Public Health*, **15**, 157–179.
- Labonté, R., Schrecker, T., Packer, C. and Runnels, V. (eds) (2009) *Globalization and Health: Pathways, Evidence and Policy*. Routledge, UK.
- Labonté, R., Blouin, C. and Forman, L. (2010) Trade, growth and population health: an introductory review. *Transdisciplinary Studies in Population Health Series*, **2**, 1–94.
- Labonté, R., Mohindra, K. and Schrecker, T. (2011) The growing impact of globalization for health and public health practice. *Annual Review of Public Health*, **32**, 263–283.
- Labonté, R., Runnels, V. and Gagnon, M. (2012) Past fame, present frame, and future flagship? An exploration of how health is positioned in Canadian foreign policy. *Administrative Science*, **2**, 162–185.
- Lee, K. and Smith, R. (2011) ‘What is global health diplomacy?’ A conceptual review. *Global Health Governance*, **5**, 1–12.
- Lee, K., Koivusalo, M., Ollila, E., Labonté, R., Schuftan, C. and Woodward, D. (2009) Global governance for health. In Labonté, R., Schrecker, T., Packer, C. and Runnels, V. (eds.), *Globalization and Health: Pathways, Evidence and Policy*. Routledge, UK, pp. 289–316.
- Ministers of Foreign Affairs. (2007) Oslo ministerial declaration-global health: a pressing foreign policy issue of our time. *The Lancet*, **369**, 1373–1378.
- Moyo, D. (2009) *Dead Aid*. Farrar, Straus and Giroux, New York.
- Ndikumana, L. and Boyce, J. (2011) Capital flight from sub-Saharan Africa: linkages with external borrowing and policy options. *International Review of Applied Economics*, **25**, 149–170.
- Nussbaum, M. (2000) *Women and Human Development: The Capabilities Approach*. Cambridge University Press, Cambridge.
- Office of the High Commissioner for Human Rights. (1993) Vienna Declaration and Program of Action. Available at: <http://www.ohchr.org/en/professionalinterest/pages/vienna.aspx>.
- Packer, C., Labonté, R. and Runnels, V. (2009) Globalization and the cross-border flow of health workers. In Labonté, R., Schrecker, T., Packer, C. and Runnels, V. (eds), *Globalization and Health: Pathways, Evidence and Policy*. Routledge, UK, pp. 213–234.
- Pogge, T. (2004) Relational conceptions of justice: Responsibilities for health outcomes. In Anand, S. et al. (eds), *Public Health, Ethics and Equity*. Clarendon Press, Oxford.
- Polaski, S. (2006) Winners and losers: impact of the Doha round on developing countries. Carnegie Endowment Report. Carnegie Endowment for International Peace, Washington, DC.
- Ravallion, M. (2006) Looking beyond averages in the trade and poverty debate. *World Development*, **34**, 1374–1392.
- Ruckert, A. and Labonté, R. (2012) The global financial crisis and health equity: towards a conceptual framework. *Critical Public Health*, **22**, 267–279.
- Ruckert, A. and Labonté, R. (2013) The financial crisis and global health: The International Monetary Fund’s (IMF) policy response. *Health Promotion International*, **28**, 357–366.
- Ruger, J. (2008) Normative foundations of global health law. *The Georgetown Law Review*, **96**, 424–443.
- Schaefer, D. (2006) Procedural versus substantive justice; Rawls and Nozick. *Social Philosophy and Policy*, **24**, 164–186.
- Sen, A. (1999) *Development as Freedom*. Oxford University Press, Oxford.
- Sen, A. (2004) Elements of a theory of human rights. *Philosophy and Public Affairs*, **32**, 315–356.
- Smith, R., Fidler, D. and Lee, K. (2010) Global health diplomacy research. Trade, Foreign Policy, Diplomacy and Health Draft Working Paper Series, 1–18. WHO Network on Global Health Diplomacy.
- Stuckler, D. and Basu, S. (2013) *The Body Economic: Why Austerity Kills*. Basic Books, USA.
- Sundaram, J. and Arnim, R. (2009) Trade liberalization and economic development. *Science*, **323**, 211–212.
- UN General Assembly. (2000) United Nations Millennium Declaration. Available at: <http://www.un.org/millennium/declaration/ares552e.htm>.
- World Bank. (1993) *World Development Report 1993*. Oxford University Press, Oxford.
- Yamin, A. (2008) Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care. *Health Human Rights*, **10**, 45–63.