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Michelle L. Gagnon & Ronald Labonté

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## **Human Rights in Global Health Diplomacy: A Critical Assessment**

MICHELLE L. GAGNON AND RONALD LABONTÉ

*There is no question that health has risen higher in foreign policy, with health aid quadrupling in the past 20 years and most Millennium Development Goals (MDGs) directly (or indirectly via determinants) addressing critical health inequities. The idea that governments should consider health seriously within their foreign policy became an official UN General Assembly Resolution in early 2009. Several countries have already issued formal statements on health as a foreign policy issue while others are crafting thought pieces that are nudging health forward in foreign policy discussions. There is even a new movement combining academia and bureaucracy under the rubric of global health diplomacy; the process by which government, multilateral, and civil society actors attempt to position health higher in foreign policy arguments. But for global health diplomacy (the “how”) to have traction in foreign affairs, it needs a clear articulation of the “why.” In looking more closely at country statements, what is apparent is the confusing mix of interconnections between wildly differing motives and drivers for the integration of health into foreign policy, not all of which cohere with one another. What arguments exist for why health (and notably health equity, the reduction of preventable inequalities in health within and between nations) should be a prominent foreign policy concern? Within the polyphony of possible arguments, where is there reference to human rights and have invocations to human rights by governments with stated commitments to health in their foreign policy mattered in how they actually behave? This article begins to address these questions.*

### **Introduction**

In 2006, the foreign ministers of seven countries met and formed the Global Health and Foreign Policy Initiative to increase awareness of health as a cross-cutting foreign policy issue (Ministers of Foreign Affairs 2007). In 2007, this group issued the *Oslo Ministerial Declaration* identifying “global health” as “a pressing foreign policy issue of our time” (Ministers of Foreign Affairs 2007: 1373). The *Declaration* was clear that

Health is deeply interconnected with the environment, trade, economic growth, social development, national security, human rights and dignity. In a globalised and interdependent world, the state of global health has a profound impact on all nations—developed and developing. Ensuring public health on a global scale is of benefit to all countries. (Ministers of Foreign Affairs 2007: 1373)

What is immediately apparent from this quotation is that the rationale for ratcheting up health in the foreign policies of national governments is a confusing mix of interconnections

Address correspondence to Michelle L. Gagnon, Institute of Population Health, University of Ottawa, 1 Stewart Street, Ottawa, Ontario K1N 6N5, Canada. E-mail: mgagn023@uottawa.ca

between wildly differing motives and drivers, not all of which cohere with one another. Trade liberalization treaties, at best, have done little to improve global health and there is evidence that they are creating negative health externalities (Birdsall 2006; Thorbecke & Nissanke 2006). National security evokes images of a *cordon sanitaire* in which the goal is self-protection, not global health enhancement. Economic growth may be necessary (for some countries) but insufficient (for all countries) to create better health (Globalization and Health Knowledge Network 2008) and faces absolute limits in terms of natural resources essential for life. Somewhere in the midst of this polyglot stands dignity (the foundational bedrock of Western moral philosophy) (Sen 2004; Yamin 2008) and human rights (the most articulate incorporation of this bedrock of human dignity in policy-relevant legal obligations) (Clapham et al. 2009). What are we to make of this *pastiche*?

To begin, there is no question that health has risen higher in foreign policy, with health aid disbursements quadrupling in the past 20 years (Ravishankar et al. 2009) and most of the Millennium Development Goals (MDGs) directly (or indirectly via social determinants) addressing critical health inequities (United Nations General Assembly 2000). The idea that governments should consider health seriously within their foreign policy became an official UN General Assembly Resolution in early 2009 (United Nations General Assembly 2009). Several countries have already issued formal statements on health as a foreign policy issue or global development (in which health figures prominently) among them the United Kingdom, Switzerland, Norway, Brazil, and Sweden (see Table 1). Many others are crafting thought pieces that may not (yet) rank as policy statements but that are nudging health forward in foreign policy discussions. There is even a new movement combining academia and bureaucracy under the rubric of global health diplomacy (GHD); a term used to describe the processes by which government, multilateral, and civil society actors attempt to position health higher in foreign policy negotiations and to create new forms of global governance for health.

But for global health diplomacy (the “how”) to have much traction in the *realpolitik* of foreign affairs, it needs a clear articulation of the “why.” What arguments exist for why health (and notably health equity, the reduction of preventable inequalities in health within and between nations) *should* be a prominent foreign policy concern? Within the polyphony of possible arguments, where is there reference to the International Human Rights Framework (IHRF)? And have invocations to human rights by governments with stated commitments to health in their foreign policy mattered in how they actually behave? This article begins to address these three questions.

First, we identify the range of arguments advanced for why health should be a foreign policy concern, amongst which human rights is one of several. Second, we explore why human rights hold (or should hold) a central place in global health diplomacy, including a discussion of the potential importance of referring to the right to development alongside the right to health. Third, we analyze the extent to which the formalized structure embodied in the IHRF is reflected in existing government policy statements on health and foreign policy, in interviews with key informants from a few of the countries with such policies, and in publicly available reviews of these countries’ human rights records. We conclude with a discussion of how human rights arguments should be positioned in global health diplomacy, including consideration of the importance of collective over individual rights.

## Methods

We analyzed global health policy statements or governmental commentaries from the United Kingdom, Switzerland, Sweden, Norway, and Brazil (see Table 1) and conducted

**Table 1**  
Health and Foreign Policy Key Documents

Title (Abbreviated)	Country, Year	Comment, Source
<i>Shared Responsibility: Sweden's Policy for Global Development</i> (80 pages) (SW)	Sweden, 2003	Legislation requiring annual report to parliament on how all foreign policies worked towards goal of global development (including health): Gov. Bill 2002/03:122, 15 May 2003 <a href="http://www.sweden.gov.se/sb/d/574/a/24520">http://www.sweden.gov.se/sb/d/574/a/24520</a>
<i>Swiss Health Foreign Policy: Agreement on Health Foreign Policy Objectives</i> (20 pages) (FDHA)	Switzerland, 2006	Published by Federal Office of Public Health and Federal Department of Foreign Affairs <a href="http://www.bag.admin.ch/org/01044/index.html?lang=en&amp;download=M3wBPgDB/8ull6Du36WenojQINTTjaXZnqWfVp3Uhmfnapmmc7Zi6rZnqCkkIZ2fHh/bKbXrZ6lhuDZz8mMps2gpKfo">www.bag.admin.ch/org/01044/index.html?lang=en&amp;download=M3wBPgDB/8ull6Du36WenojQINTTjaXZnqWfVp3Uhmfnapmmc7Zi6rZnqCkkIZ2fHh/bKbXrZ6lhuDZz8mMps2gpKfo</a>
<i>Meeting Global Challenges: International Cooperation in The National Interest</i> (202 pages) (SW-GPG)	Sweden, 2006	Issued by the International Task Force on Global Public Goods: Stockholm: Department of Development Policy, Ministry for Foreign Affairs, 2006 <a href="http://www.cic.nyu.edu/internationalsecurity/docs/Global%20Challenges%20OCT%2010%2006%5B1%5D.pdf">http://www.cic.nyu.edu/internationalsecurity/docs/Global%20Challenges%20OCT%2010%2006%5B1%5D.pdf</a>
<i>Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time</i> (6 pages) (OSLO)	Norway, France, Brazil, Indonesia, Senegal, South Africa, and Thailand, 2007	Statement issued by foreign ministers published in <i>The Lancet</i> 369(9570) April 2007, 1373–1378.
<i>Coherent for Development? How Coherent Norwegian Policies Can Assist Development in Poor Countries</i> (196 pages) (PCC)	Norway, 2008	Report of a two-year all party commission: Official Norwegian Reports, 2008 <a href="http://www.regjeringen.no/en/dep/ud/dok/rappporter_planer/rappporter/2008/nou_coherent.html?id=528066">http://www.regjeringen.no/en/dep/ud/dok/rappporter_planer/rappporter/2008/nou_coherent.html?id=528066</a>

(Continued on next page)

**Table 1**  
Health and Foreign Policy Key Documents (*Continued*)

Title (Abbreviated)	Country, Year	Comment, Source
<i>Health is Global: AUK Government Strategy, 2008–13</i> (39 pages; Annex, 109 pages) (UKHG) and (UKHG Annex) <i>Foreign and Commonwealth Office Departmental Strategic Objectives 2008/09–2010/11</i> (3 pages) (UKDSO)	UK, 2008	Issued by the Department of Health: <a href="http://www.dh.gov.uk/publications">www.dh.gov.uk/publications</a>
<i>The National Security Strategy of the United Kingdom: Security in an interdependent world</i> (64 pages) (UKFP)	UK, 2008	Issued by the Foreign and Commonwealth Office: <a href="http://www.fco.gov.uk/resources/en/pdf/pdf1/CSR-07">www.fco.gov.uk/resources/en/pdf/pdf1/CSR-07</a>
	UK, 2008	Issued by the Cabinet Office: Cm7291: March 2008 <a href="http://interactive.cabinetoffice.gov.uk/documents/security/national_security_strategy.pdf">http://interactive.cabinetoffice.gov.uk/documents/security/national_security_strategy.pdf</a>

interviews with key informants from all of these countries apart from Sweden, which was excluded for practical reasons associated with the primary study design. The purpose of the analyses and interviews were to assess the extent to which (1) the policy statements reflect human rights obligations and (2) human rights were considered as a rationale for the integration of health into foreign policy. These countries were chosen because they have demonstrated considerable normative leadership in GHD and in making the case for integrating health into foreign policy. In 2008, the United Kingdom launched *Health is Global: a UK Government Strategy 2008–13*, described by the UK government as an international first (HM Government 2008a). Norway played a key role in initiating the Oslo Ministerial Declaration (Ministers of Foreign Affairs 2007) and engaged an all-party commission to study coherence in its overall suite of foreign policies (The Policy Coherence Commission 2008). Switzerland developed a health foreign policy paper in 2006 (Federal Department of Home Affairs (FDHA) and Federal Department of Foreign Affairs (FDFA), while Brazil has been active in promoting the concept of global health diplomacy and was actively involved in the WHO Commission on Social Determinants of Health. To triangulate observations and conclusions drawn from document review and interviews, we also analyzed publicly available reports of human rights records of these countries from the UN Committee on Economic, Social and Cultural Rights (CESCR).

Each author reviewed the policy documents and results were compared. A systematic search for relevant keywords and concepts was also conducted to determine the extent to which the policies included references to concepts that Pogge, among others, argues are directly related to human rights, such as health equity and social justice (Braveman and Gruskin 2003; Pogge 2005; Robinson 2007; Ruger 2009; Yamin 2008). Interview data were reviewed and analyzed using similar keywords and concepts.

## **Policy Arguments for Global Health Diplomacy**

In the first instance, it is important to acknowledge that human rights present only one of many discursive arguments, or policy frames, for why health should be considered more central in foreign policy. As such, it competes with or complements other policy frames. A limited number of such frames have been identified, all of which have some presence (explicit or implicit) in national global health policy statements (Labonté 2008; Labonté and Gagnon 2010): health and security; health and development; health and global public goods; health and trade; health and human rights; and health and ethical/moral reasoning. We describe briefly the first four, before turning this article's attention to human rights. We set aside discussion of ethical/moral arguments for positioning health higher in foreign policy debate, as this is covered in greater depth in our earlier article (Labonté & Gagnon 2010) and a longer monograph (Labonté in press, Web published version being finalized).

### ***Security***

Security, the dominant rationale for integrating health into foreign policy, has two major aspects: national (border protection) and economic (growth and competitive advantage). The security concerns relate primarily to the cross-border risk of pandemic disease or pestilence, an effect of the increased scale in the global movement of goods and people; and how unchecked disease in poorer countries can lead to failed states and domestic/regional conflict, posing national security risks with knock-on health effects in nations not directly affected by the disease (Cheek 2001; Feldbaum, Lee, and Michaud 2010; Fidler and Drager 2006; Hewitt, Wilkenfield, and Gurr 2008; Mykhalovskiy and Weir 2006; Peterson 2002;

Price-Smith 2009). National health security requires global health security that “is only as strong as its weakest link” (Ministers of Foreign Affairs 2007: 1374) implying national self-interest in strengthening such links. A third security discourse exists, that of human security, which is person rather than state centered. It privileges the protection of “the vital core of all human lives in ways that enhance human freedoms and human fulfillment” (Chen 2004: 2; Commission on Human Security 2003: 4) over the protection of national borders and arguably is more consistent with a human rights approach. Human security, however, is rarely encountered by name in the literature on health and foreign policy.

### *Development*

Development provides the second most frequently encountered rationale for health in foreign policy. Health has long been regarded as one of the positive externalities of economic development, and development assistance, in turn, has long been one element of (wealthier) countries’ foreign policies. Since the 1990s, a growing body of evidence shows that improvements in health (and in its social determinants such as education, sanitation, and gender empowerment) are not merely positive externalities to development but are causally associated with economic growth (Commission on Macroeconomics and Health 2001; Global Forum for Health Research 2004). This aligns development instrumentally with national and economic security. The Millennium Development Goals (MDGs) set the context for increased foreign policy attention to health (three of the goals are directly health related, the others indirectly so) and constitute a global compact amongst the world’s nations to lessen poverty and health-related barriers to development (United Nations General Assembly 2000). Development assistance, however, has generally been allocated more by the political, economic, and strategic interests of donors than by global health need, indicative of it being used more as a tool for other foreign policy goals than as an end in itself (Feldbaum, Lee, and Michaud 2010; Labonté and Gagnon 2010; Labonté, Schrecker, and Sanders 2007). Recent attention by donor countries to maternal/child health may signal a slight break from this subordination as improved maternal/child health has little immediate or direct bearing on donor countries’ national or economic security. It also aligns more closely with human rights’ concerns with emphasis on the rights of the most disadvantaged.

### *Global Public Goods*

Arguments based on global public goods (GPG) offer one of the strongest theoretical bases for GHD. Public goods arise from market failures that are only overcome through public provision or regulation as a form of collectivization of both costs and benefits. No consensus exists on the boundaries demarcating a “global” public good from one that is international (a few nations only), regional (a geographic clustering of nations), club (a political clustering of nations), national or local (Kaul et al. 2003; Woodward and Smith 2003). However, peace, prevention of pandemics, financial stability, human rights, free access to knowledge, and a stable climate all have characteristics of such goods (International Task Force on Global Public Goods 2006; The Policy Coherence Commission 2008). As with human security little reference in existing government health and foreign policy statements is made to global public goods by name; although several of these goods are given as examples where greater foreign policy attention (and high-income country financing) should be given.

### ***Trade***

A rules-based global trading system is regarded as another global public good for the putative global public bad of economic decline that it avoids. It is also referenced as one of the partnership areas under MDG 8, and the goal of an open global trading system is viewed favorably in all of the policy reports we reviewed. However, as has been argued by many, the definition and enforcement of such rules remains largely dependent upon countries' economic and political power and past development history (Globalization and Health Knowledge Network 2008), leading to a skewing of benefits largely favoring wealthier nations (Gallagher 2007; Thorbecke and Nissanke 2006). There is also an asymmetry in trade-bargaining power that has tended to negate or worsen global health equity outcomes potentially achievable through trade-related growth and development (Globalization and Health Knowledge Network 2008). More specific to this article's focus on human rights, the progressive liberalization requirement of trade treaties can also conflict with the progressive realization obligation of several important human rights (to health, to water, to food, to development) (Chapman 2009b; Hunt 2005b). As this article details later, the greatest potential incoherence (or conflict) in health and foreign policy arguments revolves around the relation between a country's trade ambitions and other health and foreign policy goals (Labonté, Schrecker, and Sanders 2007).

It is amongst these differing foreign policy frames that human rights arguments fit, arguably more comfortably with those of global public goods, human security, and (to varying degrees) development, but less so with the frames that privilege national/economic security and trade. We are not the first to comment on this: Bustreo and Doebbler have complained that foreign policy rarely embraces the legal obligations under international human rights covenants, contending that if it did so health would be far more of "an imperative" in foreign policymaking processes (Bustreo and Doebbler 2010: 47). To what extent, then, have recent policy statements (official or otherwise) on health and foreign policy embraced human rights, signaling their (possible future) inclusion within the foreign policymaking of (at least some) governments?

### **Human Rights in Global Health Policies**

First, and a point emphasized by Bustreo and Doebbler, that nations rarely invoke human rights treaty obligations in their foreign policy choices does not remove their legal or normative requirement to do so (Bustreo and Doebbler 2010). The 1993 Vienna Declaration and Program of Action is widely regarded as a state consensus on the moral primacy of human rights over other public interests; with 171 signatory states proclaiming the protection and promotion of human rights and fundamental freedoms as the first responsibility of governments (World Conference on Human Rights 1993). The right to health (technically, the Right to the Highest Attainable Standard of Physical and Mental Health) is the human rights statement most central to GHD, and every country is now party to at least one international instrument that includes health-related rights (Chapman 2009b). Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most detail on this right and specifically obligates states to ensure equitable access to a minimum set of health services. General Comment 14 (GC 14), legally less binding than Article 12 itself, elaborates a broader range of actions required for the progressive realization of this right (United Nations Economic and Social Council Commission on Human Rights 2000). GC 14 further states that "collective rights are critical in the field of health" (United Nations Economic and Social Council Commission on Human Rights 2000: Notes

Paragraph 30) implying a need to counterbalance individual entitlements; a point we return to later in this article.

The importance of human rights is underscored in all of the policy statements we reviewed. The *Oslo Declaration* refers to human rights several times, accepting that “health is a fundamental right of every human being” and, in line with legal scholarship, that “life is the most fundamental of human rights, and that life and health are the most precious assets” (Ministers of Foreign Affairs 2007: 1347).

The UK *Health is Global* policy states as its intent the promotion of “health equity within and between countries” (HM Government 2008a: 8). It makes some explicit references to human rights with an emphasis on gender rights with particular reference to HIV treatment and reproductive health. Somewhat ironically given its embrace of free trade orthodoxy, it also cautions that unfair or unethical trade can deprive workers of their “rights to security of employment and compensation” (HM Government 2008b: 60). Other UK foreign policies to which *Health is Global* is subordinate similarly reference human rights. The 2008 national security strategy of the United Kingdom includes human rights as one of the values that define “who we are and what we do” (The Cabinet Office 2008: 6). The UK Foreign and Commonwealth Office departmental strategic objectives, in turn, include a commitment to achieving “greater international institutional effectiveness in promoting respect for human rights” with a focus on “the reduction of poverty and inequality” (The Foreign and Commonwealth Office 2008: 3). Its inclusion of open markets in the list, however, remains empirically problematic.

The Swiss *Health Foreign Policy* states that “one of its main objectives is to strengthen the global partnership for development, security and human rights that has been agreed upon and implemented in the context of the UN” (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 12). Sweden’s 2003 legislated *Policy for Global Development* proposes that “two perspectives permeate all parts of the policy: a rights perspective based on international human rights conventions; and the perspectives of the poor” (Government Bill 2002/2003: 1). Its entire policy document references specific rights issues throughout.

Norway’s Policy Coherence Commission similarly devotes considerable attention to the importance of a human rights framing in its country’s foreign policy and describes human rights as a “pure” global public good vital to development in all countries (The Policy Coherence Commission 2008: 21). It further argues the importance of related rights to water and to food, chiding the international trading system and the financial institutions for emphasizing growth through agricultural export without due attention to domestic food security. Unlike other policy statements, it also specifically cites the right to development in relation to greenhouse gas emissions and the financing of climate initiatives, stating that these “must be based on countries’ historical responsibility and financial capacity, and safeguard the right to development for poor countries” (The Policy Coherence Commission 2008: 115). Although the commission’s work is advisory only, Norway’s official governmental position, at least with respect to intellectual property rights (IPRs) and access to medicines, embraces the emphasis on human rights, arguing that IPRs “must be regarded in a human rights perspective” (The Policy Coherence Commission 2008: 133).

Brazil, while lacking an official statement on health in foreign policy, nonetheless argues that having the right to health in its federal constitution provides a strong base for arguing health in its foreign policy agendas. In his address about global health and foreign policy from a Brazilian perspective to at a Chatham House Roundtable in September 2009, Minister of Health of Brazil, His Excellency Dr. José Gomes Temporão emphasized the importance in the context of globalization of introducing or reinforcing new

themes such as health and human rights into the traditional foreign policy agenda (Gomes Temporão 2009).

### **A Critical Reflection**

Despite the frequent reference to human rights in governmental policy or declarations, little specific reference is made to the actual international human rights edifice, its covenants and state obligations, and its reporting requirements. A bibliometric search of the policy reports found few mentions of the international human rights framework, related conventions or specific (reporting), or other obligations (see Table 2). There is a sense in reviewing the statements that, with the exception of Sweden's legislated requirements and, to a lesser extent, Norway's Commission report, human rights are declared more as a normative gesture than as a set of legally binding obligations with specific requirements of states in their domestic and foreign policy decisions. That states have ratified or acceded to at least one of the major human rights instruments addressing the right to health does not necessarily mean that they fulfill the requirements specified therein, despite their legal obligations or normative commitments to do so (Chapman 2009b). Many countries appear to lack sufficient political will (or civil society activism to provoke such will) to give human rights the priority they are due under international law. When there are demands imposed by powerful economic and trade institutions such as the World Trade Organization (WTO) or the World Bank that conflict with the requirements necessary to realize human rights obligations, virtually all governments tend to neglect their human rights commitments (Chapman 2009b).

### ***Health, Human Rights, and Trade***

At present, health has a higher profile in international trade law than the protection of human rights; an objective that trade treaties do not recognize as a legitimate reason for restricting trade (Blouin, Drager, and Smith 2010). Even as health has gained some attention in WTO trade disputes (Labonté 2010), trade treaty negotiations and dispute resolutions have been deafeningly silent on human rights and their state obligations (Harrison 2007). The same can be said for how trade liberalization is referenced in several of the global health policies we reviewed, notably those of Switzerland and the United Kingdom. One area that generates the most controversy and creates significant challenges to a human rights approach in foreign policy resided in the global expansion of intellectual property rights (IPRs). The Swiss health policy is most explicit on this, noting that "Switzerland, with its major pharmaceutical industry and long humanitarian tradition, is committed both to adequate protection of intellectual property as well as access to essential drugs for the world's poorest countries" (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 13). It further cautions that "'Switzerland must . . . represent the interests of the pharmaceutical industry, which is a major player in its economy, and safeguard the industry's base here'" (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 12). It reconciles the conflict by arguing that "appropriate protection for intellectual property [is] an essential incentive for research into, and development of new drugs and vaccines" (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 15).

The United Kingdom makes a similar argument in its policy statement in its call for "a robust system of intellectual property rights, used innovatively and flexibly to promote access to medicines" (HM Government 2008a: 10). It also qualifies the right of developing

**Table 2**  
Bibliometric Search Results

Title (Abbreviated)	Country, Year	Keyword Search Results
<i>Shared Responsibility: Sweden's Policy for Global Development</i> (SW)	Sweden, 2003	Human rights: 50 IHRF: 8 Labor law conventions/International Labor Organization (ILO): 1 International environmental conventions: 2 Obligations: 3 Health equity: 0 Social justice: 0 Key HR argument: Human rights are based on the principle of the equal dignity and rights of all human beings; and the idea that individuals have rights and states have obligations. They adjust an unequal power relationship in favor of the weaker party, and represent a minimum level of rules for any society that aspires to fulfill the vision of a dignified life for all.
<i>Swiss Health Foreign Policy: Agreement on Health Foreign Policy Objectives</i> (FDHA)	Switzerland, 2006	Human rights: 2 IHRF: 0 Labor law conventions/ILO: 2 International environmental conventions: 1 Obligations: 0 Health equity: 0 Social justice: 0 Key HR argument: Commit to strengthen the global partnership for development, security, and human rights that have been agreed upon and implemented in the context of the UN.

<p><i>Meeting Global Challenges: International Cooperation in the National Interest (SW-GPG)</i></p>	<p>Sweden, 2006</p>	<p>Human rights: 10 IHRF—United Nations Human Rights Council: 2 Labor law conventions/ILO: 0 International environmental conventions: 0 Obligations: 3 Health equity: 0 Social justice: 0 Key HR argument: In keeping with the UN's position, human rights must be defended in the struggle against terrorism. Nonstate human rights organizations play a key role in providing cross-the-board monitoring of states' human rights performance on an independent basis.</p>
<p><i>Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time (OSLO)</i></p>	<p>Norway, France, Brazil, Indonesia, Senegal, South Africa, and Thailand, 2007</p>	<p>Human rights: 6 IHRF: 0 Labor law conventions/ILO: 0 International environmental conventions: 0 Obligations: 0 Health equity: Social justice: 0 Key HR argument: A recognition that life is the most fundamental of human rights, and that life and health are the most precious assets.</p>

*(Continued on next page)*

**Table 2**  
Bibliometric Search Results (*Continued*)

Title (Abbreviated)	Country, Year	Keyword Search Results
<i>Coherent for Development? How coherent Norwegian policies can assist development in poor countries</i> (PCC)	Norway, 2008	Human rights: 50 IHRF: 1 Labor law conventions/ILO: 1 International environmental conventions: 0 Obligations: 65 Social justice: 1 Health equity: 0 Key HR argument: Norwegian foreign policy must defend and further develop rights for states and individuals as laid down in the UN pact, the Geneva Convention and the Declaration on Human Rights.
<i>Health is Global: AUK Government Strategy, 2008–13</i> (UKHG) and (UKHG Annex)	United Kingdom, 2008	Human rights: 5 IHRF: 1 Labor law conventions/ILO: 1 International environmental conventions: 0 Obligations: 3 Social justice: 1 Health equity: 2 Key HR argument: A belief that every individual, whatever part of the world they come from or live in, is of equal value. The UK government is one of the original signatories to the UN Declaration of Human Rights. The strategy's principles and actions are practical ways of upholding these rights.

countries to make use of flexibilities in the Trade-Related Intellectual Property Rights (TRIPS) Agreement by referring to “the judicious use of compulsory licensing,” which should not be at the expense of damaging incentives to invest in research and development (HM Government 2008, Annexes: 64). These qualifications are not part of the TRIPS flexibilities, implying that the UK policy promotes a tougher stance on IPRs than what had been agreed to multilaterally during the 2001 WTO Ministerial meeting in Doha, Qatar.

Switzerland’s difficulty in balancing policy directions that promote access to essential medicines with those that aim to protect IPRs is apparent in its role in negotiating TRIPS+ provisions, which the Globalization and Health Network of the WHO Commission on Social Determinants of Health found jeopardize equitable access to patented medicines (Globalization and Health Knowledge Network 2008). The 2008 Norwegian Policy Coherence Commission puts some of the blame for TRIPS+ provisions negotiated through the European Free Trade Association on Switzerland, “which has strong interests within the pharmaceutical industry, has been an active driving force for extensive international copyright protection and wants more stringent patent protection in bilateral agreements as well” (The Policy Coherence Commission 2008: 132). The Swiss government’s 2008 *Report on Foreign Economic Policy* readily acknowledges this (State Secretariat for Economic Affairs 2008), even as its development agency advocates “for the priority of public health matters in debates on intellectual property and in trade considerations” (Federal Department of Foreign Affairs 2003: 10). Informants involved in that country’s global health diplomacy efforts acknowledge this entrenched conflict of interests, with the economic tending to trump health and human rights.

Another area related to trade and health that puts coherence with a human rights perspective at some risk pertains to trade in health services. The United Kingdom states its economic interests in such trade couched in mutual benefit:

Trade in health services, drugs and medical devices contribute significantly to the UK and global economies. The marketplace for these commodities means that the UK and other economies can benefit from the opportunities that come through freer and fairer global trade in health services and commodities. (HM Government 2008b: 59)

It goes on to say that it will work to enhance “the UK as a market leader in well-being, health services and medical products” (HM Government 2008b: 66) targeting specifically “the health sector in India, China and Brazil” (HM Government 2008a: 29). This appears to vaunt the United Kingdom into a globally competitive market for private health services, either as direct providers, contractors, or technical consultants. While medical products need to be traded in order to meet health needs in other countries, the same does not necessarily apply to health services if their provision is undertaken as a commercial venture. Specifically, the weight of evidence finds that commercialization in health services or insurance creates inequities in access and also in health outcomes (Barrientos and Lloyd-Sherlock 2000; Bennett and Gilson 2001; Hutton 2004; Koivusalo and Mackintosh 2005). The 2008 *World Health Report* was forceful on this point:

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

ability of health authorities to protect the public. (World Health Organization 2008: 14)

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

We want to promote the best in British healthcare because we believe we can make an effective contribution to health systems in other countries. We also recognise that there are significant benefits for the UK economy. (HM Government 2008a: 29)

This statement appears at odds with the UK commitment to strengthen through its health development assistance *public* health systems in poorer countries. Its commercial claim is somewhat nuanced by the statement that “where we promote UK services and products (including pharmaceutical and medical devices) overseas, we will make sure that our approach fits with the country’s strategy and that it neither increases health inequalities nor becomes an obstacle to poverty eradication and the achievement of the MDGs” (HM Government 2008b: 67). At present, none of its health care export activities include products and make no reference to the use of trade treaties to expand international commercial exchange in health services (which may conflict with obligations under the right to health) (Labonte, Blouin, and Forman 2010). Yet, as with Switzerland’s equivocation about IPRs and essential medicines, this signals a potential conflict or lack of coherence in the UK strategy, one that could deepen as the UK domestically increases the commercialization and privatization of different aspects of its National Health Services (Ramesh and Williams 2010).

### ***Health, Human Rights, and Security***

Security arguments, in particular those pertaining to protecting national security, figure prominently in the global foreign health policies we reviewed. Protecting the health interests of the Swiss population is the first ranked main interest of the Swiss policy (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006) and protecting “the health of the UK proactively, by tackling health challenges that begin outside our borders” is one of the 10 principles included in *Health is Global* (HM Government 2008a: 8). Self-interest and a focus on the more traditional “high politics” preoccupations of foreign policy appear to underpin these countries global health policies. Economic prosperity, security, and stability for the United Kingdom and the rest of the world are the ultimate goals of *Health is Global*, while improving health appears to be a means to this end and not necessarily a worthy endpoint in its own right (HM Government 2008). The question then becomes: Can self-interest as manifested through a focus on security (high politics) coexist in a coherent manner with a human rights approach to promoting global health equity (low politics)?

To date, the answer to this question is not sanguine. The securitization of health disproportionately directs funding and attention to those ills deemed politically to be national security risks, such as HIV/AIDS and pandemic influenza. Such designation is not based upon the global burden of disease, since easily preventable maternal and childhood illnesses and a number of so-called “neglected diseases” exact a higher toll in poorer countries than does HIV. Rather, the securitization of health risks privileging those diseases

most likely to inconvenience national security, global trade, and finance or to travel to high-income nations, reversing global health responses from their historic people-centered values to a narrow understanding of health as a national security risk (Thieren 2007). The limitation of the self-interest/national security argument for global health policy is recognized by some pronouncements, such as the *Oslo Declaration*:

In our time, the pursuit of pure self-interest of nations might undermine the solutions that respond to the challenges of growing interdependence. We must encourage new ideas, seek and develop new mechanisms for partnerships, and develop new paradigms of cooperation. This new reality creates a need to find shared values that are embodied in the relations between countries. (Ministers of Foreign Affairs 2007: 1375)

According to international relations scholars, narrow self-interest has failed historically to motivate any sustained commitment to international health cooperation (Peterson 2002), implying that other motivations or values are at work or need to be. It also fails to cohere with the emphasis human rights places on the most disadvantaged or vulnerable.

### ***Health, Human Rights, and Development***

A final reflection pertains to health and development aid. The human rights framework focuses attention on “vulnerable populations, minorities, the rural poor and women especially, who are most often neglected and marginalized” (Robinson 2007: 241) and thereby “forces those in authority to ask hard questions about whose needs are not being met and whose voices are not being heard” (Robinson 2007: 241). Based on this premise, it can logically be assumed that countries that have developed global health strategies that include a commitment to human rights would also include a focus on providing health assistance (i.e., aid) to those with the greatest need. There is some evidence that this is the case, notably with the recent push for more assistance towards the maternal and child health goals of the MDGs. It is slow progress on these goals that partly led to the *Oslo Declaration* in the first place: “[I]f nothing changes, many countries will not attain the health-related MDGs by 2015” (Ministers of Foreign Affairs 2007: 1374).

At the same time, most development assistance (and notably bilateral or country-to-country aid) follows a trajectory of donor country economic and strategic self-interest (World Bank 2008). The average of gross bilateral aid for 2005–2006 and for 2006–2007 shows strong preference towards countries either in conflict or of economic importance to donors (Harbom and Wallenstein 2007; Organisation for Economic Co-operation and Development 2008a) rather than on health need. Expressing earlier concern of such a triage, the World Bank in 2006 noted that over 60 percent of aid increases between 2001 and 2004 went to just three countries (Afghanistan, Iraq, and Democratic Republic of Congo), which accounted for less than 3 percent of the world’s population living in extreme poverty (World Bank 2006). The 2007 Organisation for Economic Co-operation and Development-Development Assistance Committee (OECD-DAC) Report did find that the amount disbursed by poverty need is continuing to increase (Organisation for Economic Co-operation and Development 2008a), albeit from a very low baseline. Only Norway’s Policy Coherence Commission commented explicitly on this practice, noting that, despite Norway’s high level of donor funding, and over 40 percent of its bilateral aid going to Africa, an independent assessment found that “no more than 37 per cent of Norwegian

bilateral and multilateral aid went to the least developed countries in 2005” (The Policy Coherence Commission 2008: 26).

Somewhat ironically, donor countries that have issued global health policy statements are not more generous in the level of health aid disbursements than those that have not (Organisation for Economic Co-operation and Development 2007). None disbursed the full amounts of their committed health aid funds for 2005–2006 (Organisation for Economic Co-operation and Development 2008b). In fairness, it is not clear whether a country’s policy commitment to global health necessarily equates to an increased volume of health aid. The Swiss policy emphasizes improving “the *efficiency* of multilateral players in the fields of health, development cooperation and humanitarian aid,” but not aid volumes noting that “no additional human or financial resources are planned for the implementation of this agreement” (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 13). This undermines at least one component of its policy’s stated objective, notably “to strengthen the global partnership for development, security and human rights, making a credible and acknowledged contribution” (Federal Department of Home Affairs [FDHA] and Federal Department of Foreign Affairs [FDFA] 2006: 12). Its major development contribution is cited as support to the Global Fund, but this support compares poorly to other countries claiming alignment with the “health is global” concept (Organisation for Economic Co-operation and Development 2007).

### **How Global Health Diplomats View Human Rights**

As part of a broader study examining global health diplomacy and the motivations underpinning the integration of health into foreign policy, we held semi-structured interviews with 19 key informants, 13 from the United Kingdom and 2 from each of Norway, Switzerland, and Brazil. Of the 18, ten were national-level government bureaucrats, four academics, and five representatives of nongovernmental organizations.

Overall, findings from the interviews corroborate those distilled through the document review and analysis. Human rights were mentioned by the majority of the interviewees as an important consideration in global health and GHD. Of the 18, five (all UK key informants) did not make any reference to human rights, and only two interviewees mentioned IHRF explicitly in their responses. The majority of those who referred to human rights did so simply to affirm that human rights had been a consideration in their respective country’s global health-related policy deliberations and processes. The UK strategy, for example, was informed by stakeholder workshops in which the organizers aimed to have diverse viewpoints “at the table,” including those focused on human rights (29 September 2009). The Swiss policy aimed to address “our value base,” including “being a country that is very committed to human rights” (5 October 2009). As with the policies we analyzed, these references were broadly normative and lacked instrumental detail. Only one interviewee explicitly referred to health as a “right” (10 December 2009) while others referred to concepts related to human rights such as health equity, social justice, and improving global health as an obligation. For example, one of the key informants referred to health equity as a “moral imperative” (27 October 2009) and one of the legitimating policy discourses behind the UK’s global health strategy. Another aligned social justice with health equity and another referred to improving health through “humanitarian” (29 September 2009) aid in conflict situations.

The most prominent theme in the interview data was challenges associated with ensuring that a human rights perspective had an equal seat at the table in policy discussions along with trade, economic growth, and security. One interviewee referred to needing to “fight so

hard” (26 August 2009) to get human rights into the UK global health strategy and talked about “people only playing the human rights card when it suits them” (26 August 2009) in reference to the Department of Trade. Another highlighted that “the things that are at stake are security on the one hand and equity on the other” (27 October 2009). Another simply stated that the security focus is “unjust” (26 August 2009), and another warned that the security agenda would eventually diminish the health equity agenda since it is primarily about protecting state borders and as such threatens the UN’s approach that “health is a human right and the right to achieve health for all is their basic principle” (16 October 2009).

A few key informants talked at considerable length about the inherent conflicts of interest and tensions that arise when trying to reconcile economic and trade interests associated with the pharmaceutical industry or the arms industry with improving equitable global health outcomes: “On the one hand we say we want to see an ethical foreign policy . . . but on the other we also find ourselves pushing for the promotion and protection of a patent system that makes it harder for middle income countries to exploit generic drugs that may possibly infringe on the intellectual property of major pharmaceutical companies” (16 October 2009).

In general, key informant responses empirically reinforced some of the conclusions drawn from the document review. These include a recognition of and practical experience with the challenges that states encounter when attempting to achieve global health policy coherence in the face of conflicting interests—human rights on the one hand and economic interests and security on the other—and how these challenges can pose significant risks to policy coherence and ultimately global health equity.

### **Country Compliance With Human Rights Obligations**

The document review and interviews highlight the difficulty states encounter when aiming to fulfill international human rights obligations in the face of widely conflicting economic, security, and domestic political agendas. Publicly available reports of human rights records of the countries in this analysis from the UN Committee on Economic, Social and Cultural Rights (CESCR; hereafter referred to as the Committee), the human rights treaty monitoring body that oversees implementation of International Covenant on Economic, Social and Cultural Rights (ICESCR or “the Covenant”), provide further evidence of state practices or actions related to human rights that also support this conclusion.

We reviewed the most recent publicly available “Concluding Observations” reports prepared by the Committee (United Nations Committee on Economic 1998; United Nations Committee on Economic 2005; United Nations Committee on Economic 2008; United Nations Committee on Economic 2009a; United Nations Committee on Economic 2009b). These Committee findings are based on periodic reports that states submit to it (Brazil 2008; Norway 2004; Sweden 2006; Switzerland 2009; United Kingdom of Great Britain and Northern Ireland 2008) and include two main sections, conclusions about positive aspects of state compliance, and principal subjects of concern with corresponding recommendations.

The most pertinent findings from these reports indicate that none of the countries focused on in this article, even those with reputations as human rights supporters and advocates, comply fully with obligations under the IHRF and its treaties. The United Kingdom, Norway, Switzerland, and Sweden still need to ensure that all of the provisions of the Covenant are given effect in domestic courts and that the Covenant rights can be directly invoked before the courts. To elaborate further, in the case of the United Kingdom, the Committee expressed regret over the statement made by the UK delegation

that economic, social, and cultural rights are mere principles and values and that most of the rights contained in the Covenant are not justiciable. The Committee urged the United Kingdom to ensure that the Covenant is given full legal effect in its domestic law, that the Covenant rights are made justiciable, and that effective remedies are available for victims of all violations of economic, social, and cultural rights. It emphasized that the United Kingdom is under a legal obligation to comply with such an instrument and to give it full effect in its domestic legal order. Furthermore, the United Kingdom has not yet adopted a national human rights plan of action, as recommended by the 1993 Vienna Declaration and Programme of Action (United Nations Committee on Economic 2009a). In May 2009, the Committee deemed that Brazil had yet to comply with the 1993 Principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles) and recommended that the state adopt the necessary measures to do so. It also urged Brazil to intensify its efforts to reduce the persisting inequalities and social injustice between different regions, communities, and individuals (United Nations Committee on Economic 2009b).

In keeping with the 2000 general comment that updated Article 12 of the ICESCR to extend the “right to health” to include access to the determinants of health, particularly for the most vulnerable (Chapman 2009b), the Committee’s concluding observations for each country commented on this broader set of obligations. For example, the Committee expressed concern with the growing number of HIV/AIDS cases registered during the last decade in Brazil; although treatment with antiretroviral drug therapy is available free of charge. It recommended that measures to address the special vulnerability to HIV/AIDS of marginalized sections of society be strengthened (United Nations Committee on Economic 2009b). It expressed concern related to access to education for asylum seekers in Norway (United Nations Committee on Economic 2005), found the level of poverty among the poor in Switzerland to be unacceptable, in particular among women, and costs for private healthcare too high (United Nations Committee on Economic 1998), expressed concerns about the increasing number of children living in poverty and the extent of homelessness in Sweden (United Nations Committee on Economic 2008) and urged the United Kingdom, in the face of widening health disparities (4 percent among men and 11 percent among women), to fulfill its commitment to reducing health inequalities, in particular for the most disadvantaged and marginalized individual and groups (United Nations Committee on Economic 2009a).

As Chapman writes, one of the factors limiting the effectiveness of health-related obligations is that Article 2 (1) of ICESCR permits the full realization of its enumerated rights to be accomplished gradually as resources permit through the principle of progressive realization (Chapman 2009b). This principle acknowledges that full and timely realization of all rights will generally not be achievable in a short time period, particularly for low- and middle-income countries. Thus it may stand to reason that Brazil seems to lag further behind in meeting human rights obligations than the other countries we studied. Considering, however, that the United Kingdom, Sweden, Norway, and Switzerland are high-income countries, it is revealing that they still have not met all ICESCR obligations and expectations, despite their levels of aggregate wealth and repeated policy statements to do so.

To compensate for the limits of the principle of progressive realization, Article 2 (1) mandates states to maximize resources to ensure that obligations are fulfilled, both through existing resources and international assistance. It also implies that the human rights responsibilities of states, particularly, high-income countries, “extend beyond their borders” (Chapman 2009b: 103). Evidence of the importance of this obligation appears in the Committee’s concluding observations for Sweden, the United Kingdom, and Norway. Each

of these country's contributions to reaching certain levels of development assistance is regarded as a positive aspect of the country's progress towards achieving ICESCR obligations. However, according to Paul Hunt, a former Special Rapporteur on the right to health, international assistance, and cooperation, must include more than financial and technical assistance. He also asserts that a responsibility to reduce poverty through equitable, multilateral trade, investment, and financial systems be part of this process (Hunt 2003). The Committee's concluding observations do not include references per se to the respective country's international cooperation obligations beyond a brief reference to the levels of development assistance in the three reports mentioned. This does not mean that the country reports submitted to the Committee should not include such references, however. Indeed, each country is required to address how the promotion of the realization of economic, social, and cultural rights is considered as part of the state's development cooperation, where relevant (International Human Rights Instruments 2004). The countries we reviewed all make some reference to their international activity directed at fulfilling Covenant obligations; however, they do not uniformly state how they are actively working towards reducing poverty in the manner that Hunt recommends.

### **Conclusion: How Should Health Human Rights Inform Foreign Policy?**

We return to an earlier comment: That states are only minimally taking account of health human rights obligations with their foreign policies at present does not mean they are exempt from doing so much more vigorously. The primacy of human rights over other international or multilateral policies (including trade treaties), though still contested, is nonetheless supported by a number of legal and scholarly texts including Section 103 of the Charter of the United Nations, and the 1993 Vienna Declaration and Program of Action (World Conference on Human Rights 1993). It has been further argued that international law "presupposes that there is a minimum substantive normatively inherent in the international legal order, a kind of foundation or floor, grounding the aspirations and efforts of the international legal system" and that the preservation of human life and health can be understood to comprise that floor (Howse and Teitel 2007: 10).

As Meier argues, attention to collective rights is particularly important in the context of globalization and the renewed foreign policy attention to health. The right to health cannot as an individual right respond to the societal harms of globalization that give rise to the need to prevent disease and to promote health through collective rights mechanisms (Meier 2007). This argument supports the role of the state in imposing interventions through "broad public health systems that move beyond the individual model of medicine" (Meier 2007: 551). In practice, however, balancing individual and collective health human rights is challenging, and there is no clear guidance on when an individual health right claim might compromise a collective health right claim (Mathews 2007).

There are particular concerns about such a compromise with respect to access to costly patent drug treatments. Right-to-health arguments were important in Brazil's policy to supply antiretroviral drugs (ARVs), to issue compulsory licenses, and to finance the costs through a financial transaction tax. However, civil society mobilization around the right to health in Brazil has been co-opted in a way that the pharmaceutical industry can take advantage of the many judicial decisions granting individuals a right to receive expensive medicines that this industry produces (Da Silva and Terrazas 2010). The cost of distributing these drugs to Sao Paulo's state health ministry alone (1 of 26 such state ministries across Brazil) is USD 530 million annually (Jurberg 2008). Pharmaceutical companies have also established so called "astroturf" civil society organizations in the names of different patient

groups and diseases to create demands for patent drugs in other jurisdictions, often using similarly rights-based claims.

An assessment of “judicial activism” in Colombia highlights this dilemma. Since the early 1990s, Colombian courts have ruled on “tens of thousands” of health rights cases, some of which were driven by demands for access to high-cost drugs. This led to a 2008 Constitutional Court decision calling for a complete overhaul of the country’s mixed private/public system and “deliberate measures to progressively realize universal coverage by 2010” (Yamin and Parra-Verra 2009: 148). This is a dramatic decision in a country characterized by entrenched neoliberal political ideology and a measure of how powerful right-to-health legislation has been in Colombia. Cautions, however, have also been raised that the costs of universal coverage could compromise state obligations to progressively realize other human rights associated with important social determinants of health, such as housing, education, and prevention of gender or other forms of discrimination. This is similar to findings from a comprehensive review of 71 right-to-health court cases in low- and middle-income countries (Hogerzeil et al. 2006).

This has led some analysts to argue the right to health, based on individual claims, is a less useful tool with respect to ensuring access to the resources that improve public health: “Configuring health services in response to litigation may, ironically, give rise to further inequity, resulting in services based on the needs of individuals or minority groups rather than populations” (D’Ambruoso, Byass, and Qomariyah 2008: 7). In the Colombian case, while no *de jure* prejudice towards higher income individuals was found in decisions under right-to-health appeals, there was a *de facto* inequity owing to higher income individuals having greater resources to access judicial interventions. The right to development is suggested as forming a more powerful logic for health rights arguments.

The right to development provides another rationale for a human rights framing of global health and is argued by many to imply that rights are collective rather than individual in entitlement. Adopted by the UN in 1986, the Declaration on the Right to Development defines it as a “comprehensive economic, social, cultural and political process, which aims at the constant improvement of *the well-being of the entire population*” (United Nations General Assembly 1986: para. 2). The emphasis highlights the right’s collective nature, which may actually entitle poorer countries (through their states) to make claims for assistance from higher income nations (Kirchmeier 2006). The right to development is also reiterated in the UN Millennium Declaration of December 8, 2000, which commits to “making the right to development a reality for everyone and to freeing the entire human race from want” (United Nations General Assembly 2000: 4) and to striving for the “full protection and promotion in all our countries of civil, political, economic, social and cultural rights for all” (United Nations General Assembly 2000: 7).

The state-centric nature of these treaties (as duty-bearers to respect, to protect, and to fulfil the rights) in a world in which nonstate actors exert enormous policy influence has come under criticism. However, human rights treaties attach other duties to state parties that include regulation of private actors whose international behaviors may impinge upon other countries’ abilities to meet their human rights obligations. To overcome constraints on this realization due to resource limitations, especially in poorer countries, Article 2(1) of the ICESCR further mandates that each state party “take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources” (Chapman 2009a: 103; United Nations General Assembly 1966: 2). Paul Hunt, former UN Special Rapporteur on the right to health, argues that this obligates developed states “to take measures of international assistance and cooperation towards the realization of economic, social and cultural rights, including the right to health”

a normative affirmation of which exists in the MDGs (Hunt 2005a: 16). Although there is scholarly momentum to create stronger, binding language on the collective aspects of human rights, including the right to health, even if this occurs there remains the “soft law” problematic. Governments, in their international negotiations, may be obligated to take full account of human rights treaties in their deliberations, but, as our interview data and document analyses suggest, this account appears to be largely tokenistic at best. We might draw three inferences from our findings in this article about how to move forward from the stasis of national security and economic mercantilism that dominates much foreign policy. First, as the Brazilian example argues, having provisions for human rights within national constitutions or legislation creates a base for strengthening their articulation across all foreign policy discussions in which the country engages. Second, those charged within governments to move the health agenda higher within foreign policy (i.e., those who might be considered global health diplomats) need a robust grounding in human rights treaties and how their particular articles and obligations might affect a particular policy domain—in brief, a capacity to undertake a rapid human rights impact assessment of any given foreign policy issue. Third, civil society activism around human rights has proved useful in holding domestic governments to account on their international practices. Whether or not a human rights infusion in current global health diplomacy is sufficient to tame the global marketplace (a topic of other articles in this series) is moot, but it is likely one of the necessary steps in attempting to do so.

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