

Flavia Bustreo, MD, MSc, is Director of the Partnership for Maternal, Newborn & Child Health, hosted by the World Health Organization, Geneva, Switzerland.

Curtis F. J. Doebbler, JD, m/LLM, PhD, is Professor of Law at An-Najah National University in Nablus, Palestine, and UN representative of Nord-Sud XXI, in Geneva, Switzerland, and New York.

Please address correspondence to the authors c/o Curtis Doebbler, Faculty of Law, An-Najah National University, Nablus, Palestine, email: cdoebbler@gmail.com.

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MAKING HEALTH AN IMPERATIVE OF FOREIGN POLICY: THE VALUE OF A HUMAN RIGHTS APPROACH

Flavia Bustreo and Curtis F. J. Doebbler

“[For] . . . the happiness of the people and the power of the country . . . [t]he care of the Public Health is the first duty of a statesman.”

— Benjamin Disraeli, Prime Minister of Great Britain¹

ABSTRACT

Health is increasingly seen as relevant to foreign policy; nevertheless, it remains subordinate to other interests. In particular, the interests of security and economics are often presented as more critical than health. This is due to a failure to sufficiently recognize the legal obligations that states have undertaken to ensure the human right to health. This article argues that health should be an imperative of foreign policy, equally valid, and prioritized in resource allocation. We suggest application of the human rights approach with attention to the legal duty of cooperation and the necessity of ensuring broad participation. We suggest that the human rights approach to health can contribute to achieving this result and is compatible with, and beneficial to, other foreign policy concerns. Finally, we conclude that the human rights approach to health requires that health be an imperative in foreign policymaking processes.

INTRODUCTION

Despite recent significantly increased attention to global health in foreign policy, the relationship between policy and the many aspects of health remains unclear. Is attention to health issues merely a means for achieving other foreign policy goals? Is health an imperative that foreign policy must take into account? The relationship between health and foreign policy is “vital, complex and contested.”² In this paper we argue that such a relationship is also crucial for the “attainment by all peoples of the highest possible level of health.”³

Health is often subordinate to other foreign policy concerns despite the fact that states are obliged to fulfill, through their foreign policy, the solemn international legal commitments they have undertaken to ensure the human right to health. In this paper we argue that states can enhance their ability to meet their international commitments by adopting a human rights approach to health (HRAH). This, we argue, will make achieving improved global health an imperative of foreign policy.

Our argument is organized into four parts. First, we review a number of common perceptions about the relationship between health and other foreign policy interests that have confined health to a subordinate role. Second, we suggest how the application of an HRAH can contribute to making health an imperative of foreign policy. Third, we look at the important requirement of participation. Fourth and finally, we discuss briefly the limitations of the HRAH.

THE CURRENT RELATIONSHIP BETWEEN HEALTH AND FOREIGN POLICY

There has been a longstanding relationship between health and foreign policy. The “interdependency of nations in health planning and operations” had already been recognized in the 1960s.⁴ In 2005, David P. Fidler noted that “[t]he nature and extent of foreign policy attention devoted to health today is historically unprecedented.”⁵ Moreover, Fidler observed, the “last decade witnessed relationships between public health and foreign policy intensify, expand and become more explicit,” and thus “[i]n terms of foreign policy, public health has a profile higher than ever before.”⁶ The international effort to control the use of tobacco is an example of how traditional diplomatic means have been used to address a key global health issue.⁷

Even today, however, health is a foreign policy consideration that has “remained ... implicit and mostly assumed.”⁸ Health is not an imperative of foreign policy, but rather viewed as a means to other ends. This view has been reinforced by leading research done on the relationship between health and foreign policy. In research published by the Nuffield Trust, for example, health is treated as a variable that can influence foreign policy, but not as an imperative — that is, an essential inclusion — in and of itself.⁹ This encourages attention to health in foreign policy processes, but also allows health to be accepted as a mere interest, rather than giving it the weight it deserves.

Nor do either the influential declaration of the Norwegian–French initiative on the relationship between health and foreign policy or the Bangkok Charter on Health Promotion consider health as an imperative of foreign policy.¹⁰ The declaration of the Norwegian–French initiative concedes that the challenge is still to “build the case for why global health should hold a strategic place on the international agenda.”¹¹ Similarly, the European Union, Switzerland, and the United Kingdom have all adopted foreign policy positions on health that treat health as an item of “wealth” for European citizens, an issue of security for Swiss citizens, or an item of unilateral policy for the UK.¹² None of these documents view health as an imperative of foreign policy.

As a result, health is not viewed in foreign policy discussions as a “right” that governments have committed to ensure, but rather as a “luxury good” that only need be provided if it does not conflict with other foreign policy objectives. This can be understood by

reviewing how health has been dealt with in comparison to other prominent foreign policy interests.

HEALTH IN RELATION TO OTHER FOREIGN POLICY INTERESTS

Attention to health in foreign policy has been expressed in the context of other interests such as 1) security; 2) economic considerations, especially trade; and 3) development.¹³ Each of these interests can either complement health or compete for scarce attention and resources in foreign policy processes, as described below.

Security

An overriding concern of almost all governments’ foreign policy has traditionally been national security. In no country has this been more strikingly apparent than in the United States.¹⁴ Nevertheless, other commentators have reached similar conclusions reviewing the foreign policy priorities of other countries.¹⁵

One commentator, Colin McInnes, has suggested that “public health systems have fallen into the orbit of security” as a result of the resurgence of traditional national security concerns and new national security fears.¹⁶ Consequently, McInnes argues, “a relatively narrow conception of the relationship between health and foreign and security policy has begun to emerge, one which is related to harder security issues ... and which primarily addresses the concerns of the security community.”¹⁷ This trend is, at least in part, “the result of foreign and security specialists beginning to deal with health issues from their particular perspective” as well as “some in the public health community who see these ‘harder’ security issues as a means of getting health onto the foreign [policy] and security agendas.”¹⁸

Security concerns often create an imbalance in foreign policy that focuses on infectious diseases and not the diseases that may affect more people in low-income countries. This focus imbalance forms an impediment to improving global health on a broad scale.

One example is the initial international reaction to the “Swine Flu” pandemic that was declared on June 11, 2009, whereby security interests appeared to be prioritized even in a situation of health emergency.¹⁹ The initial reaction of many states was to impose travel restrictions.²⁰ This reaction appeared to discriminate against Mexicans, or any person traveling

through Mexico, in a manner that was incompatible with the underlying values of the HRAH. This reaction appeared to suggest that rushing the needed medication to victims and making it available at an affordable price was of secondary importance compared to the perceived priority of travel restrictions. Thus, faced with an international public health threat, states reacted by first protecting their populations rather than ensuring treatment and vaccinations for the most vulnerable.

Economics and health

Economics and health are also inextricably linked in foreign policy. States have an interest in creating markets for their health products and services, and states often invest money in confronting global health problems. This link is seen in overseas development assistance (ODA) that is committed to health projects. During the 1980s and 1990s, the amount of ODA designated for health remained virtually unchanged in the 23 Development Assistance Committee members of the Organization for Economic Co-operation and Development (OECD).²¹ However, during the past decade, as health increased in prominence in foreign policy discussions, there was a marked corresponding increase in ODA designated for health.²² When economic conditions subsequently deteriorated in the global economic crisis of 2008 and 2009, however, this trend reversed. Despite pleas by the World Health Organization (WHO) that health needed to be protected, donor governments responded to this global crisis with significant cuts in ODA.²³ At the same time, government representatives recognized that, in the most vulnerable states, the economic crisis reduced both access to health care services and governments' abilities to maintain social safety nets.²⁴

The protection of economic concerns such as trade are also increasingly regarded as crucial interests in international health policy. As WHO has acknowledged, often “[i]ssues of international trade impinge on health.”²⁵ Studies indicate that trade policies have direct and indirect effects on public health.²⁶ Numerous trade agreements often protect trade-related interests (such as intellectual property) more than public health, or even threaten public services, including health care.²⁷

While trade issues may override health concerns in foreign policy, in some instances health may benefit from trade.²⁸ Statistical analysis of data from 219

countries found a “positive correlation between trade and health.”²⁹ The researchers suggested that this was due to trade openness increasing technology and knowledge transfers that benefitted health care.³⁰ Moreover, economic policy based on openness to trade may increase donors' confidence and thus improve the level of external investment in health on which some of the poorest countries depend for providing basic health services.³¹

Jaye Ellis and Alison FitzGerald noted in 2004 that while “[c]onclusions such as ‘trade is good’ or ‘public health is good’ are easy enough to defend, questions such as how much trade/health, where, when, and at what cost are obviously more difficult.”³² To date, foreign policy has usually answered such questions in favor of trade.

Development

As Director-General of WHO, Gro Harlem Brundtland stressed a positive relationship between health and development in foreign policy, arguing forcefully that

[t]here are some who questions whether good development policy is also good foreign policy. What is the political advantage, to a wealthy nation, of investing in global health? How does it compare with the application of sanctions, the supply of peacekeepers and the promotion of good government? Are not the outcomes of investing in health frustratingly vague, imprecise and long-term? The simple answer is NO.³³

The United Nations Development Program suggests that aid for health interventions is necessary for development and, by implication, for foreign policy.³⁴ In other words, as the *Report of Commission on Macroeconomics and Health* states, “disease is a drain on development.”³⁵ Policy experts have often urged strengthening the role of health in their country's development assistance policies, arguing that it is necessary to ensure security.³⁶

When discussing the relationship between economics and health, we have already seen how overseas development assistance, a primary consideration of both foreign policy and development, provides a crucial

link between health and foreign policy. The significant amount of overseas development assistance that is invested in health make this relationship unavoidable.³⁷ But it also makes it an unequal relationship, or one of subordination. As noted above, for example, ODA is often cut when economic times get hard. At the same time, the significant growth in health assistance as a proportion of ODA would indicate that perhaps health is gaining ground on development in foreign policy forums.

MAKING HEALTH AN IMPERATIVE OF FOREIGN POLICY THROUGH THE HUMAN RIGHTS APPROACH

Can health become an imperative of foreign policy? How can such a goal be realized through applying the HRAH? The human rights approach to health is based on governments' own voluntary agreements about their imperatives for their policies and actions regarding health. Such a human rights approach encourages governments to follow through on what they have agreed to do in legally binding treaties by providing a framework for enhancing accountability of the achievement of health commitments. It is therefore key to making health an imperative of foreign policy.

For the purpose of this article, we rely on aspects of the HRAH that relate, first, to the imperative nature of legal norms that have been voluntarily agreed to by states; second, to the relevance of a state's approach to resource distribution; and third, to the duty of cooperation. Each of these is briefly discussed below.

The human right to health: A summary of legal obligations

Before discussing the imperative nature of the legal norms, a short historical summary of specific documents is useful. This summary indicates the relatively recent but repeatedly affirmed nature of the right to health.

The preamble to the WHO Constitution (1946) recognized that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."³⁸ The most commonly cited contemporary interpretation of this right today is found in the International Covenant on Economic, Social and Cultural Rights (ICESCR), which 160 states have ratified as of March 20, 2009. Article 12

of the ICESCR states that "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."³⁹ According to the ICESCR, the types of acts that are necessary are those that ensure the following:

- provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
- improvement of all aspects of environmental and industrial hygiene;
- prevention, treatment, and control of epidemic, endemic, occupational, and other diseases; and
- creation of conditions that assure medical service and medical attention to all in the event of sickness.⁴⁰

The legal obligations in Article 12 are authoritatively interpreted by the UN Committee on Economic, Social and Cultural Rights (CESCR), which in the future is likely to express its views on individual petitions.⁴¹ The CESCR's General Comment on Article 12 explains that "[h]ealth is a fundamental human right indispensable for the exercise of other human rights."⁴² It goes on to explain that although "the right to health is not to be understood as a right to be *healthy*," it does create states' obligations, and these obligations may be violated.⁴³ The duties are defined generally as the "immediate obligations ... [to] ... guarantee that the right will be exercised without discrimination of any kind" and to take steps towards the "full realization" of the right that must be "deliberate, concrete and targeted towards the full realization of the right to health."⁴⁴

The legal obligations in Article 12 are also authoritatively interpreted by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, a post created by the UN Commission on Human Rights' in 2002.⁴⁵

Additional expressions of the right to health are found in specific human rights treaties, such as:

- the International Convention on the Elimination of All Forms of Racial Discrimination;
- the Convention on the Elimination of All Forms of Discrimination against Women;
- the Convention on the Rights of the Child;
- International Labour Organisation Convention

- No. 169 concerning Indigenous and Tribal Peoples in Independent Countries;
- the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families; and
- the Convention on the Rights of Persons with Disabilities.⁴⁶

In addition, other legal instruments that contain the human right to health in regional contexts include the following:

- African Charter on Human and Peoples' Rights;
- Protocol to The African Charter on Human and Peoples' Rights on the Rights of Women in Africa;
- African Charter on the Rights and Welfare of the Child;
- San Salvador Protocol to the American Convention on Human Rights;
- European Social Charter of the Council of Europe;
- Charter of Fundamental Rights of the European Union;
- Cairo Declaration on Human Rights in Islam;
- Arab Charter on Human Rights; and
- Charter of the Association of South East Asian Nations.⁴⁷

Finally, there are numerous UN and regional resolutions that reiterate the right to health. For example, in June 2009 the Human Rights Council adopted a resolution on preventable maternal mortality and morbidity and human rights.⁴⁸ Such resolutions represent authoritative interpretations of the various legally binding obligations.

The health imperative

As the above summary makes clear, the human right to health is well established in international law. It has been agreed to by almost all states. The imperative nature of this right is the bedrock of the HRAH. At the most formal level of international discourse, states have agreed, in legally binding instruments, to ensure the right to the best attainable physical and mental health for all. States' proclamations of the right to health are numerous. The repeated agreement about the existence of the right makes it an undeniable and relevant restraint on foreign policymaking. As the numerous reiterations of the right to health indicate, it is impossible for any country to deny the existence

of this right. Nevertheless, it is not uncommon for diplomats and politicians to be unaware of these legal obligations. Making diplomats and politicians aware of their governments' undertakings and encouraging them to take these commitments seriously will help to ensure that their foreign policy is consistent with their legal obligations to ensure the right to health.

While there may be other means of making health an imperative of foreign policy, using the HRAH has the added value of relying on existing commitments that states have already voluntarily undertaken. Moreover, unlike many other policy arguments, those based on the human right to health can rely on a multitude of international instruments in which this right has been agreed upon. As the human right to health is recognized in all regions of the world, it therefore follows that every government has in some measure agreed to the responsibility to make health an imperative.

The legal duty of cooperation

Traditionally, human rights are held by individuals in relation to the state under whose jurisdiction they find themselves — usually their state of nationality or habitual residence. Nevertheless, the duty of states to cooperate with each other to ensure the right to health is also a legally binding obligation.

This obligation is enshrined in the Charter of the United Nations, which has been ratified by 192 states.⁴⁹ By ratifying this treaty, the consenting states agreed to give its provisions precedence over all other treaties.⁵⁰ Article 55 of the UN Charter provides imperative language that the UN “shall promote . . . higher standards of living . . . conditions of economic and social progress and development . . . solutions of international economic, social, health, and related problems . . . and . . . universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.” Article 56 of the UN Charter further provides, in similarly imperative language, that all member states “pledge themselves to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.”⁵¹

According to the CESCR, “Articles 55 and 56 of the Charter of the United Nations . . . with well-established principles of international law” are evidence that “international cooperation for development

and thus for the realization of economic, social and cultural rights is an obligation of all States.”⁵² Furthermore, when a state does not devote adequate resources to improving international health, it may be violating international law because its legal obligations require that “every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.”⁵³ This obligation applies both within states and between them.

The ICESCR further clarifies this point in Article 2(1), by which each state

undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means.⁵⁴

Although it is often forgotten during foreign policy discussions, the obligation of states to cooperate with each other to achieve the right to health is fundamental to the HRAH and is vital to understanding health as an imperative of foreign policy.

Resources

Among the duties of cooperation is the obligation to invest appropriate resources into ensuring respect for the right to health both within state and across borders.⁵⁵ To date, such an investment — although shown to be well within the capabilities of developed states — has not been forthcoming.

Although the G8 countries account for 75% of global development assistance and have repeatedly pledged to improve global health, the aid directed towards basic health needs in the neediest countries is insufficient. This has occurred because “[m]ainstream perspectives on international relations are sceptical about applying ethical criteria to the actions of national governments, viewing expectations that they will be driven by considerations other than national self-interest as unrealistic.”⁵⁶

Despite such skepticism, at the Financing for Development Conference held in Monterrey, Mexico, in 2002, states committed to increasing development

resources, including an increase in official development assistance to 0.7% of states’ GNP by 2015 (originally 1%).⁵⁷ Most donor countries are not, however, meeting this commitment.⁵⁸ It does not appear that it is impossible for states to meet these commitments, but there seems to be a failure of political will.

This failure is related to the misunderstanding of legal commitments to ensure the right to health or treat it as an imperative in foreign policy discussions. Stating that the right to health is an imperative — meaning here a binding legal obligation that must be achieved — emphasizes that sufficient resources must be allocated to achieving adequate access to health care. Indeed, the WHO Director-General declared in 2002 that “[i]t is now no longer a question of whether to make investment in global health an element of foreign policy. It is a question of how to turn policy into measurable results — and how to ensure the benefits reach future generations of world citizens.”⁵⁹

To date, governments that need assistance to improve access to health care for their citizens and to strengthen their health systems have generally resigned themselves to either requesting donations or relying on erratic market systems, instead of demanding that all states live up to their legal commitments to cooperate by providing financial resources. For example, when Norwegian Prime Minister Jens Stoltenberg pledged US\$1 billion for global maternal and child health during the High Level Segment of the 62nd UN General Assembly, and when global leaders announced a series of new financing measures worth US\$5.3 billion to support the International Finance Facility for Immunisation in 2006, neither referred to the existing obligations of states to cooperate to achieve greater respect for the right to health.⁶⁰ In fact, this duty to cooperate would obligate countries participating in these initiatives to provide adequate resources for improving health in needy countries. As a result, even these financial contributions, however laudable, appear to be voluntary contributions rather than the fulfillment of a legal obligation.

A concern for countries implementing a human rights approach in foreign policy processes may be the perceived consequences for resource allocations. The human rights approach has much to say about this that both addresses donor concerns and clearly identifies the extent of donor obligations in relation to ensuring adequate resources.

On the one hand, a central focus of human rights is the duty of states to invest sufficiently in the provision of health care to their own people. The 2001 Commission on Macroeconomics and Health report estimated that most states (in low- and middle-income countries) needed to “increase their budgetary outlays for health by 1 percent of GNP by 2007 and 2 percent of GNP by 2015” compared with 2001 levels in order to achieve the eight MDGs.⁶¹ A human rights approach to health in foreign policy encourages a world order in which donor states can point out human rights obligations to recipient countries, while recipient countries can point out the duties to cooperate to ensure human rights, including the obligations for providing adequate resources that are incumbent upon donor countries. These obligations have been voluntarily taken by the states concerned. The mutual obligation creates a more equal and respect-based engagement between donor countries and countries that receive aid. At the same time, the focus on human rights, taking into account the duty to cooperate to achieve respect for these rights that has been indicated above, also requires states with available resources to share these resources not as charity, but in fulfillment of their legal obligations to cooperate to ensure respect for the right to health.

In other words, applying an HRAH can assist in dealing with one of the most troublesome issues in the relationship between health and foreign policy — the allocation of resources — by providing a common basis for both domestic and international action. The common denominator of the right to health allows both donor and recipient countries to feel that they are being treated with respect, and increases the chances that their constituents will support government policies with this basis.

Participation

The HRAH also encourages governments to involve more actors in the discussion of foreign policy priorities. By virtue of the fact that human rights are shared public goods, states are strongly encouraged to include a wide range of actors in their consideration of policies that might have consequences for the enjoyment of human rights. As Ilona Kickbusch and Christian Erk observe, in an increasingly globalized world “[f]oreign policy and diplomacy no longer reside solely with the traditional diplomats but also include a wide variety of the state and non-state actors.”⁶² The Chief Medical Adviser of the UK gov-

ernment, Sir Liam Donaldson, has also recognized that “[p]rotecting and promoting health is a duty of our global citizenship.”⁶³ Nevertheless, it has been recognized that there is “weak health knowledge” among foreign policy makers.⁶⁴

Paul Hunt, Former UN Special Rapporteur on the right to health, suggests that improving the substantive content of the dialogue between the human rights community and the private sector can elevate health on governments’ agendas.⁶⁵ Further, in response to the Bangkok Charter, non-state actors have expressed the expectation that their views should be considered when states decide how health influences foreign policies. They did this by drawing attention to the Charter’s call that states live up to their commitments towards ensuring global health with effective action.⁶⁶

It is not unusual for states to be very protective of their foreign policy decision-making processes. Even when states have considered health within their foreign policy, it has been through processes that significantly limited participation. For example, the Swiss government’s agreement on health foreign policy objectives was based on an “internal agreement between the relevant services of the Swiss federal administration” that was requested by a “closed session” of the Federal Council.⁶⁷ There were no direct inputs by outside voices, including international organizations, specialized bodies of professionals, non-governmental organizations, and academics. In Malaysia, “health diplomacy is coordinated principally by means of interministerial working parties and liaison between the health and foreign affairs ministries.”⁶⁸ Often global health specialists are not even “in the room” when important foreign policy decisions are being made, and sometimes advice from health specialists in foreign policy forums has been deliberately suppressed by the opaque process that characterizes foreign policymaking. This can also occur nationally, as when, for example, the US government blocked a report of its own Surgeon General because it called for the US to play a greater role in tackling global health problems.⁶⁹

Inter-governmental organizations should also play an important role in the dialogue on health in foreign policymaking. WHO is naturally placed to raise the profile of health in foreign policy forums. WHO’s Annual Report for 2007 argued for placing “global public health security” higher on the international agenda.⁷⁰ This encourages making health a more

important issue in the foreign policy of states. Yet, while WHO has undoubtedly been active in profiling the importance of global public health in states' domestic policies, it has often shied away from too strongly pressuring governments to prioritize health in their foreign policies and in international forums. In part this may be due to WHO's apparent caution about using the HRAH. To redress this shortcoming, the World Health Assembly — the most authoritative body of the WHO — could adopt a resolution reaffirming its commitment to the right to health.

But the HRAH requires even more. As Mary Robinson, former President of Ireland and second UN High Commissioner for Human Rights, has pointed out, “those suffering the most from these health problems — poor people in general and poor women in particular — lack the political voice and resources needed to demand change at home and on the international stage.”⁷¹ The HRAH requires that these diverse victims' voices be taken into account. Indeed, the right to health is something that people want, according to a poll commissioned by the UN Secretary-General for the Millennium Summit in 2000 showing that “good health consistently ranked as the number one desire of men and women around the world.”⁷² Thus it is reasonable to suggest that, if people are made aware that their own governments have solemnly pledged to provide them the human right to health, pressure might be increased on governments to achieve this right. Conversely, participation by a wider range of actors to express this “need” as a right in foreign policy processes will undoubtedly enhance the role of health in foreign policy.⁷³

Many of the processes of participation also contribute to education of both foreign policy makers and those who might hold the governments to the solemn commitments they have undertaken. Proper education about the human right to health, especially its legally binding nature and the consequences it has for governments, is an essential condition for implementing the human rights-based approach to health.

Limitations of the HRAH

The human rights approach to health has some limitations. One is that it is based on legal instruments that are often neither known nor widely respected in practice. This makes it difficult for political actors

who are not familiar with the binding nature of international legal instruments to use them in policymaking. This lack of awareness does not, however, change the legally binding nature of these documents. Rather, as indicated above, it places an additional responsibility on individuals and organizations that do or should understand the legally binding commitments of states to ensure that these commitments are taken seriously. As human rights address the most basic needs of people, direct appeals to legislators or their constituents are additional means for reiterating the priority of health on governments' competitive agendas.⁷⁴

Further, the right to health may be subject to the limitation that, when a state's available resources prevent it from immediately ensuring the right for all persons under their jurisdiction, it may do so progressively.⁷⁵ The burden for showing a lack of resources falls on the state; the use of resources for purposes that are not rights-based will not be a valid excuse. In any event, a state must make constant progress towards achieving the right to health when it is possible to do so.⁷⁶ Additional limitations based on resources are confined to the special situations of developing countries that may protect their national economies by determining to what extent they will guarantee the right to non-nationals.⁷⁷

CONCLUSIONS

In this essay we have shown that although health is increasingly viewed as relevant to foreign policy, such a view is usually presented in a manner that subordinates health to other foreign policy interests. We have argued that this subordination is inconsistent with the HRAH, which is based on the legal obligations that states have undertaken. Further, we have suggested that the HRAH can contribute to making health an imperative of states' foreign policy.

We have demonstrated that the human right to health is widely accepted as an obligation voluntarily undertaken by the overwhelming majority of governments. Moreover, we have shown that these obligations extend not only to states' relationships with their own citizens, but also — of particular importance for the foreign policy context — to the relations between states. This is because the HRAH is based upon normative obligations of states relating to health, the duty of states to

cooperate with each other, obligations involving the provision of adequate resources, and need to ensure broad participation in decision making.

Above all, we suggest that the HRAH can make an important contribution to building the “will” that is needed to make health a more important part of foreign policymaking. The HRAH does this by classifying health as an imperative that must be taken into account in foreign policymaking. The HRAH also provides individuals and civil society with the tools to hold foreign policy makers accountable for legally binding obligations they have undertaken in treaties and the morally and politically important commitments they have made in non-binding aspirational statements.

However, both in domestic foreign policy forums and in inter-governmental forums, actors are often not fully informed about the legally binding nature of the human right to health. Further education and training is undoubtedly needed to create a “global health diplomacy.”⁷⁸ Education and training should be used to sensitize foreign policy makers so that they consider health as an imperative and to encourage health specialists to better understand how they can influence foreign policy. Such capacity-building, however, will face severe limitations unless it is accompanied by confidence-building efforts through which diplomats and politicians come to respect the legally binding nature of the human right to health.

Almost all world leaders have committed themselves to ensuring that all individuals enjoy the right to health. They have also agreed to cooperate to realize this right for people everywhere. They must now back these words with their actions. It is a task by which they are likely to be judged by future generations.

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