Moving from the General to the Specific:
The Emergence of a Right to Health Regime and Global Governance Reforms

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Introduction: From the General to the Specific

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

- World Health Organization Constitution, 1946.¹

The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

The right to health contains both freedoms and entitlements. Freedoms include the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

The right to health is a broad concept that can be broken down into more specific entitlements such as the rights to: maternal, child and reproductive health; healthy workplace and natural environments; the prevention, treatment and control of diseases, including access to essential medicines; access to safe and potable water.

- UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Office of the UN High Commissioner for Human Rights, according to General Comment No. 14 of UN Economic and Social Council on the Right to the Highest Attainable Standard of Health.²

“They have moved from the general to the specific,” the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, reports in 2007 on the progress made by the health and the human rights movement.³

Perhaps this one phrase—moving from the general to the specific—best summarizes the tremendous trajectory of the international human rights movement in the past sixty-five years. This chapter focuses on the right to health movement that ruptured in the local and global scene in the last three decades. What is the role of the right to health movement in global health governance reforms? I use a poststructuralist narrative approach to frame and situate the right to
health movement as a knowledge regime in competition with four other predominant global health regimes—health security, health commodity, health philanthropy, and health partnership. Using a nodal governance framework (Shearing and Wood 2003), I argue that the right to health movement has made its most significant contribution in the discursive, rather than resource, legal or organizational interfaces in global health governance. This chapter is structured in five parts. Part II lays out a theoretical framework contrasting five different approaches—realism, liberalism, neoliberalism, constructivism, and feminist theory of justice—to global health governance regimes. Focusing on the People’s Health Movement and the Access to Essential Medicines Campaign, Part III discusses the emergence of a right to health movement in the context of a global justice movement. Part IV evaluates the right to health movement in relation to a fragmenting global health governance architecture and provides a preliminary basis for comparison with the right to education movement. I conclude by exploring some issues concerning the engagement of civil society in global health governance reforms.

Global Health as Knowledge Regimes

Traditionally, in the field international relations, international regimes are defined as “implicit or explicit principles, norms, rules and decision-making procedures around which actors’ expectations converge in a given area of international relations (Krasner 1983).” In this chapter, however, I draw upon the Foucauldian concept of discursive discontinuity to look at global health as competing knowledge regimes.

According to Foucault (1982), the problem with historical analyses is not how structural continuities are established, but how discontinuity is marked by discursive events. He asks,
How is one to specify the different concepts that enable us to conceive of discontinuity (threshold, rupture, break, mutation, transformation)?... One is led therefore to the project of a pure description of discursive events as the horizon for the search for the entities that form within it... according to what rules has a particular statement been made, and consequently according to what rules could other similar statements be made? The description of the events of discourse poses a quite different question: how is it that one particular statement appeared rather than another?\(^4\)

A historical, genealogical approach to the rise of the right to health movement as a new knowledge regime is not to discredit the validity of the norms and rules that exist within the global health architecture. Rather, the purpose of a poststruturalist take on international regimes is to move away from the search for a metanarrative Truth/one way of understanding global health to focus on how discursive events constitute a new knowledge regime and how power operates behind competing global health regimes.

Given the density in terms of actors, action, claims, and dollars spent, the idea of global health has been up for grabs. For the sake of conceptual discussion, I forward five prototypical global health regime types (Fig. 1)

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**Fig. 1 Global Health Regimes**

<table>
<thead>
<tr>
<th>Neorealism</th>
<th>Dependent Variable</th>
<th>Independent Variable</th>
<th>Global Health Discourse</th>
<th>Examplary Institution</th>
</tr>
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<tr>
<td>Liberalism</td>
<td>international relations</td>
<td>state power/capabilities</td>
<td>health security</td>
<td>Pepfar</td>
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<tr>
<td>Neoliberalism</td>
<td>international cooperation</td>
<td>state preferences including market power</td>
<td>health commodity</td>
<td>World Bank/World Trade Organization</td>
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<tr>
<td>Constructivism</td>
<td>international cooperation</td>
<td>Interests</td>
<td>health philanthropy</td>
<td>Gill and Melinda Gates Foundation</td>
</tr>
<tr>
<td>Feminist Theory of Justice</td>
<td>(global) injustice</td>
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People’s health movement; Access to essential medicines campaign
A classic neorealist approach to international relations focuses on state power (Waltz 1979). Outcomes in international politics often depend on a balance of power between states. A neorealist global health regime looks at international health cooperation as an extension of states’ foreign policy goals. A prototypical example is the US President's Emergency Plan for AIDS Relief (PEPFAR) established in 2003. I call this a health security regime, one that follows very closely the interests of a hegemon. A liberal approach to international cooperation does not assume the state as unitary and incorporates economic interests as part of state preferences that drive international behavior (Krasner 1983). In this light, international health cooperation is pursued to the extent that market outcomes are optimized. Two representative organizations are the World Bank and the World Trade Organization. Since the focus is on a market-driven health agenda, I call this a health commodity regime.

A neoliberal approach goes beyond predominant state and market power to entertain the possibility of international cooperation out of shared interests and interdependence (Keohane 1984). The creation of the UN system is often seen as an example of a neoliberal undertaking. Various forms and organizations in global health that are perceived as mutually beneficial to various parties have emerged in the past fifteen years. The Bill and Melinda Gates Foundation is a prime example of a health philanthropy regime where health-compromising corporate behavior supported by Bill Gates Investment is not seen as incompatible with the global health agenda of the Foundation. A fourth constructivist approach flips the neorealists, liberals, and neoliberals on their head and argues that ideas and norms drive state identity and behavior, not the other way around. Material interests still matter, but they alone cannot account for myriad new forms of international cooperation (Ruggie 1998). The Global Fund as well as the
Millennium Development Goals can be seen as a norm-driven enterprise embedded in a hard-core neorealist and neoliberal UN setting. A health partnership regime is often a fragile compromise out of a constant tug of war between competing interests and agenda of various parties involved.

Finally, a feminist theory of justice zooms in injustice as its core focus and emphasizes exclusionary structures and processes. Traditional theories of justice have been predominantly domestic. Only recently have various theorists—including a capability approach used by Amartya Sen’s (1999) and Martha Nussbaum (2006), and a social connection model of structural injustice and responsibility by Iris Marion Young (2002) and Nancy Fraser (2003)—taken up issues of global justice. A capability approach emphasizes the ability of an individual to use resources according to her ends. In contrast to the neorealist, liberal, neoliberal, and constructivist regimes that are deeply anchored in a redistribution ideology, a feminist theory of justice according to Young and Fraser focuses on structural injustices that exclude. A right to health knowledge regime is best understood from a feminist theory of justice perspective as it narrows its lens on global health equity. It is in this broader context of competing global health regimes that one can discuss and evaluate the emergence of a people’s right to health movement.

**Right to Health Movement**

For the first hundred years, from 1851 to 1951, international health diplomacy was characterized by a disease control approach, Euro-American focus, reliance on treaties and formal international organizations, and limited involvement of nonstate actors such as the Rockefeller Foundation and International Union against Tuberculosis (Fidler 2001). Although the right to the enjoyment of the highest attainable standard of health was clearly stipulated in the
World Health Organization constitution, it was not until the Alma Ata Declaration at the International Conference on Primary Health Care in 1978 that grassroots groups found a mobilizing frame for a people’s centered approach to health. The historic Declaration affirms that health is a fundamental human right. It emphasizes health inequalities and the necessity of an alternative economic and social development model based on a New International Economic Order. It puts the responsibility for primary health care squarely on governments and sets a target for health for all by the year 2000.8

A People’s Health Movement (PMH) based out of grassroots movements in the Majority World emerged out of Alma Ata.9 It is a coalition of local popular health movements organized in the form of country circles. Their stated objectives are to pursue the health for all goal as a rights issue; demand government to ensure universal access to health care; encourage people’s participation; promote health as a national and international policy goal; stimulate local solutions; and hold international organizations, corporations, and national and local governments accountable.10 A people’s health movement methodology centers on advocacy, research, and education to realize health for all. One of the current global advocacy efforts is the Right to Health and Healthcare campaign. The idea “is to change the international approach to health and development, and, via a ‘Global Action Plan on the Right to Health Care,’ convincingly show how quality essential health care services (based upon the Alma Ata Primary Health Care model) could be made available NOW to every human being on earth, provided certain key reallocation of priorities and resources.”11 An instrument, The Assessment of the Right to Health at the Country Level: A People's Health Movement Guide, has been developed for country PHM circles to analyze the denial of the right to health and healthcare by their governments based on
international human rights law. In terms of research, the PMH publishes a Global Health Watch that offers an alternative to the current economic development model that embraces the principles of a bottom-up social determinant of health approach to encourage democratic participation and global governance reform according to health, education, and environmental objectives. More than a report on individual issues including poverty eradication, debt relief, global taxation, tradable carbon emission permits and alternatives to free trade agreements, the Global Health Watch proposes a different global governance model that emphasizes inclusiveness, equality of voice, transparency, and accountability. In addition to advocacy and research, one of the key working methods of PMH is the people’s health assembly and international people’s health university. The peoples’ health assembly has gathered twice, in Bangladesh in 2000, culminating in the People’s Health Charter, and in Ecuador in 2005. The international people’s health university is part of the educational branch of the People’s Health Movement. It offers short courses around health for all and primary health care for activists.

Just as there is no one feminist or environmental movement, the right to health movement is a movement of movements. Moving from the general to the specific, one of the most effective right to health movements that emerged in the 1990s in the context of a global justice movement—that ties in a range of issues including debt relief, climate change, food sovereignty, water rights, indigenous struggles, and anti-corporate globalization—is the Access to Essential Medicines Campaign (Huang 2006).

By the late 1980s and early 1990s, one of the strongest foci of the right to health movement fell on the AIDS epidemic. As a prominent sociologist of biomedicine, Steven Epstein, comments, “perhaps the most striking feature on the landscape of AIDS politics is the development of an ‘AIDS movement’ that is more than just a ‘disease constituency’ pressuring
the government for more funding, but is in fact an alternative basis of expertise (1996: 8).” A social movement that transformed disease ‘victims’ into activist-experts quickly emerged in the United States. The AIDS Coalition to Unleash Power (ACT UP), established by gay men in 1987, grew to become a strong international movement that not only successfully lobbied for affordable drugs within the US, but also worked with its counterparts in Thailand, Brazil, and South Africa etc. on the issue of access to treatment globally. One of the watershed moments of this growing right to health movement from the angle of access came with the declaration of the “GIIPA” (Greater Involvement with People Living with HIV/AIDS) principle at the AIDS Summit in Paris in December 1994. Networks of gay men, sex workers, and injecting drug users affected by AIDS made it clear to global health policy makers that rather than being passive recipients, they are actors to “make new demands on the political system (Altman 1994: 30).”

In 1999, Médecins Sans Frontières (MSF) set up the Access to Essential Medicines Campaign to lobby against the high cost of existing medicines for global neglected diseases including HIV/AIDS. The Campaign became the basis of a transnational advocacy network on access to affordable treatment. In 2001, a coalition including ACT UP, MSF, Treatment Action Campaign (TAC), and the Global Network of People Living with HIV/AIDS successfully lobbied for the insertion of a public health clause within the Trade-Related Intellectual Property Rights (TRIPS) Agreement of the World Trade Organization (WTO) in the Doha Round, stipulating that TRIPS “can and should be interpreted and implemented in a manner supportive of WTO members’ right to protect public health, and in particular, to promote access to medicines to all.” After Alma Ata, this marks a second major epistemic shift in global public health from the predominant intellectual property rights paradigm to a universal right to health framework.
Redefining Global Health

It is difficult to evaluate the impact of the right to health movement in the past three decades. In the context of a rapidly multiplying and fragmenting global health governance structure, evidenced in the emergence of extraordinarily endowed foundations and innovative partnerships (Buse and Harmer 2009), the role and boundary of civil society keeps shifting. Here, I would like to use a nodal governance framework (Shearing and Wood 2003) to discuss the place that the right to health movement occupies. According to Shearing and Wood, a nodal governance framework decenters a traditional understanding of global governance structure according to existing power structures. Instead, no set of nodes—formal or informal institution—is given conceptual priority so that power mapping can be done along different interfaces, depending on a specific governing configuration. For example, discursive interfaces “relate to interactions aiming at changing perceptions, concepts and norms held by different nodes of governance… Resource-transfer interfaces involve the relationships between donors (countries, foundations) and recipients… Organizational interfaces refer to decision-making structures linking different actors… Finally, the level of legal interfaces… relates to the most highly formalized norms for regulating human relations and resolving social and political conflicts (Hein, Burris and Shearing 2009).”

Apart from the public health clause within the TRIPS Agreement and a few domestic legal triumphs such as the 1988 Hope Act, 1997 Medicines Act in South Africa, and the 2004 Canadian Access too Medicines Regime, the right to health movement seems to have had rather minimal impact on legal interfaces, whether those pertain to the formal legal stipulations of various international organizations or institutions such as the predominant intellectual property
rights regime that protect drug patents. One of the latest developments in this area is the patent pool recently approved by UNITAID, an international drug purchasing facility, in December 2009. The pool allows “generic companies to make lower cost versions of widely patented new medicines by creating a common space for patent holders to license their technology in exchange for royalties. This will spur competition and further bring down the price of vital new and effective medicines, giving hope to millions of patients.”16 It remains to be seen whether the major patent holders of AIDS drugs will participate. In terms of organizational interfaces, there seems to be some limited success as well. The often quoted examples of the inclusion of civil society (CS) voice include the structure of UNAIDS (five non-voting seats for civil society on the Program Coordinating Board); the 2001 Global Strategy Framework on AIDS and Declaration of Commitments (which specifically emphasizes civil society engagement); and the structure and mechanism of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (civil society organizations are members of the country coordinating mechanism, CCM, through which grant proposals are developed). The Global Fund goes so far to acknowledge that the Fund “was an initiative that they [civil society organizations] had helped to create, fund and govern”17 and, at an international AIDS conference, one CCM manager commented that the inclusion of civil society actors in the multi-stakeholder approach to the Global Fund represents a “revolution” in global health governance.18 Others such as McCoy and Hilson, however, caution “if (and how) the voice of CS has changed as a result of being included or co-opted into the formal structures and systems of governance (2009: 212).”

The issue of whether civil society has made a significant change in the global health resource-transfer interfaces is a tricky one. One the one hand, it does seem that the highly visible and effective transnational mobilization for access to treatment in the past decade has led to
unprecedented level of funding on neglected global diseases, so much so that there has been critiques of overspending on HIV/AIDS. The Global Fund alone has managed to raise and disburse $15 billion since its creation in 2002 ($2 billion for the latest Round 9). Funding has increased multifold in areas of malaria, AIDS vaccine, and microbicides research. On the other hand, what we observe is the emergence of a global health funding oligopoly dominated by a few key players including the Gates Foundation with a $60 billion endowment ($1.22 billion in global health for 2007), PEPFAR ($15 billion from 2003-2008 and $48 billion for 2008-2013), and the World Bank. Preliminary analyses show that Gates funding in global health is heavily skewed towards funding research capacity in the US and UK, vertical programming, and focus on technology (McCoy et al 2009). Others have critiqued how PEPFAR funding follows more the logic of domestic US agenda (rules concerning abortion, needle exchange, condom use, and the role of faith-based organizations etc.) rather than science (Dietrich 2007). The impact of the “Gates-Buffet effect (Okie 2006)” on global health resource interface and the role of civil society in this new funding oligopoly are yet to be fully understood through more research.

Finally, it is my contention that the single area where civil society has made an undeniable impact is the discursive interface in global health governance. A right to health knowledge regime emerges from popular social movements as a critique to predominant global health regimes. Posited on five core principles of human rights, equity, participation, sustainability, and accountability, the right to health movement deconstructs macroeconomic, biomedical, free-market, and realpolitik approaches to global health. It is largely through their success in the discursive interface by redefining global health as a rights issue that changes in the other three interfaces occurred. In its report to the Human Rights Council in 2007, the UN Special Rapporteur on the Right to of Everyone to the Enjoyment of the Highest Attainable
Standard of Physical and Mental Health (established by the Commission on Human Rights in April 2002) highlighted the success of civil society, especially in low- and middle-income countries, in using a rights-based approach to health and relationships with other rights; insisting that the right to health as specific, accessible, practical, and operational; and employing a clear methodology for right-to-health impact assessment (A/HRC/4/28). One of the latest examples of translating a right to health discursive to organizational change is the creation of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property Rights within the World Health Organization in 2006 to work out the fundamental tensions between a private intellectual property rights regime and a public health regime within the current global health governance system.

To what extent can we compare the right to health with the right to education movement? There is clearly a certain overlap in ideology as they both form part of the global justice movement. Both health and education have been recognized as fundamental ingredients of development. Both figure prominently among the Millennium Development Goals. The core principles of the two movements rest on similar norms: universal human rights, equity, participation, sustainability, and accountability. Both movements emerge as alternatives to predominant development paradigms and global governance structures. The global financing of both health and education fall under an ongoing global process concerning innovative development funding. On the other hand, however, the nature of pandemic, global governance structure, level of funding, and the impact of rapidly evolving technologies differ significantly in the field of health compared to education. One possibility for future research could be to use a nodal governance approach to compare the right to health and right to education movements in terms of their impact on discursive, resource-transfer, organizational, and legal interfaces.
**Conclusion**

Social injustice is killing people on a grand scale… The unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinant of health and are responsible for a major part of health inequities between and within countries... It is only through such a system of global governance, placing fairness in health at the heart of the development agenda and genuine equality of influence at the heart of its decision-making, that coherent attention to global health equity is possible.


In this chapter, I borrow from a Foucauldian concept of discursive discontinuity to analyze the emergence of a global right to health movement as a competing knowledge regime against predominant neorealistic, liberal, neoliberal, and constructivist approaches that emphasize power, interest, free market, and norms. Further, I use a feminist theory of global justice focusing on a social connection model to health equity to look at the claims of the right to health movement. Through a brief discussion of the People’s Health Movement and the Access to Essential Medicines Campaign, I discuss how a right to health movement of movements has been pushing for an epistemic shift in global public health from a predominant intellectual property rights paradigm to a universal right to health framework.

The study of civil society is often plagued by various methodological concerns. One of these relate to different definitions of “civil society.” Far too often, research on civil society leans heavily on the dominant axis of civil society-state relations. Can civil society be seen and measured on its own terms, for example, concerning movement ecology, empowerment, and change etc.? As Alagappa argues, “it is crucial to view civil society as an arena of governance in its own right, not just an adjunct or means to influence the state, political society, or the market.
The notion of civil society as an end in itself is relevant not only to totalitarian and authoritarian states but also to liberal-democratic states (2004: 32).” In the case of global public health, the inclusion of civil society in a multitude of funding and governance partnerships has blurred the boundaries and made evaluation a complex task.

The use of a rights-based discourse to health (and education) is by no means universally accepted. As the 2007 Special Rapporteur report to the Human Rights Council comments, the engagement of mainstream human rights nongovernmental organizations as well as health professionals remains inadequate. Finding ways to exploit cracks/new nodes in a constantly changing and rapidly multiplying global health governance present opportunities as well as challenges for global and local civil society to translate a right to health discursive regime into funding, organization, and legal gains. What we will continue to witness is likely the role of civil society to move from the general to the specific. Far from being abstract, the broad concept of a right to health includes the duty to respect, fulfill, and protect; specific entitlements, progressive realization, resource availability, and immediate obligations; and available, accessible, acceptable, and good quality care.23
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21 In 2002, the International Conference on Financing for Development in Monterrey brought the issue of innovative financing to the forefront (http://www.un.org/esa/ffd/ffdconf/). The issue was reaffirmed at the World Summit on Sustainable Development in Johannesburg in 2002 (For the plan of implementation of the World Summit, see http://www.un.org/esa/susdev/documents/WSSD_POL_PD/English/WSSD_PlanImpl.pl). In 2003, French President Jacques Chirac commissioned a working group on new international