

Global health diplomacy – a bridge to innovative collaborative action



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“Medicine is a social science, and politics nothing but medicine on a grand scale.”
RUDOLF VIRCHOW, 1858

Global health diplomacy may be thought of as a political activity that meets the dual goals of improving health while maintaining and strengthening international relations. As diplomacy is frequently referred to as the art and practice of conducting negotiations, the term “global health diplomacy” aims to capture the multi-level and multi-actor negotiation processes that shape the global policy environment for health. It bridges the commitment to development and the need to define collective action in an interdependent world. This emerging field draws on a broad range of disciplines including international relations, medical anthropology, political science, history and public health. Therefore it is important to understand some of the historical and conceptual underpinnings of this emerging field. Academic rigour applied to global health diplomacy is a critical leaven in a chaotic global health environment. This paper presents a brief review of the issues that provide a possible focus for future training, research and service in global health diplomacy.

Historical roots

A historical perspective may help illustrate an emerging tension surrounding health cooperation and diplomacy. In fact, international public health agreements were originally created to protect against the importation of foreign-born diseases and as a defence for national commercial and trading interests, going as far back as the Middle Ages in Europe.

We may also find some roots of health diplomacy in early missionary work, which adopted medical treatment as part of evangelical activities. For example in India, Fitzgerald described the emergence of medical assistance as a tool for religious conversion among British colonial subjects¹. There is thus a need to consider the normative foundations of global health diplomacy, such as in the humanitarian activities of the Red Cross Movement, with equity and social justice being key components². The current structures of global public

health may perpetuate the imbalance of power between the developed and the developing world. However, we now see a power shift in the role of the emerging economies, as in the recent Doha rounds of World Trade Organization negotiations.

From the mid 1850s, countries have dealt with the increasing risk of disease from beyond their borders as a national and economic security issue³. These national interests now mandate that countries engage internationally as a responsibility to protect against imported health threats or to help stabilize conflicts abroad so that they do not disrupt global security or commerce. Concerns for health security include the threat of bioweapons (accidental or purposeful) as well as both infectious diseases and noncommunicable diseases that can wreak havoc on global economies. It is the careful balancing of sometimes competing global health priorities, playing out both nationally and globally, that make partnership across disciplines essential in raising the profile of health as a foreign policy concern. Global health efforts will founder unless and until nation states cooperate in combining their national interests with the global public good.

Contributing concepts

Humanitarian assistance

The notion of humanitarian assistance as part of foreign policy was described in a 1974 editorial in *Preventive Medicine*, wherein Cahill advocated using medicine as a tool of modern diplomacy⁴. His more recent work suggests that health is a common ground for understanding and cooperation among peoples and nations with differing traditions and values⁵. This is especially true in nations that are shattered by war, civil conflicts and ethnic violence. Over the next 25 years, humanitarianism rather than foreign policy per se was the focus for health diplomacy. However, humanitarian assistance provided by the United States and others to disaster areas such as Sudan fulfilled broader political and economic objectives rather than just beneficence⁶. Aligning aid organizations with dysfunctional governments may enable these governments to be unresponsive to their own national crises⁷. These examples suggest that aid organizations must be politically and ethically more savvy in order to assure justice-based approaches to international health assistance⁸. Health diplomacy attempts

to prioritize the health outcomes of humanitarian aid as a route to negotiations in the political sphere.

A critical new development in global health is the proliferation of private sector and government donations in international aid; these have been largely disease-specific enterprises (such as the Global Fund for AIDS, TB and Malaria). A 2004 estimate suggested that international funding for global health reached US\$ 14 billion in that year, due largely to contributions from the Bill & Melinda Gates Foundation and the US government's Presidential Emergency Plan for AIDS Relief (PEPFAR)⁹. The proliferation of smaller nongovernmental organizations (NGOs), privately funded and focused on single communities, specific health outcomes or specific medical interventions is also unprecedented in history. Along with this bonanza, there is increasing convergence of thought on the evidence of effectiveness for global health interventions¹⁰. This evidence has been thoroughly reported in the hallmark publication, *Disease control priorities in developing countries*¹¹. What may be missing from these discussions, however, is a sense of the absorptive capacities and global governance needs that are necessary for both recipients and donors to manage these resources¹².

Human rights

The emergence of human rights as a global movement clearly sparked challenges and debates within the field of humanitarian assistance that have yet to be resolved. The notion of human rights and health assistance has emerged as a basis for cooperative action across nations, the private sector and NGOs. The right to health became a key element of this discourse, but its importance remained largely understated until the world acknowledged the enormous impact of HIV/AIDS. Health and human rights emerged as a distinct movement and was made concrete with the 1994 founding of the *Journal of health and human rights* by Jonathan Mann, head of the WHO HIV/AIDS programme at the time. He clarified this union of human rights and health, stating "that the human rights framework provides a more useful approach for analyzing and responding to modern public health challenges than any framework thus far available within the biomedical tradition"¹³. Building on this foundation, Paul Farmer's written works and leadership have dramatically advanced the human rights agenda in health diplomacy, arguing that the international public health and foreign policy communities both fail to recognize the needs of the world's poor and neglect to address the structural inequalities that lead to illness among them¹⁴. Given a decade since health and human rights emerged as a movement, health diplomacy must now incorporate both a concern for resource equity and a concern for social justice in health assistance. It must also consider the political and economic landscape in which these standards must be defended.

Globalization

During the 20th century, researchers have recognized the spread of both communicable and noncommunicable diseases as a consequence of globalization. Global changes

in trade, transport, medicine and society have created ideal conditions for emerging infections with potentially devastating impacts¹⁵. However, deficiencies in public health infrastructure argue for greater public health preparedness to prevent global pandemics¹⁶.

Globalization has also expanded the threat of noncommunicable disease to populations and economies worldwide¹⁷. This latter set of threats (tobacco-related diseases, obesity, injuries, mental health problems, cancers, stroke and cardiovascular disease) are much less attention-grabbing as global health problems compared with the high-profile infectious diseases that are now so well funded; nevertheless, they are the largest contributors to the global burden of disease¹¹. Noncommunicable diseases have emerged as global threats, no longer considered a condition of only affluent populations¹⁸. These conditions may contribute to developmental stagnation in emerging economies, and they may lead to inordinate demands on health systems that disrupt production and trade capacities of these economies.

Enlightened self-interest

Improvements in health status globally – especially in developing countries – promote economic and security interests for both donor countries and the larger global community¹⁹. In 1997, the Institute of Medicine (IOM) published a volume of evidence supporting the United States' critical need to address global health as a vital national priority²⁰; following this, infectious diseases were recognized in the National Intelligence Estimate as a significant threat to national security, with an emphasis placed on the importance of HIV/AIDS²¹. Recently, some have even suggested that the avian influenza threat presents potential for cooperation between the militaries of, for example, the United States and China. They may be encouraged to pool their resources in order to address a common threat such as this²².

Given the potential for new commitments to global health diplomacy in a changing global political environment, the IOM's Board on Global Health is now organizing a 14-month consensus study to examine and articulate the case for why multiple agencies from government and the private sector in the United States should make a deeper commitment to global health. This study will greatly expand on the 1997 IOM report to consider the diplomatic agenda, expanded global research cooperation and perhaps new ways of addressing the global health workforce crisis (see www.iom.edu/CMS/3783/51303.aspx).

Multinational cooperation

In December 2004, the United Nations issued an important report, *A more secure world: our shared responsibility: report of the high-level panel on threats, challenges and change*²³, a follow-up to the 2000 UN Millennium Summit, where commitments to global cooperation were made in response to several major health and development challenges. The 2004 report emphasized the need to achieve the Millennium Development Goals (MDGs; see Table 1), with a focus on health and biological security.

The focus of the UN report also extends to the social determinants of health (especially poverty and economic

<ol style="list-style-type: none"> 1. Eradicate extreme poverty and hunger; 2. Achieve universal primary education; 3. Promote gender equality and empower women; 4. Reduce child mortality; 5. Improve maternal health; 6. Combat HIV/AIDS, malaria and other diseases; 7. Ensure environmental sustainability; and 8. Develop a global partnership for development.
<p>Table 1: The United Nations Millennium Development Goals for 2015</p>

inequities), infectious diseases and environmental degradation. Although sovereign states are the front line in dealing with health threats, the report emphasized that no state can stand wholly alone and that collective strategies, collective institutions and a sense of collective responsibility are indispensable in addressing the global health challenges of the 21st century. The WHO has flexed its muscle in this arena with new instruments, such as the Framework Convention on Tobacco Control (see below). Additionally, governments have begun to align themselves in new arrangements, such as in the 2007 Oslo Declaration, wherein the Ministers of Foreign Affairs (not of Health) of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand recognized the need for new forms of cooperation to support development, equity, peace and security²⁴. The UN MDGs are a framework for multinational health diplomacy, monitored and promoted by the member states of the United Nations, and some have called for codifying them in a Framework Convention on Global Health²⁵. Today's health diplomats must understand how global health governance has and must change.

Global health governance

The shifting role of nation states and the growing insecurity in global public health has generated tremendous discussion concerning global health governance, particularly given the rise of new actors within the field. Cohen drew attention to the increasing role of private philanthropy, illustrating the nearly unfettered influence and unintended consequences of efforts by wealthy individuals and organizations now active in the field²⁶.

Further, sovereign nations may lose their power to set other priorities if they must adhere to donor priorities for disease-specific activities (such as in the first version of PEPFAR). In fact, the World Bank has suggested a moral hazard argument regarding external funding such as that which is now proliferating: if upwards of 50% of government spending comes from external sources, a country may lose control of its priorities, programmes and strategies, yielding all control to the donors²⁷. In this context, what should be the global health governance structure and what should be the role of multinational membership organizations in governing global health? Without systematic attention to the governance needs and social justice issues of health assistance, global health financiers will fall short of their intended humanitarian goals.

The role of nonstate actors, including private philanthropies, private individuals and private industry, has emerged as a concern from both political²⁸ and social science perspectives²⁹. These new global networks are clearly a 21st century humanitarian assistance phenomenon. The

disparate, uncoordinated efforts within global health call for a more systematic global cooperative effort^{30,31}. However, neither the traditional state actors nor the modern nonstate actors are likely³² to accept either centralization under a ruling global authority or harmonization of goals, practices and procedures across organizations. Nonetheless, the acceptance and integration of health as a global public good has crossed a variety of thresholds, including trade, security, bioethics, international relations and economics. This suggests that the principles and policies of global health governance, what Fidler terms the “source code”, have functioned independently of centralized efforts. Instead of developing a new governance structure, global health actors should consider how successful applications of this source code will look in the 21st century. A range of proposals that build on network governance and aim to bring together the many actors in this new political space have since been put forward³³. A growing international consensus on what works and what does not work in global health, and the growth of the new academic global health programmes and philanthropic structures will redefine global health governance in the years to come.

What should also be evident is the need for new public health instruments to support collective health efforts. Fidler calls for further examination of new efforts in global health governance such as the Framework Convention on Tobacco Control (FCTC) and the revised International Health Regulations (IHR). The FCTC was the first treaty implemented under the WHO's constitutions, Article 19. It has now been ratified by 155 countries and will call for national policies to assure full participation in the Conference of the Parties, the supervising entity for the treaty³⁴. In addition, there are challenges posed by the new IHR as a consensus agreement within the WHO for countries to support global responses to critical public health problems and to share information and responses to these problems³⁵.

Emergence of health diplomacy in the United States

In 2001, the Council on Foreign Relations³⁶ made a strong case that the US government had a critical responsibility to make health a priority in foreign policy. US global health policy today is rooted in both national security concerns and a worldwide desire for social justice and equity³⁷. Health diplomacy offers the potential for breaking free of the governance dilemma by bringing together health and foreign policy based on a concept of human security that embraces rights and well-being rather than only enlightened national self-interest.

Recently several US government officials have discussed medical diplomacy as an element of foreign policy, often focusing on the delivery of health care within low-resource settings and the distribution of medical technology^{38,39}. In 2005, the IOM reviewed a number of international models for increasing humanitarian assistance within the HIV/AIDS epidemic with the suggestion for development of a Global Health Corps that would provide for improved global health capacity through elective service by US health professionals⁴⁰. This programme would actually emulate

efforts such as those provided by Cuba over recent decades⁴¹ and that China has recently adopted⁴².

Conclusions

This brief review provides an overview of the history, conceptual basis and new inputs into the growing field of health diplomacy, and it provides some perspectives that we may include as elements of professional education and research in the coming years. Health diplomacy is a field in the making⁴³, and there is ample material in the history of international relations, humanitarian aid and medical assistance with which to begin serious analytic work as well as to develop pedagogy within the academic environment. Today, there are literally dozens of global health educational programmes in the United States and Europe, and many of these were described in a recent (January 2008) special issue of *Academic medicine*. Yet there are few educational initiatives that focus specifically on the interface between international relations, diplomacy and public health (Personal Communication, I Kickbusch and C Erk, *A survey of training programmes and courses*, 11 August 2008). With so many new educational programmes involving multiple disciplinary approaches to global health education, it is clear that health diplomacy will be an exciting new academic pursuit within these programmes in the coming decades. □

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