

Influence And Opportunity: Reflections On The U.S. Role In Global Public Health

Lack of a central government leader has led to a global public health crisis.

by **Ilona Kickbusch**

ABSTRACT: Today's global health crisis illustrates many of the transnational governance challenges the United States faces today. In the arena of global health, the United States can create a new role for itself by moving beyond a national-interest paradigm and strengthening its "soft power" position in health. Health in recent administrations has moved beyond being "just" a humanitarian issue to being one with major economic and security interests. Despite U.S. unilateralism, new approaches to global health governance are being developed by other actors, who have influenced the U.S. agenda and made important contributions. Yet a larger leader is still needed, especially in identifying and following a sound legal and regulatory global health governance system; bringing political legitimacy; and setting priorities. Responsible political action is needed to develop a new mindset and lay the groundwork for better global health in the future.

It is justice, not charity, that is wanting in the world.

Mary Wollstonecraft, 1792

IN HIS RECENT ANALYSIS OF U.S. FOREIGN POLICY, Joseph Nye, dean of Harvard's Kennedy School of Government, argued that the United States must come to terms with what he calls the paradox of American power: The stronger the United States is, the more it must orient itself toward a new global community. It must rely less on traditional measures of power such as military strength and more on the "soft" power that comes from culture, values, and institutions.¹ This differentiation between hard and soft power has been a major subtext of all discussions on America's role in the new global environment since the fall of the Berlin Wall and in particular in the aftermath of the September 11 attacks on the World Trade Center and the Pentagon.

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Ilona Kickbusch is head of the Division of Global Health at the Yale University School of Medicine, Department of Epidemiology and Public Health. From 1994 to 1998 she was director of communication at the World Health Organization in Geneva.

In the face of a global health crisis, Nye's paradox can help to define a new role that America can play. This role would imply strengthening the U.S. soft-power role in health by moving beyond both a national-interest paradigm and an international disease-control model based on macroeconomic arguments. A key dimension of this new global health strategy would be to address the larger issues of social justice, democracy, and law that are paramount to health in the context of globalization and that are part of U.S. political tradition. The global community expects the United States to take soft-power leadership. The repeated suggestion of a new Marshall Plan or the call to contribute more generously to the new Global Fund on AIDS, Tuberculosis, and Malaria is not just about more dollars. It is the plea of the global community that the United States apply the strength of vision and determination that it has shown in other historical crises to health and development today.²

Linking Health And National Interest

In recent years the United States has in general favored unilateralist approaches in world affairs, rather than committing to common endeavors with other nations. Samuel Huntington has termed this tendency "global unilateralism," meaning that all global involvement is defined first and foremost by the particularist interest of the United States.³ It therefore comes as no surprise that since the mid-1990s the arguments for greater U.S. engagement in global health have increasingly been expressed in terms of national interest or enlightened self-interest. Within this paradigm, it is simple to take the position that giving "higher priority to international health is good for the United States and good for the world."⁴

Robert Kagan explains why the United States, precisely because of its strength, is also more vulnerable and tends to frame issues as threats rather than challenges.⁵ Global health advocates recognized this window of opportunity in the mid-1990s in the absence of other major hard-power challenges and framed health as a threat scenario. Books such as Laurie Garrett's *The Coming Plague* in 1994 dealt with the consequences of negligence and lack of investments in public health systems around the world.⁶ A 1996 Institute of Medicine (IOM) report stated that it is in both the political and the economic interest of the United States to invest in combating disease abroad.⁷ Others have focused on the intentional spread of disease and on the impending threat of biological warfare, such as in *The Plague Wars* by Tom Mangold and Jeff Goldberg in 1999.⁸ In 2000 both the National Intelligence Council and the Chemical and Biological Arms Control Institute issued reports on the global threat of infectious disease.⁹ The Council on Foreign Relations followed with the report, *Why Health Is Important to U.S. Foreign Policy*, in 2001.¹⁰

■ **Federal activity.** This advocacy based on security threats was highly successful in the short run—helped by events such as the appearance of the West Nile virus in the United States—and numerous bills to fight infectious disease at home and abroad were passed. A noteworthy example now going through Congress is the

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Global Pathogen Surveillance Act of 2002, S. 2487 (passed by the Senate 1 August 2002). Many organizations and agencies involved in infectious disease control and research—such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH)—received large increases in funding and were able to create new departments that deal with global issues. The NIH budget has doubled over 1998 levels to provide financing for important research.¹¹ Of this increase in funding, a portion will fall to international health, with the president recognizing that research will advance the health and well-being of Americans and those living beyond our borders.”¹² A recently established Web site of the Department of Health and Human Services (HHS), www.globalhealth.gov, provides an overview of global-health activities in the U.S. government and its health agencies. The Global Health section of HHS has many bilateral partnerships with countries such as South Africa, Mexico, and Egypt and multilateral partnerships with topical orientations that also serve U.S. domestic interests. Following 11 September 2001 this move was further expanded to include preparedness of the public health system and a wide network of other agencies for potential terrorist attacks. A noteworthy example is H.R. 3448, which became the Public Health Security and Bioterrorism Preparedness Act of 2002, P.L. 107-188, 12 June 2002, to improve the ability of the United States to prevent, prepare for, and respond to bioterrorism and other public health emergencies. Public health is now part and parcel of the new Department of Homeland Security’s U.S. national policy agenda, as authorizing legislation continues through Congress.

■ **U.S. role in the global arena.** It seems at first instance that the United States is pursuing a vigorous international health policy that provides an opportunity for leadership that is grounded in the United States’ strength in biomedical sciences and its application.¹³ The concept of global health has been developed in large part in U.S. academe, think tanks, foundations, and nongovernmental organizations (NGOs), which have played a key role in setting the global health agenda and in framing the international debate. The U.S. government during the Clinton administration played a persuasive role in the global arena in moving health from being defined as “just” a humanitarian issue to being one with important economic and security consequences. With strong U.S. support at the Okinawa Summit in July 2000, the G8 leaders committed themselves to halve the global infectious disease burden by reducing the share of the world’s population living in extreme poverty to half its 1990 levels by 2015 and establishing a global fund to fight infectious diseases, primarily AIDS.¹⁴ Under U.S. leadership in a March 2000 session chaired by then Vice-President Al Gore, the United Nations (UN) Security Council debated a health issue for the first time in history when it discussed HIV/AIDS. In May 2001 President

George W. Bush announced \$200 million as the first contribution of a government to the new Global Fund on HIV/AIDS, Tuberculosis, and Malaria.¹⁵ In late July 2002 the full Senate approved S. 2525, the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2002, which authorizes \$2.2 billion to go to the Global Fund, pending approval from the Appropriations Committee later this year.¹⁶ This pledge makes the United States the largest single donor to the Global Fund.¹⁷

Linking Health And Microeconomics

Global unilateralism has not only changed U.S. policy, it has also changed the way health advocates frame the global-health agenda to make it acceptable to policymakers. The subtle but definite shift in orientation and language is very evident, and indeed many international documents read as if they have been written for members of the U.S. Congress rather than for the broader global health community. This is clearly an expression of American hegemony at work. Not only has there been a major effort to link the global-health agenda to the U.S. national interest, there has also been a systematic effort to respond to the challenge of the present U.S. administration, which argues that more U.S. support would be forthcoming for programs that were shown to be effective.¹⁸ In this vein, on the occasion of the Monterrey summit, “Financing for Development,” in March 2002, President Bush promised a 50 percent increase in overall foreign aid to \$15 billion in 2006.¹⁹ These funds have begun to be committed to the leaders of the G8 countries, with their promise of \$6 billion in yearly aid starting in 2006 to African nations that reform their economies and governments.²⁰

■ **Dollars for disease eradication.** The four Es—economics, effectiveness, efficiency, and evidence—are the new battle cries in the development community, and the fight against infectious diseases fits well with this shift in health development thinking. The premise of this approach is that a reluctant United States might contribute more dollars to a global war on infectious disease because such an effort lends itself particularly well to the new conditionalities and managerialism of the aid and poverty-alleviation approaches—and has a beneficial effect on the domestic U.S. agenda at the same time. Successful health programs—such as the eradication of smallpox and the near eradication of other infectious diseases such as polio and measles—are frequently cited as the most efficient use of the development dollar.

The most recent 2002 report by the World Health Organization (WHO) on infectious diseases cites the following figures: For an investment of US\$66 billion per year as of today, the world can expect economic benefits of more than US\$360 billion per year by 2015–2020.²¹ Not only do these interventions cost only a few dollars or cents for every life saved (for example, tuberculosis medicines cost US\$10 for a six-month course of treatment, antimalarials cost US\$0.12 per tablet, and condoms cost US\$14 for a year’s supply), but they can in turn save the developed world millions of dollars by rendering the immunization of their own populations unnecessary.

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■ **Health as economic growth.** A key document is the report, *Macroeconomics and Health*, based on the work of a commission initiated by the WHO and chaired by economist Jeffrey Sachs.²² This report picks up many of the arguments initially put forward in the World Bank’s *World Development Report 1993: Investing in Health*. One of the main proposals of the commission’s report is “an expanded aid effort to the world’s poorest countries more generally,” which is explicitly termed as a “war against disease.”²³ It calls for annual donor spending of US\$27 billion for health by 2007 and US\$38 billion by 2015 but remains silent on where these funds should come from. The significance of the report lies in its implicit ideological orientation: It frames health mainly in terms of economic productivity. With such a premise, it need not challenge models of globalization and growth because the rich can grow richer and healthier as long as the poor receive welfare and basic health care. A strong part of the argument is how cheap it would be for the developed world to generate such enormous health benefits in the developing world and how great the contribution to global economic growth would be that follows.

Howard Waitzkin of the University of New Mexico has drawn attention to how close these recommendations of the report on macroeconomics and health are to early Rockefeller Foundation–supported endeavors, which recognized that endemic infections blocked key infrastructure projects and were an impediment to labor productivity. As in the earlier Rockefeller statements, attempts at reform as highlighted in the report will improve entrepreneurs’ economic prospects, without making long-term and sustainable changes on the burdens of poverty, disease, debt, and early death.²⁴ The arguments are also reminiscent of the environmental debate of the 1980s as exemplified in the recommendations of the 1987 report of the World Commission on Environment and Development, which underlines that sustainable development is possible without challenging dominant models of economic growth; in fact, they are seen as complementary.²⁵ “The time has come for the marriage of economy and ecology,” states this report, yet fifteen years later the global community is still waiting for its consummation. At the World Summit on Sustainable Development, Rio+10, in Johannesburg in late summer 2002, “the outcome fell far short of what was needed to address global problems.”²⁶ The investment-based global-health debate uses essentially the same arguments for a marriage of economy and health: increased interdependence, threat to the rich countries if they do not act, and great economic benefits for all if they do. For this argument to hold, the global disease burden must be explained by a lack of good governance, of money, and of efficiency in implementation rather than as the result of inherently political decisions and the distribution of power.

Hegemonic Power

The United States has developed mechanisms and points of view for responding to issues of global health. All nations, donors, and players in this area, however, may not share these approaches. Many of the global-health policy documents gloss over the political and ideological differences in donors' approaches and perspectives. It might be timely to embark on an open debate on the priorities and approaches and to analyze in detail the hegemonic power the United States exerts in the global-health arena. Kagan recently argued that the United States and Europe have parted ways "on the all important question of power" and its application.²⁷ He provides a set of historical and political arguments for why on average the Europeans opt for a multilateral approach, while the United States prefers unilateral mechanisms. For Kagan it is clear that Europe and the United States no longer share a joint view of the world, and if this is so, it has consequences not only for issues of military engagement (which he primarily analyzes) but for all areas of international cooperation and foreign aid, including health.

Two recent cases illustrate this point. One is the U.S. decision to stop its \$34 million contribution to the UN Population Fund (UNFPA), a multilateral agency that supports family planning based on the global accord reached at the International Conference on Population and Development in Cairo in 1994, in which the United States was an active participant and signatory.²⁸ It aims to distribute the funds through its bilateral aid agency, USAID, instead of by giving direct grants to NGOs that are "willing to accept American restrictions on any involvement with abortion or abortion rights," thus bypassing UN organizations and governments.²⁹ In this case, the European Union has agreed to fill the gap in the UNFPA budget.

The second case, even more recent, concerns the grants available through the Global Fund to Fight AIDS, Tuberculosis, and Malaria, for which the United States has demanded the setting up of "a new delivery system" rather than relying on UN agencies and the World Bank. The U.S. position explicitly makes reference to differences with European donors who—according to the view of the quoted official—"just dish the money out."³⁰

These are illustrations of the present U.S. tendency to move out of multilateral approaches and toward reinforcing global unilateralism at a time when many of the health issues require a truly global response and the cooperation of many actors.³¹ In health, as in other arenas, the United States retreats when it sees a threat to its own economic or domestic policy interests, including upcoming elections. The United States is not particularly active in support of the International Framework Convention on Tobacco Control, despite having some of the most restrictive laws within its own borders. It has supported industry positions during the negotiations on TRIPS (Agreements on Trade-Related Aspects of Intellectual Property Rights), and it sided with a group of nondemocratic governments at a recent UN Special Summit on Children on matters of reproductive health, despite being a

world champion on human rights. Increasingly, it seems that the U.S. domestic agenda is driving the global agenda.

Persistence In Error

The lack of leadership in global health has led to a global public health crisis. It constitutes a political failure best described as a “march of folly,” using the criteria Barbara Tuchman developed in her seminal study of great military mistakes.³² To qualify for folly, she says, a policy must fulfill three criteria: (1) It must have been perceived as counterproductive in its own time and not only in hindsight; (2) a feasible course of action must have been available; and (3) the policy in question should be that of a group, not an individual ruler, and persist beyond any one political lifetime.

The ease with which Tuchman’s analysis can be applied to global health indicates that it is not only great hard-power errors but also great soft-power errors that cost the lives of millions. Clearly, neither the argument of self-interest nor that of economic investment has been sufficient to sway the rich parts of the world to put in place the global mechanisms of governance and finance that would help to alleviate the plight of the poor. The report of the Commission on Macroeconomics and Health, despite having brought together hundreds of health and economics experts from around the world, makes no mention of new types of finance mechanisms that would challenge the status quo—be that a version of the so-called Tobin tax on currency transactions or some other model that allows for a global public-goods solution for access to essential drugs or AIDS treatments. Tuchman points out that “wooden-headedness” plays a large role in the march of folly: “It consists in assessing a situation in terms of preconceived fixed notions while ignoring or rejecting any contrary signs.”³³

Dimensions Of Power: How Realistic To Expect Change?

The history of the U.S. role in global health has been investigated, and its current state analyzed. Now the question remains, Where are we going, and what role should the United States play? It has frequently been stated that reforms of the international system have only been possible after major wars. Yet it seems that despite U.S. unilateralism, new approaches to global health governance are being developed by other actors, particularly in response to the global HIV/AIDS crisis. Power in the new global arena, particularly soft power, no longer lies with nation-states alone. Nye maintains that while global governance in its initial essence requires a large state to take the lead, foreign policy will no longer be the province of governments only.³⁴ Indeed, the expansion of ideas through global policy networks, the spread of organizational innovation through public-private partnerships, and the rapid dissemination of information through new technologies have all changed the face of global health.³⁵

■ **“Collective intentionality.”** Seen from a perspective of diffusion of power, the

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United States has made a truly important contribution to global health governance over the past ten years. For example, the Bill and Melinda Gates Foundation, in the short period of three to four years, has contributed much to a shift in global health through a focused investment strategy and insistence on partnerships. Other philanthropists such as Ted Turner and George Soros have made a strong impact as well. AIDS activists have ensured a broader access to treatments in the poorest countries. Together these players have been laying the ground for what Chris Patten in his 2000 Reith Lecture called a new political ecosystem that derives its energy from collective intentionality.³⁶

NGOs exert increasing influence on the global health agenda, and their main points of reference are human rights and ethics, the global-health gap, and health as a component and expression of global citizenship.³⁷ While recognizing that technical solutions exist for many of the most pressing infectious diseases, they refuse to separate health from human rights, democracy, and the development of civil society. New technologies, such as the Internet, allow for rapid communication and exchange between global civil society and the many new policy networks that exist. NGOs insist that to close the global-health gap, the primary answer might not always lie in the usually top-down financial and technical provision from the donors, but in the political solutions that are based on the common global public interest in health.

■ **Roots of the global health gap.** From such a perspective, the global-health gap is about power; it is political and normative and reflects a lack of law, democracy, and justice in today's global political reality.³⁸ A recent UN Development Program (UNDP) report on global public goods indicates the need to address the policy root cause of many of the problems: “The pervasiveness of today's crises suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than from issue specific problems. If so, issue specific responses, typical to date, would be insufficient—allowing global crisis to persist and even multiply.”³⁹ To move from battling one disease after another, successful engagement in global health must be measured not only in terms of lives saved but also in terms of its contributions to a better rule of law, more democracy, and increased justice at the global level—thus laying the groundwork for better sustainable health in the future. The scope of the challenges indicate that no amount of philanthropy or NGO action can replace the responsibility of nation-states both for their own population and for the global community at large.⁴⁰ Although a variety of NGOs, foundations, and charismatic individuals have stepped forward and have been active in the realm of global health, a central governmental leader is still needed.

A Change In Perspective

The issues raised in this essay indicate the close interplay between the global-health debate and the wider political and economic context within which the United States defines its role. American unilateralism weakens international organizations and mechanisms, and its hegemonic power defines the strategies proposed in the global forum. The global-health challenge is increasingly defined in economic and managerial terms rather than as a commitment to equity, justice, democracy, and rule of law. But a discussion of global-health governance must identify a sound legal and regulatory system because without it, other global policy issues such as trade and finance cannot be resolved. For a leadership role to be taken, a system must be created, adopted, and followed. This moves global health into the larger policy forum and recognizes the extent to which it depends on addressing health determinants and building civil societies. A recent report by the Rockefeller Foundation has identified the necessary actions as follows: promote healthy macropolicies; improve living and working conditions; build social cohesion and mutual support; create supportive environments for behavioral changes; and build equity-oriented health care systems.⁴¹

■ **Building a soft-power leadership role.** What could be the first steps in building a soft-power leadership role for the United States, taking into account its tendency toward global unilateralism within the administration and political system, on the one hand, and the collective intentionality for recognizing health as a global public good in the nongovernmental community, on the other? It is not helpful to give a long list of “shoulds,” ranging from financial contributions to world agreements, when what is needed is a change in mindset.

A first step would be to initiate a truly high-profile public debate on America’s role in global health that gives voice to the many actors, including government, NGOs, the private sector, universities, foundations, the media, and professional organizations. Such a debate would include a series of public hearings on the issues of equity, trade, access to drugs, governance mechanisms, financing global public goods, and the like, thus moving the agenda beyond disease control. It would therefore need not only to be a dialogue of health experts but also to include foreign policy, security, and other policy arenas of relevance.

Such a dialogue would go far beyond analyzing the U.S. role in international health agencies and beyond the financial contributions it makes either in multilateral or bilateral actions. It would focus in a much broader fashion on how the United States as a whole—its government, its private sector, its NGOs and foundations, its academic institutions, and its citizens—contributes to and is affected by the global distribution of health and disease. It would take global health from a technical focus into the political arena and identify the political choices that are at stake as well as priority responses.

■ **Setting national goals.** Such an initiative, perhaps taken by one of the large new philanthropies and headed by a strong personality, could contribute toward

creating a platform for global health in the United States that would include setting national goals for global health—for example, to jointly contribute to the proposed doubling of international development aid to 0.5 percent of gross national product in order to reach the millennium targets. It would symbolize that development is no longer only an issue of nation-states but a joint effort of public-private partnerships.

A range of complementary measures could be considered—for example, to establish a system of “global health accounting” in which the many U.S. actors would commit to greater accountability and transparency in their involvement in global health, or to initiate an “externality profile” with regard to the health impact of other U.S. policies as proposed in the UNDP report. Independent tracking mechanisms could be established for both of these measures. These mechanisms, in turn, would be the basis for a regular debate with politicians and the American public to explain the strategies required to achieve major progress. Such an approach would signal that accountability to global health is also practiced in the developed world.

A NATIONAL DEBATE ON GLOBAL HEALTH would reflect the disappearing borderline between domestic and foreign policies. As Fareed Zakaria has outlined clearly, if globalization fails as a positive development concept then it is for lack of responsible political action.⁴²

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NOTES

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