HEALTH IN FOREIGN POLICY: AN ANALYTICAL OVERVIEW

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Introduction

The relationship between foreign policy and health has gained increasing prominence in world politics in recent years. For example, in November 2008, the United Nations General Assembly (UNGA) adopted a resolution on Global Health and Foreign Policy (United Nations General Assembly, 2008a). This resolution focuses not, as the UNGA often does, on specific health problems, for example, UNGA, 2008b (on malaria), 2008c (on sickle cell anemia), but rather, it highlights the importance of global health within the foreign policy processes of UN members. The resolution recognizes “the close relationship between foreign policy and global health and their interdependence,” urges UN members “to consider health issues in the formulation of foreign policy,” and places the foreign policy-global health relationship on the agenda of the UNGA meeting in 2009.

This UNGA resolution highlights, and draws additional attention to, the growing significance of health as a foreign policy challenge. It supplements other developments that focus on the relationship between foreign policy and health, including:

- The Foreign Policy and Global Health (FPGH) initiative, launched by the Oslo Declaration and Agenda for Action (2007), and issued by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand;
- Attempts by leading states to organize their foreign policy aims and processes to pursue global health objectives more effectively (Swiss Departments of Home and Foreign Affairs, 2006; UK Government, 2008); and
- Growing interest and activities within the World Health Organization (WHO) on the health-foreign policy nexus (WHO, 2007) and the dynamics of global health diplomacy (Chan, 2008a).

This level of interest in health as a foreign policy and diplomatic concern is unprecedented and raises questions about the relationship between foreign policy and the pursuit of health protection and promotion. Improving how states address national and global health concerns in their foreign policies is a complex endeavour that exhibits ambiguities and uncertainties. As the WHO Director-General, the Norwegian Foreign Minister, and the French Minister of Foreign and European Affairs argued, “moving towards a more sustainable relationship between foreign policy and health … requires more strategic inputs from policy analysis and research” (Chan et al., 2008, 498).

Achieving better understanding of the relationship between foreign policy and health requires unpacking and analyzing different, sometimes conflicting, perspectives about this relationship and its future. Enthusiasm for health’s potential in foreign policy, and cynicism

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about foreign policy’s manipulation of health, are both present in debates about linkages between foreign policy and health (Fidler, 2005). Such diversity of opinions is not surprising, especially with respect to developments as recent as those that have transformed health’s place in the foreign policies of many countries.

As part of the effort to focus more critical analysis on health’s status in foreign policy, this article explores the range of views that exist and focuses on key questions that illuminate the current state of affairs, particularly

• Why the relationship between foreign policy and health has gained importance;
• How this transformed relationship has developed its present features;
• What the foreign policy and health connections mean for foreign policy and efforts to protect and promote health; and
• Where opportunities and obstacles exist for efforts to solidify health’s place in foreign policy and shape global health diplomacy in ways that sustain a high profile for health in how countries make and implement their foreign policies.

Explaining the Transformation of Health as a Foreign Policy Issue

Foreign Policy and Health in the Past

The interest of the FPGH, WHO, governments, non-governmental organizations (NGOs), and scholars in the heightened importance of health in foreign policy reflects the widespread perception that recent events in world politics have transformed the foreign policy and health relationship. Health has long been a foreign policy and diplomatic concern, as illustrated by the history of international health diplomacy from the mid-nineteenth Century to the mid-twentieth Century (Howard-Jones, 1975; Weindling, 1995). The history of health’s place in foreign policy reveals, however, that it has generally been a marginal and neglected issue for foreign policy makers.

The main reason for health’s lack of importance in foreign policy is that health problems rarely intruded on the central concerns of those responsible for a state’s international relations, particularly the tasks of ensuring national security and a country’s economic power and well being. When health was the subject of foreign policy attention, as occurred with the international sanitary conferences and conventions, a leading objective was to minimize the burden that national health measures, such as quarantine or heightened occupational health and safety standards, imposed on national economic capabilities and international trade and commerce.

With improvements in the public health systems of developed countries, economic and trade concerns about public health measures diminished, and the nature of international action on health began to focus more on improving health in developing countries than on balancing divergent national interests in economic power, trade, and health-centric policies. The approaches WHO took to its mandate after World War II reflected this change in strategy, perhaps captured best by the WHO Constitution’s broad definition of health and its declaration that “the highest attainable standard of health was a fundamental human right” (WHO, 2006: p.1). This new focus still made health a foreign policy issue, but, with more pressing threats to their national interests, states increasingly tended to see international
cooperation on health as a form of scientifically oriented humanitarianism best left to technical experts and physicians, rather than to politicians and diplomats.

During the Cold War, health issues occasionally flared into the foreign policy mainstream, but typically these incidents involved health’s insertion into existing political and ideological competition in international relations. Thus, in the 1970s, developing countries connected WHO’s strategy to achieve health for all by the year 2000 with controversial efforts to establish a New International Economic Order. For example, the International Conference on Primary Health Care adopted the Declaration of Alma-Ata in September 1978, which called for “urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries … in keeping with a New International Economic Order” (WHO, 1978, §X). In the 1980s, concern with the threat posed by the Soviet Union appeared in analysis by the US intelligence community about HIV/AIDS in Africa (National Intelligence Council, 1987).

Generally speaking, prior to the end of the Cold War, health had little political traction in the high politics of foreign policy and largely remained marginal to how states, particularly the great powers, calculated and pursued their national interests. Attempts to elevate health as a foreign policy and diplomatic priority, as President Jimmy Carter attempted in the United States in the late 1970s (Carter, 1978; White House, 1978), tended to have little, if any, impact on how important and powerful countries engaged in foreign policy.

**Politics Confronts Health: Foreign Policy Awakens to Health Challenges**

The post-Cold War period witnessed dramatic changes in foreign policy perceptions about health problems. The reasons for this transformation are complex, but they cluster around a growing realization that health issues increasingly affect, directly and indirectly, core functions of foreign policy. In short, formulation and implementation of a post-Cold War foreign policy could not avoid addressing health-related threats and dilemmas across the range of objectives countries sought to achieve through foreign policy action.

Analytically, foreign policy serves specific political functions for states, and the most common functions are

- Protecting national security, for example, by developing military power and entering into security alliances with other countries;
- Preserving and increasing national economic power and well being, for instance, through opening foreign markets for exports and foreign investments;
- Fostering development of strategically important regions and countries through bilateral and multilateral development assistance; and
- Supporting human dignity through, for example, humanitarian assistance and human rights strategies.

Identifying these foreign policy functions does not imply that states fail to pursue other objectives (e.g., spreading political or religious ideology), or that every state engages in foreign policy activities under each function, or that any given state pursues these functions coherently or effectively. Describing the basic functions helps, however, to centre analysis on what states seek to achieve through their foreign policies. Generally, what states do in their foreign policies slots into one of these functions.
Traditionally, these foreign policy functions have existed in a hierarchy, with national security and economic power and well being receiving the lion’s share of attention. During the Cold War, national security and economic power were tightly connected, especially for the great powers, which illuminates why foreign policy makers viewed virtually everything through the lenses of security and material power. Hence, provision of development assistance, humanitarian aid, and support for human rights were largely caught up in the geopolitical competition for security and power fostered by the bipolar international system. In this environment, health issues essentially had no independent effect on foreign policy making.

What happens in the post-Cold War period is remarkable, given the historical subordination of health within the traditional functions of foreign policy. Foreign policy makers became more aware of health problems because these problems began to affect more seriously what they did. As a foreign policy issue, health started to become more of a strategic issue rather an occasional humanitarian concern, as illustrated by the attention given to health by the US intelligence community since the turn of the century (National Intelligence Council, 2000, 2002, 2003, and 2008). Similarly, the UK government has concluded “in our independent world, we cannot guarantee environmental, physical or economic security in the UK without promoting it overseas. Poor health … is a threat to the economic and political interests of all countries. Working for better global health is integral to the UK’s modern foreign policy” (UK Government, 2008, 14).

Analytically, health’s rise within foreign policy thinking reflects the fact that health threats, particularly from emerging and re-emerging communicable diseases, increasingly agitate the core functions of foreign policy.

**Protecting national security.** Experts and governments began to frame the dangers of biological terrorism and pandemic communicable diseases as threats to national security and international security (e.g., HIV/AIDS and pandemic influenza conceptualized as threats to national and international security).

**Preserving and increasing economic power and well-being.** Increases in actual and projected economic costs and burdens of global disease threats (e.g., HIV/AIDS, malaria, SARS, avian influenza, pandemic influenza), including damage potentially resulting from country responses to disease dangers (e.g., restrictions on trade and travel), have made states more aware of the need to address health-related economic problems as part of formulating and articulating the national interest through foreign policy and diplomacy.

**Providing development assistance.** The existing and potential impact of epidemics and pandemics, especially HIV/AIDS, on development strategies caused re-evaluation of the relationship between health and development (Commission on Macroeconomics and Health, 2001) as policy makers began to situate health goals closer to the centre of development thinking, for example, the central importance of health objectives in the UN’s Millennium Development Goals (MDGs).
**Supporting human dignity.** Health crises, especially the HIV/AIDS pandemic and controversies pitting access to medicines against protection of intellectual property rights, produced a renaissance of interest in the human rights aspects of public health and individual health with respect to both civil and political rights, such as public health restrictions on individual liberties, and economic, social, and cultural rights, (e.g., the right to health).1

Health-related agitation of foreign policy processes should not, however, be mistaken with widespread adoption of more coherent and effective health-responsive foreign policies. The point is more basic—foreign policy makers are increasingly confronted in their traditional areas of operation with health-related issues, problems, and crises. The frequency and intensity with which foreign policy makers have had to deal with health-connected concerns in the post-Cold War period are unprecedented, and this change helps to explain why the foreign policy-health relationship experienced transformation.

**Health Gets Political: Health Encounters Foreign Policy**

The transformation, however, did not run in only one policy direction. In the same period, the health policy community found itself forced to participate in foreign policy and diplomacy in ways it previously had not done. In short, events after the end of the Cold War turned the world of public health upside down. Globalization shattered the traditional distinction between domestic health activities and international health efforts. Through this process, health policy makers realized the need for more collective action among States, by intergovernmental organizations, and through non-State actors, across the wide range of public health concerns.

The collective action needed for many public health threats emerging as globalization accelerated around the world was not, however, the same as the conventional action undertaken in international health since the establishment of the WHO. Many rising global health challenges did not have scientific, medical, or technological answers (e.g., vaccines, antibiotics, health technologies) but were, rather, deeply political in nature. With health emerging as a problem in many policy domains, action within the health sector alone was not sufficient. Health policy makers faced the challenge of breaking out of traditional patterns of behaviour and grappling with a broader, more diverse range of politics that the health community was not well prepared to understand and influence.

Thus, many health policy makers began to advocate for more political attention on health by appealing more directly and forcefully to the national interests of States in terms reflecting the traditional functions of foreign policy. These appeals included arguments based on health’s importance to a State’s security and material power. A good example of this appeal to national interests can be found in the title of an Institute of Medicine (1997) report: *America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests*. More traditional health policy tropes, such as emphasizing health as important in its own right and supporting the right to health, continued but the discourse surrounding health became more politically diverse, reflecting the new political context in which health policy makers found themselves operating.

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1 The WHO Director-General and the Foreign Ministers of Norway and France utilized this functional approach in explaining why health is a growing foreign policy concern: “Pandemics, emerging diseases and bioterrorism are readily understood as direct threats to national and global security. But health issues are also important in other core functions of foreign policy, such as pursuing economic growth, fostering development, and supporting human rights and human dignity.” [Chan et al., 2008: 498].
For many in the health policy community, this change was disconcerting because they perceived that it threatened the ideals and humanitarianism long associated with international health. For example, experts have addressed concerns about the implications of conceptualizing health problems as security threats (Elbe, 2005; Feldbaum et al., 2006; Aldis, 2008; Maclean, 2008). At the same time, political, economic, and epidemiological developments in the post-Cold War period meant that, like it or not, the health community had to come to grips with the new politics of health policy. The new players from foreign policy were not going to wait patiently for leaders and practitioners in health to work through their professional angst.

**Understanding the Transformed Relationship between Foreign Policy and Health**

Understanding the Transformed Relationship between Foreign Policy and Health

Underneath health’s rise as a foreign policy issue are developments that reveal how the foreign policy-health linkage has been transformed in the last 10 to 15 years. This transformation flows from the convergence of unprecedented changes and events in international relations. Understanding this convergence helps to communicate that the new context of health in foreign policy emerges from factors that have reshaped how foreign policy processes incorporate health concerns.

First, as mentioned earlier, the foreign policy-health relationship underwent transformation in the post-Cold War period. The end of the rigid, bipolar international system, characterized by superpower competition for security and material power, radically altered the context in which states constructed their national interests for foreign policy purposes. This structural change opened political space for countries to think about security, economic power, development, and human dignity in different ways. This new political space helped to explain, for example, the many attempts made in this period to re-conceptualize security and to broaden it to include threats not emanating from military violence perpetrated by enemy states (Bergen & Garrett, 2005). Prominent in this re-conceptualization of security was the attention paid to the idea of human security (Paris, 2001; Kaldor, 2007), which opened up opportunities for, among other things, health threats to be discussed as security issues (Commission on Human Security, 2003).

Second, the post-Cold War acceleration of globalization took advantage of this new political space by challenging conventional thinking about foreign policy and calling into question long-held assumptions about sovereignty and collective action among states. Globalization upset traditional distinctions between the domestic and the international in virtually all policy fields, not just health. Globalization helped to create and illuminate new forms of interdependence and interconnectedness between states and peoples, which forced countries to reconsider the scope and substance of the national interest in making foreign policy and conducting diplomacy. The impact of globalization in the health context has been clear in the heightened sense of vulnerability present in societies, especially in developed countries, to transboundary flows of products, pollutants, people, and pathogens.

Third, the breakdown of the Cold War system and expanding speed and scope of globalization combined to give non-state actors more political space and material means to play a larger role in international relations. Non-state actors, including multinational
corporations, NGOs, terrorist groups, and transnational criminal syndicates, escaped from the margins of the superpower system to have direct and indirect impact on foreign policies and diplomatic processes. This development challenged traditional state-centric perspectives on foreign policy and forced states to address these new actors and influences in world politics.

Fourth, as these global changes emerged, the world experienced a proliferation of serious global health problems that heightened the epidemiological awareness of states, intergovernmental organizations, and non-state actors. These problems included the global crisis in emerging and re-emerging communicable diseases (e.g., HIV/AIDS, SARS, avian influenza, malaria, tuberculosis, and antimicrobial resistant pathogens) and the spread of non-communicable diseases related to consumption of harmful products (e.g., pandemic in tobacco-related diseases), transboundary pollution, or diet and lifestyle changes (e.g., adult and childhood obesity). Such a parade of global health problems in such a short time period was unprecedented, and, however unfortunate, the parade kept global health on foreign policy and diplomatic agendas when otherwise it may have again fallen to the margins.

The structural political changes created by the end of the Cold War, globalization’s far-reaching impact, and the increasing influence of non-state actors in political and diplomatic processes enabled these serious global health problems to gain footholds in domestic and foreign policy agendas within and among countries as never before. Without the convergence of these four developments, the transformation of the relationship between foreign policy and health may never have occurred or may look less robust or necessary than it does today. In addition, the importance of this convergence means that the foreign policy-health relationship may change again under the influence of other significant structural, political, and economic changes that may arise to reshape world affairs. In other words, the transformed relationship is neither static nor permanent.

Assessing the New Relationship between Foreign Policy and Health

Interdependence versus Interconnectedness

Despite widespread acknowledgement that foreign policy has a new relationship with health issues, less consensus exists with respect to what the new relationship means for foreign policy and for health. Competing perspectives differ on how much health concerns have changed foreign policy, or vice versa. These different views suggest that the transformation in the foreign policy-health nexus has not settled into a sustainable equilibrium, a situation that raises concerns about the prospects for health’s role in foreign policy specifically and global health diplomacy generally.

One perspective on the new foreign policy-health relationship asserts that it reflects the potential transformation of the very nature of foreign policy. As an editorial in The Lancet argued, health’s new status in foreign policy may signal the end of foreign policy in the service of state-centred, narrow national interests, and the beginning of foreign policy focused on global altruism (Horton, 2007). Other experts have similarly argued “foreign policy is now being driven substantially by health to protect national security free trade and economic development” (Kickbusch et al., 2007: 971). The opposite perspective holds that
health possesses no special place in, and no transformative power over, foreign policy, and that health is simply an issue, like many others, that states consider in prioritizing their national interests vis-à-vis other states and non-state actors (Fidler, 2005).

Arguments that health has the potential to revolutionize the theory and practice of foreign policy have little credibility. The practice of foreign policy has long resisted being revolutionized by other ideas, including peace through trade, communism, human rights, democratic peace theory, functionalism, and environmentalism. The evidence from the recent period in which health emerged as a more important foreign policy concern suggests that serious divergences of state interests on global health problems persist, often in deeply debilitating ways.

The normative attractiveness of health as a transformative endeavour in foreign policy reflects confusion about what ramifications health has on international relations. Global health challenges often reveal interdependence and interconnectedness among countries and societies, and these realities persuade many people to believe that such interdependence and interconnectedness produce a harmony of interests among states in engaging in effective collective action. This line of reasoning contains some problematical features that deserve examination.

To begin, interdependence and interconnectedness are not the same things. Interdependence means that two countries are mutually dependent with respect to specific activities, events, resources or problems. Such mutual dependence can create strong national incentives to engage in collective action, but interdependence does not eliminate differences in national interests, which interdependent states must overcome through often difficult and time-consuming negotiations on cooperative strategies.

Within global health, interdependence is strongest with respect to the potential spread of epidemic and pandemic communicable diseases. With such diseases, the ability of one country to protect the health of its population can directly depend on whether another country has the capacity to detect and respond to mobile, readily transmissible communicable pathogens, and vice versa. This mutual dependence explains why such diseases have received the most foreign policy attention on health historically and during the recent transformative period in the foreign policy-health relationship.

By contrast, interconnectedness does not involve relationships of mutual dependence among states and, thus, does not provide robust incentives for reciprocal undertakings to lower risks. In global health, interconnectedness is often a feature of non-communicable disease problems. For example, the export by a developed country of processed foods high in added sugars and salts may contribute to the prevalence of childhood or adult obesity in a developing country; but the health, security, and economic well-being of people in the developed country do not depend on whether the developing country controls or reduces the prevalence of obesity in its territory. Interconnectedness exists between the trade interests of the developed country and the health interests of the developing nation, but such linkages often do not generate reciprocal incentives to engage in serious, effective collective action.

Gaining foreign policy traction in contexts of interconnectedness typically proves more difficult than with communicable disease threats. This perspective helps explain the persistent pattern in global health diplomacy of tensions between economic and health
interests in many non-communicable disease contexts, including efforts to regulate transboundary pollution, strengthen occupational health and safety standards, and manage trade in products potentially harmful to health.

Health’s Crosscutting Quality: A Strength and a Weakness

Another reason the impact of health on foreign policy does not produce a harmony of interests among states and non-state actors relates to how broadly health factors into foreign policy. As noted earlier, health has emerged as an issue across all the main functions of foreign policy, and this fact is part of the strength of health within the world of foreign policy. Efforts to improve health nationally and globally can have synergistic and multiplier effects across a country’s foreign policy actions. In this sense, a focus on health can represent an opportunity for foreign policy over the breadth of its domain, assuming that a government can coordinate health endeavours coherently across such a broad range of foreign policy concerns.

At the same time, the presence of health across foreign policy’s expanse is a weakness and vulnerability for two reasons. First, health may have emerged as more important in all foreign policy functions, but this development does not mean health is the most important security, economic, development, or human dignity issue in a country’s foreign policy. Within each foreign policy function, health has merely earned some increased visibility in the fierce competition for political attention and economic resources along with other objectives and pressing problems. Foreign policy making is a ruthless process of setting priorities, and health has to compete effectively in this process in order to influence foreign policy. In this competition, the breadth of health’s foreign policy relevance may have little to no impact within any given function of foreign policy.

Second, health’s cross cutting foreign policy relevance is not supported, as a general matter, by administrative and bureaucratic structures or resources capable of advancing the health agenda effectively. Neither foreign nor health ministries typically evolved with capacities to engage in health and foreign policy actions consistently across all relevant issue areas. This reality handicaps health in the fierce competition for attention and resources that happens in each functional area of foreign policy. The creation by some States of interagency, or whole-of-government, approaches to health’s cross cutting foreign policy relevance reveals awareness of this problem (Swiss Departments of Home Affairs and Foreign Affairs, 2006; UK Government, 2008).

Agenda Expansion, Issue Linkage, and Forum Shifting

Agenda Expansion

The broad scope of health’s relevance to foreign policy has other consequences for health as a foreign policy issue. Delivering sustainable health in any context involves the need to operate across policy spheres. Nothing demonstrates this fact better than the importance public health experts give to the social determinants of health (Commission on Social Determinants of Health, 2008). Improvements in population health depend, for example, on whether governments can reduce poverty, improve education, empower women and girls, and minimize corruption in governance. The breathtaking scope of the social determinants
approach is revealed in a core principle of action advocated by the Commission on Social Determinants of Health: “Tackle the inequitable distribution of power, money, and resources—the structural drivers of the conditions of daily life—globally, nationally, and locally” (109).

The manner in which health advocates expand the foreign policy agenda fights against the ruthless process of prioritization in making and implementing foreign policy, which traditionally seeks to limit, rather than to expand, the agenda in order to bring national power and influence most effectively to bear on specific, achievable ends. In addition, agenda expansion in health, if embraced seriously as a foreign policy matter, creates the need to contemplate interference in core aspects—power, money, and resources—of the domestic affairs of sovereign States with inequitable distribution of these political drivers, which does little to foster a harmony of interests for effective collective action.

**Issue Linkage**

The policy tendency of health issues to expand when solutions are sought also contributes to another feature of health in foreign policy—the susceptibility of health to the phenomenon of issue linkage. In international politics and diplomacy, States often link issues as they negotiate responses to problems. Issue linkage happens in two basic ways. First, one issue is linked with another issue as a way to frame a problem and its solution. For example, many governments, NGOs, and the WHO have linked health with concepts of security in order to harness the foreign policy pull of security for purposes of improving health. This type of linkage occurs to strengthen the political importance of a health concern because, without the security linkage, health-specific rationales alone carry less policy weight.

Second, progress in negotiations on one issue is made conditional on the outcome of negotiations on a separate issue. In negotiations under the World Trade Organization (WTO), developing countries linked progress on health concerns about intellectual property rights with progress on other parts of the WTO’s trade agenda, (e.g., liberalization of trade in goods and services), at the Doha Ministerial Meeting, which produced the groundbreaking Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health (WTO, 2001).

This kind of linkage can work the other way as well. Countries can link health and trade issues, for example, in ways that force other countries to accept greater trade benefits, such as preferential tariff rates in exchange for less robust health-protective policies, (e.g., greater protections for intellectual property rights for pharmaceutical products). Developed countries, such as the United States, have pursued this linkage strategy in pushing for so-called “TRIPS-plus” provisions in bilateral and regional trade agreements.

**Forum Shifting**

The crosscutting foreign policy relevance of health also plays a role in a third phenomenon—forum or regime shifting. In forum shifting, states and non-state actors attempt to move an issue from one political or diplomatic forum to one more favourable to their interests. Forum shifting has been prominent with the issue of negotiating rules on international intellectual property protections (Helfer, 2004).
Developed states shifted the centre of gravity for intellectual property rights from its traditional international forum, the World Intellectual Property Organization (WIPO), to the WTO through the adoption of the TRIPS agreement. Health-related controversies connected with TRIPS prompted developing countries and supportive NGOs to attempt to shift the controversies away from the WTO into UN human rights processes (UN Sub-Commission on the Promotion and Protection of Human Rights, 2000) and into WHO (Commission on Intellectual Property Rights, Innovation, and Public Health, 2006). Developed countries responded by re-shifting the debate to the negotiations on bilateral and regional trade agreements, (e.g., TRIPS-plus provisions in bilateral and regional trade agreements).

The Virus Sharing Controversy

Agenda expansion, issue linkage, and forum shifting can make health-related foreign policy and global health diplomacy complicated and contentious. Health issues can become entangled in a complex set of conflicting interests, making compromise necessary but difficult to achieve. Sorting out these political entanglements has long been the task of foreign policy experts and diplomats, but, for many in global health, the process of cutting deals with health concerns as one of the bargaining chips is disconcerting. Global health practitioners often want global health to be more politically important, but without all the politics.

An example of agenda expansion, issue linkage, and forum shifting creating a complex, difficult, and contentious foreign policy context involves the controversy over the sharing of avian influenza viruses. The agenda on this controversy has expanded beyond the need to share virus samples to conduct influenza surveillance to include questions of equitable access to influenza vaccines, claims of sovereignty over virus samples, the protection of biodiversity, and the role of intellectual property rights. Indonesia, supported by other developing countries and NGOs, has linked progress on sharing virus samples for purposes of global surveillance with development of a new system of sharing the benefits, particularly influenza vaccines, produced from the global exchange and exploitation of virus samples.

Indonesia’s position has also involved an attempt to shift the focus of the negotiations from WHO’s International Health Regulations, 2005, to the Convention on Biological Diversity and approaches related to this Convention (Fidler, 2008). This move, and the controversy generally, has implications for intellectual property rights, which prompted developed countries to bring WIPO and WTO rules and efforts to bear more forcefully. This entanglement of agendas, issues, and negotiating forums has, as of this writing, defied diplomatic efforts to produce a mutually satisfactory solution.

Health’s Elasticity as a Foreign Policy Issue

Another characteristic of health’s relationship with foreign policy is that the foreign policy interest in health issues tends to be crisis driven: “When foreign policy-makers do pay attention to public health, it has tended to be in times of crisis such as SARS and avian flu. Health competes poorly with other priorities in the absence of crisis” (Chan et al., 2008, 498). Put another way, foreign policy demand for health actions is highly elastic, waxing when

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2 For background on this controversy and its implications, see Fidler, 2008; Scoones & Forster, 2008; and Laboeuf, 2009.
disease crises appear and waning when crises fade from the political spotlight. Foreign policy’s
needs for other capabilities, such as intelligence and military power, are, by contrast, inelastic—the needs remain steady and foreign policy attention to them stays high across time.

The appearance of health as a concern across all the major functions of foreign policy may, at first glance, appear to contradict the notion of health’s elasticity as a foreign policy issue. Health’s rise in all foreign policy functions reflects, however, the proliferation of serious global disease problems noted earlier. But for the global ravages of HIV/AIDS, the fear produced by SARS, the framing of tobacco- and obesity-related diseases as pandemics with serious economic consequences, and the nightmare represented by the possible emergence of pandemic influenza, health would not have its present foreign policy prominence.

Health’s elasticity as a foreign policy issue creates at least two serious vulnerabilities for health. First, the crisis-driven nature of foreign policy interest in health is vulnerable to complacency. The crisis passes, and foreign policy makers do not spend time and resources on prevention and protection activities. Complacency sinks in until the next crisis hits.

Second, health’s elasticity makes health-centred issues vulnerable to subordination or marginalization by other non-health problems and crises that flare up. In 2008 and 2009, the global climate change, food, energy, and economic crises have pushed health down the foreign policy priority list. Certainly health experts have input on the health-related consequences of these problems, as illustrated by WHO’s efforts to highlight the potential impact on health of the global economic crisis (WHO, 2009a), but the field of global health offers no solutions to these major global crises.

This subordination and marginalization effect is most pronounced for (1) communicable disease problems that do not register in the security and economic power functions of foreign policy, such as the so-called neglected tropical diseases that tend to affect predominantly developing countries (WHO, 2009b); and (2) non-communicable diseases, which have more tenuous footholds in mainstream foreign policy to begin with. Matched against other foreign policy crises and priorities, these global health problems stay part of the low politics of foreign policy, where health issues historically tend to reside.

Health’s foreign policy elasticity and vulnerability to marginalization do not sit well with health experts and advocates, who would prefer health to be, and to remain, politically in demand for preventing health crises from emerging. Instead, in foreign policy, health’s political stature increases in proportion to the reality of serious problems in public health and health care systems.

Looking Ahead: Opportunities and Obstacles for Global Health Diplomacy

This critical assessment of health as a foreign policy issue suggests that the health-foreign policy link oscillates in the space between health-inspired optimism and foreign policy-laden cynicism. In this fluid and uncertain context, efforts to focus more systematic attention on the relationship between health and foreign policy are important. Despite health’s unprecedented prominence in foreign policy, the relationship remains poorly understood, particularly in the ways a health lens on foreign policy questions can operate more effectively.
This health lens harbours possibilities for making health a more sustained component of decision-making in all foreign policy’s functions. Refining the health lens on foreign policy does not and cannot ensure that health-based reasoning will prevail in foreign policy, but enough experience has been accumulated to sense realistic prospects for making health’s participation in foreign policy, and foreign policy’s sensibilities about health concerns, more sustainable and sophisticated.

Lessons for the Health Lens: Best Practices from Trade and Health Efforts

One area of foreign policy in which health has gained experience in working effectively outside the traditional health sector is in international trade (Drager & Fidler, 2007, 162). The WHO has worked with the WTO and with health and trade ministries in WHO member-states to strengthen the role health concerns play in trade negotiations (WHO & WTO, 2002). Through these efforts, the WHO and other partners have learned lessons about working in the trade-health context that represent potential best practices to consider in embedding health interests more deeply in foreign policy.

Increase mutual awareness and knowledge. Personnel from trade and health have confronted the need to become more knowledgeable about the other’s domain. When the trade and health controversies developed after the WTO’s creation, neither trade nor health possessed a sophisticated understanding how the other policy area operated. Increasing mutual awareness and knowledge does not solve all problems, but it provides a better foundation on which to interact on difficult issues.

Master the details of key international regimes. In the trade and health context, health experts started at a disadvantage because they did not have experience with international trade agreements or the requisite technical skills and training to understand and work within the complex rules of international trade law. Health ministries and experts had to develop the ability to understand the details of international trade agreements and to identify accurately where health policy makers should raise concerns with trade ministries.

Exploit existing common principles to achieve coherency. Trade and health policies share some common principles that joint efforts could exploit to increase coherency between trade and health policies. These principles include (1) using the best-available scientific evidence to inform health-related trade restrictions; (2) formulating and applying non-discriminatory trade and health measures; and (3) implementing the least trade-restrictive health measures reasonably available that achieve the health objective being sought.

Invest in interagency or intra-governmental coordinating mechanisms. Countries that invested in interagency or intra-governmental coordinating processes and mechanisms generally have operated more effectively in trade and health contexts. Recognizing the need for such mechanisms is easier, however, than spending the time and resources necessary to make the mechanisms work in a sustainable and productive manner.

Obtain and maintain political investment. Countries in which the political leadership demonstrated commitment to the trade and health challenge tended to produce more high quality results in their trade and health policies. Such commitment gave the trade and health efforts political cover from potential opponents inside and outside government, and leverage to make bureaucracies respond to requests and initiatives.
Value individual leadership. Many trade and health initiatives involving the WHO depended on the leadership of individuals who recognized the importance of the trade-health relationship and of cultivating the relationship to serve the interests of trade and health better. This individual leadership occurred at very senior levels in government, WTO, and WHO, as well as at more junior levels within the various coordinating mechanisms established to push forward the trade and health agenda.

Be crisis capable, but build for the long term. Trade and health teams had to be able to respond to crises and problems that arose in this domain, but the teams also had to sustain their cooperation and coordination in non-crisis periods in order to construct a sustainable capability to handle the tasks that the management of the trade and health relationship generate.

Anticipate problems. In addition to reacting to challenges, joint trade and health efforts also have attempted to anticipate problems and to take actions to prevent or mitigate their adverse consequences. This skill requires understanding key global changes and identifying how the changes might affect the trade-health nexus. If possible, the trade and health endeavour could move toward preventive domestic political action and global diplomacy to control or minimize potential harms.

Remain resilient. Despite good intentions and requisite skills, joint trade and health efforts do not always reach mutually satisfactory policy outcomes, as illustrated by on-going difficulties concerning the protection of intellectual property rights in health-related contexts. Setbacks should not erode the foundation for sustained cooperation on issues of mutual concern to trade and health communities.

Engage in training and education. Creating more productive trade and health endeavours benefited from planned and coordinated trading and education activities, particularly through collaboration of the WHO and the WTO. In addition, reaching out to universities and institutes that conduct research and teach trade and health subjects widened the network of people working to improve the ways in which trade and health communities work together.

Unlike the trade and health relationship, the foreign policy-trade nexus is much broader, covering a more diverse array of issues, international legal regimes, actors, and political interests. The health lens will, therefore, operate differently in this more expansive realm than it has in the specific, well-defined trade context. This reality places an extra burden on the health policy community to ensure that it develops capabilities to bring the health focus to bear on divergent questions that foreign policy makers handle.

Obstacles to More Effective Use of the Health Lens in Foreign Policy

More rigorous incorporation of the health lens in foreign policy might not produce global health results of the scope and quality needed. The seven foreign ministers who launched the FPGH initiative argued that, despite increased foreign policy attention, health remains “one of the most important, yet still broadly neglected, long-term foreign policy issues of our time” (Oslo Declaration and Agenda for Action, 2007: 1373), which suggests that the health lens in foreign policy is still not widely used. Experts have already expressed worries about the limited impact of health’s recent rise as a foreign policy issue on global health conditions, as illustrated by the conclusion that the health-related MDGs are not likely to be met by the
2015 deadline (UK Government, 2008), and the worries that the HIV/AIDS pandemic continues “with unacceptably high levels of HIV infections and AIDS deaths” (UNAIDS, 2008, 34). Foreign policy activities on health often lack coordination and integration into collective action that can produce systemic reforms and sustainable capacity, especially in developing countries. Initiatives and proposals to improve coordination of state and non-state efforts in global health, such as the International Health Partnership, recognize the threat posed by continued proliferation of fragmented foreign policy actions on health.

A potentially more profound problem looms with respect to foreign policy. Health is not the only area in which foreign policy makers face problems marked by divergent national interests and increased non-state actor involvement. The political contexts in which states make foreign policy and craft collective action might increasingly prove unable to keep pace with accelerating global problems. International politics could see a return to great power rivalries and competition for strategic resources, (e.g., oil, simultaneously with the growth in the material power of non-state actors, such as terrorist groups and global organized crime). This scenario would present efforts to keep health high on foreign policy agendas with difficulties, especially with respect to non-communicable diseases and social determinants of health, because it would produce a foreign policy tendency to neglect the health lens and relegate many health activities back to the low politics of technocratic humanitarianism.

Conclusion

As the WHO Director-General (Chan, 2008b) and the Oslo Declaration and Agenda for Action (2007) have argued, health has become a significant foreign policy of the early twenty-first Century. This article’s analysis of the foreign policy-health relationship attempted to contribute to efforts to understand and exploit the relationship more effectively from a health policy perspective. The excitement generated by the unprecedented stature that health has gained in the world of foreign policy is understandable, but foreign policy is a difficult environment, not easily transformed by new issues that emerge in response to complex and sometimes enigmatic global changes.

Strengthening health’s footholds in foreign policy requires efforts more rigorous and imaginative than describing how many health concerns are global problems and expecting foreign policy makers to respond appropriately. In the world of foreign policy, health’s importance is not self-evident. Nor is health, as an issue, necessarily robust in the midst of the relentless pressure foreign policy makers face to set limited, achievable priorities as part of formulating the national interest and projecting it in the world of diplomacy.

Thus, more systematic and rigorous understanding and assessment of the possibilities and limitations of health in foreign policy has become an imperative. In that vein, the UN General Assembly resolution on foreign policy and global health requested the UN Secretary-General to prepare “a comprehensive report, with recommendations, on challenges, activities and initiatives related to foreign policy and global health” (UNGA, 2008a). Failure to deepen our understanding of the foreign policy-health nexus will make health’s heightened status in foreign policy reliant on the continued emergence of global health crises. The relationship between health and foreign policy should be sustained by more than recurring public health nightmares. Here, then, is a task worthy of the claim of the political and moral necessity of protecting and promoting health in human affairs.
References


