

Rise and Fall of Global Health as a Foreign Policy Issue¹

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Global health has risen in prominence in foreign policy but now faces a fall in its foreign policy importance. Global health's recent rise in foreign policy has been unprecedented, but this phenomenon reveals continuity and change in how foreign policy has addressed global health in previous periods. This historical perspective points to the need for a deeper understanding of the relationship between global health and foreign policy, which reveals global health's unstable place in foreign policy, especially with respect to higher priority foreign policy objectives, such as national security, national economic power, and development. This instability is appearing again and leading to a decline in global health's foreign policy significance. Structural, political, economic, and epidemiological factors illustrate how global health is experiencing a fall in foreign policy importance. Although a fall is starting, it must be kept in perspective given the unprecedented nature of the rise and uncertainty about what unfolds for global health in the next years. Keeping an eye on key indicators will help reveal the nature and extent of any fall in global health's stature in foreign policy.

INTRODUCTION

We live in interesting times, the adage goes, and much about world politics today—from China's emergence to dire predictions about climate change to revolutions in the Middle East—fascinates and unnerves us. We are entering a period of global uncertainty where we oscillate between hope and fear, sensing we cannot really fathom what will happen. Shrouded in this fog is global health, a policy area that experienced unprecedented growth over the past ten to fifteen years in foreign policy, diplomatic, and global governance importance. Global health now confronts an unsettling transition that will shape this area for years. We witnessed global health's rise as a foreign policy issue but are starting to see a fall in its foreign policy significance. However disconcerting, understanding this rise and potential fall is important in assessing how global health factors into world affairs now and in the foreseeable future.

In this article, *foreign policy* refers to the policies a state advances in relations with other states, intergovernmental organizations (IGOs), and non-state actors (e.g., non-governmental organizations) on issues that have cross-border consequences. *Global health* means the policy realm in which states, IGOs, and non-state actors interact to address health challenges that have cross-border implications. Under these definitions, global health involves foreign policy because a state has to formulate positions on cross-border health issues in its relations with other states, IGOs, and non-state actors.

This article examines the claim that global health has risen in foreign policy prominence. The claim is not controversial, but evaluating any fall of global health as a foreign policy concern requires prior analysis of the rise. This analysis exposes features about the relationship between global health and foreign policy that requires an

understanding of how foreign policy makers address global health. A key finding is the unstable position of health within foreign policy, or health's *elasticity* as a foreign policy issue. This elasticity suggests that a *rise and fall* pattern should be anticipated, as earlier *rise and fall* episodes confirm.

However, could the recent rise of global health in foreign policy be sufficiently different to sustain the new prominence and avoid a fall into foreign policy purgatory? This article addresses this possibility by looking at structural, political, economic and epidemiological factors that suggest global health is losing traction in foreign policy. Any predicted fall has to be kept in perspective because of the unprecedented nature of the rise and uncertainty about the extent of the slippage. This article explores whether global health is settling into a *new normal* in which foreign policy makers more readily act upon global health than in the past, which would represent a marked improvement of health's status in foreign policy. This article describes indicators that bear watching in discerning whether global health's fall represents an improved new normal or a more precipitous decline. Predicting where these indicators ultimately point is foolhardy, but the omens for global health are not good.

RISE OF GLOBAL HEALTH IN FOREIGN POLICY

Global health's rise in foreign policy can be understood to mean that foreign policy makers have addressed global health challenges more frequently and prominently than in the immediately prior period. Existing literature describes how global health achieved this increased stature over the last ten to fifteen years (Table 1). This phenomenon has been sufficiently prominent that the United Nations (UN) General Assembly adopted resolutions and requested reports from the UN Secretary-General on foreign policy and global health.²

Table 1. Indicators of Global Health's Rise in Foreign Policy

<ul style="list-style-type: none"> • Funding: Development assistance for health quadrupled from U.S.\$5.59 billion in 1990 to U.S.\$21.79 billion in 2007. • Initiatives: Initiatives aimed at global health problems have increased dramatically, reaching an estimated 90 ongoing initiatives. • Governance: Countries have negotiated groundbreaking governance regimes for global health problems, including the World Health Organization's Framework Convention on Tobacco Control (2003), International Health Regulations (2005), Global Code of Practice for the International Recruitment of Health Personnel (2010), and Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Other Benefits (2011).

Demonstrating that global health has received more foreign policy attention in recent years is not difficult, whether the evidence comes from the Secretary-General's

reports,³ the World Health Organization (WHO),⁴ ministers of foreign affairs,⁵ think-tanks not previously interested in global health,⁶ scholarship exploring the foreign policy-health relationship,⁷ or increases in global health funding.⁸ Never before has global health been of such foreign policy interest.

Identifying the rise is easy, but analysis should examine the rise's connection with previous eras. Looking back, two patterns are prominent in foreign policy:

- responses to health threats, such as cross-border spread of communicable diseases, that generate international problems; and
- uses of health-related cooperation to pursue non-health objectives, such as utilizing health assistance to increase a state's influence or secure better relations with other states.

In terms of foreign policy responses to health problems, this pattern has experienced continuity and change. The continuity appears in the privileged place foreign policy has accorded communicable diseases. Foreign policy on health problems began in the mid-nineteenth century with European states addressing threats from cholera, plague, and yellow fever.⁹ The second decade of the twenty-first century sees communicable diseases receiving the lion's share of foreign policy attention.

The change appears in fluctuations in foreign policy interest in global health, especially in high-income states. In the twentieth century, high-income countries transitioned from significant communicable disease morbidity and mortality to growing non-communicable disease burdens, lessening fears about cross-border communicable disease threats.¹⁰ This shift—caused by improved domestic public health capabilities—helped shrink foreign policy interest in health among stronger countries to providing humanitarian assistance to low-income nations.

As for foreign policy use of health-related policies to achieve non-health objectives, we see continuity because states have, over time, included health in strategies to increase their stature in the international competition for power and influence. During the Cold War, the United States,¹¹ Soviet Union,¹² China,¹³ and Cuba¹⁴ utilized health-related cooperation to boost their geopolitical positions and ideological ambitions. This pattern remains prominent today, with frequent assertions that health constitutes part of “soft” and “smart” power that states can exercise.¹⁵

Changes in this pattern have been (1) country-specific, such as China's reduction of its overseas health missions during the post-Mao reform period, and (2) generated by systemic change, as happened with the end of the Cold War when geopolitical pressure to view health as a soft-power tool fell and with the recent re-emergence of a multi-polar system and renewed interest in using health to secure non-health objectives.

Therefore, global health's rise in foreign policy involves the:

- increased need for foreign policy responses to proliferating global health problems, particularly those involving communicable diseases that threaten key state interests; and
- return of health as a soft-power tool.

These developments have brought global health new political significance, but this prominence does not resonate with public health thinking. The need for more foreign policy responses to global health problems reveals failures to prevent such problems, and national and international weaknesses in surveillance and response capacities worldwide. These failures reveal lack of commitment to public health in both domestic and foreign policy. The foreign ministers behind the Oslo Foreign Policy and Global Health Initiative argued that, despite global health's increased stature, it remains a neglected foreign policy area.¹⁶

Increased soft-power use of health demonstrates greater instrumentalization of health for foreign policy purposes, challenging the ethos that health is an end in itself and not a tool for geopolitical machinations. The use of health in soft-power strategies indicates that this ethos is not transforming foreign policy concerning health. Health as soft power might produce some positive health outcomes, but such outcomes are often not the primary purpose of these strategies.

Although unprecedented, the recent rise of global health in foreign policy reflects long-standing patterns of how states use health in foreign policy, and persistent problems domestically and internationally with preventing and responding to health challenges. These characteristics invite deeper exploration of the relationship between foreign policy and global health.

ANALYSIS OF THE RELATIONSHIP BETWEEN GLOBAL HEALTH AND FOREIGN POLICY

Global health's rise in foreign policy reveals that states began to perceive health problems and soft-power opportunities as more relevant to all the basic functions of foreign policy, which are (in descending order of foreign policy importance) ensuring national security, strengthening national economic power, engaging in development with key countries, and protecting human dignity. The WHO Director-General and Norwegian and French foreign ministers used this functional approach in observing that global health issues are important for "national and global security[,] . . . pursuing economic growth, fostering development, and supporting human rights and human dignity."¹⁷

Identifying global health as important in all foreign policy's core functions reveals two developments. First, health concerns expanded beyond their conventional association with human dignity, which typically ranks last in foreign policy priorities. Locating health problems and opportunities within the security, economic, and development agendas gave global health a foreign policy profile different from its historical position as a marginalized, neglected topic associated with humanitarian assistance.

Second, health's appearance in higher priority foreign policy functions meant that, at some level, foreign policy makers were re-thinking security, economic well-being, and development—suggesting that health concerns were helping stimulate broader conceptions of foreign policy responsibilities. The changed relationship between

foreign policy and global health reveals a two-way exchange, not a foreign policy takeover of global health.

However, this new relationship exhibits characteristics that demonstrate the difficulty of sustaining health's foothold in higher-priority foreign policy functions. Few health problems qualify as national security concerns, and the ones frequently cited as such (e.g., bioterrorism, pandemic influenza, and HIV/AIDS) involve a narrow range of communicable disease threats. Using health as a soft-power tool typically happens in conjunction with many initiatives, and because of the soft-power link, foreign policy makers do not consider health efforts as useful in addressing *hard power* security challenges.

In addition, skepticism in security and public health communities about *securitizing* health remains strong and is growing,¹⁸ especially as (1) dangers from traditional (e.g., nuclear proliferation) and other non-traditional (e.g., cyber-attacks) security threats increase, and (2) security arguments fail to translate into adequate commitments to public health nationally and internationally. We also see this dynamic with global health's role in policy debates about national economic power and overseas development. As relevant as public health might be to these foreign policy functions, bigger problems preoccupy policy makers in these realms, which helps explain why public health experts lament continued underinvestment domestically and in development policy.

What emerges is *elasticity* for health in development, economic and national security policies. Global health problems more frequently appear in these areas when crises develop, such as a pandemic, but foreign policy attention fades when the crisis wanes.¹⁹ The more elevation global health receives in the hierarchy of foreign policy interests, the more elasticity we witness. Global health concerns tend to be most inelastic with respect to human dignity objectives; however, this function, historically, has been the least important in foreign policy making.

This elasticity appears today but also occurred in the past. Foreign policy attention on health began in the mid-nineteenth century because communicable disease epidemics were damaging national populations, trade, and commercial interests. Negotiations reflected balance-of-power concerns, such as the European continental powers' worries about British opposition to quarantine, combined with Britain's trade and sea power, illustrating how *realpolitik* affected responses to health problems. As the threat from large, cross-border epidemics lessened in the twentieth century (through improved domestic public health measures and medical technologies), health faded in foreign policy significance for the great powers, becoming associated largely with humanitarianism and exploiting the political advantages that providing humanitarian assistance could create.

Similarly, the WHO-led push for Health for All in the 1970s, culminating in the Declaration of Alma Ata in 1978,²⁰ converged with Cold War ideological battles, which raised this initiative's foreign policy stakes. However, in 1979, the Iranian revolution, the resulting oil crisis and its impact on economies, and the Soviet invasion of Afghanistan marginalized *health for all* as a foreign policy concern for major international players.

These older rise and fall episodes suggest that health's elasticity in foreign policy is persistent, and that the rise and fall pattern should be expected. This observation segues into evaluating whether the pattern is unfolding again, which requires determining whether the recent rise in global health's foreign policy profile represents something different—something that reduces the elasticity and embeds health more firmly in the development, economic, and security functions of foreign policy.

FALL OF GLOBAL HEALTH AS A FOREIGN POLICY ISSUE

My contention that global health's foreign policy prominence is starting to slip centers on structural, political, economic, and epidemiological factors that indicate how the global terrain is shifting under the global health-foreign policy relationship. The financial, food, energy, and climate change crises of recent years prompted health leaders to warn about dangers these crises pose to health. These warnings were also pleas to prevent these dilemmas from marginalizing health domestically and internationally. These crises do not prove global health's fall in foreign policy importance; they merely establish that global health has entered a more difficult environment in which to maintain a prominent foreign policy profile.

The first factor pointing to a decline is the changing structure of the international system. Global health's rise in foreign policy transpired in the post-Cold War system dominated by a United States that gave global health significant foreign policy attention. What is unfolding now is a multi-polar system marked by the rise of emerging powers, especially China, and the decline of U.S. power and influence.

As noted earlier, multi-polarity encourages state interest in health as a soft-power instrument, but multi-polarity also makes it more difficult for states to agree on solutions to problems, including those affecting global health. The multi-polar system will be more unforgiving concerning core state interests, which will make it harder to sustain claims about global health's contributions to security, economic power, and development. For example, efforts to make health central to climate change negotiations and the Group of 20's development strategy failed. Already challenged about their persuasiveness, health-based security arguments increasingly confront a geopolitical landscape populated by serious security threats, ranging from worries about Chinese military power to concerns about what follows upheavals in the Middle East.

In terms of political factors, a weaker United States means that U.S. foreign policy cannot play the catalytic role it did for global health over the past ten to fifteen years. None of the perceived rising powers—Brazil, Russia, India, or China—has the means or willingness to lead in global health as the United States has led. States will continue soft-power uses of health, but these efforts offer diminishing payoffs as other challenges dominate international politics. Harder and harsher questions will be asked, especially in connection with foreign aid, about the benefits foreign policy action on global health produces for priority state interests. This environment will prove conducive for non-state actors, especially the Bill & Melinda Gates Foundation (Gates Foundation), to become even more important in shaping the global health agenda. Praise and criticism of the Gates Foundation's push for global polio eradication illustrates this dynamic.²¹

Economically, sustaining global health prominently on foreign policy agendas is becoming more difficult as the global economic recession and domestic fiscal crises adversely affect states, IGOs, and non-state actors. Although fiscal travails in high-income countries have not yet gutted health components of foreign aid budgets,²² significant increases in health assistance will not happen for the foreseeable future. Instead, agonizing choices will be the order of the day. How long will, for example, the

Obama administration's financial support for global health survive at or near existing levels when the administration and Congress have already cut and are proposing more cuts to domestic public health, health care, and other programs?²³ Other high-income countries face similar dilemmas, so pressure to reduce funding for global health will continue for years.

In epidemiological terms, foreign policy action will become harder to sustain because political commitment and funding for existing efforts (e.g., HIV/AIDS)—widely recognized as inadequate—will flatline or decline, leaving progress more difficult to achieve. In addition, global health leaders want more focus on problems that have weaker foreign policy *pull*—non-communicable diseases (NCDs)—or represent more expansive projects—health-systems reform and addressing the social determinants of health (SDH).

The September 2011 UN meeting on NCDs illustrates the push to make NCDs more important to foreign policy makers. However, experts recognize that the case for more foreign policy action on NCDs is difficult to sustain, even without considering the mounting fiscal constraints.²⁴ Despite warnings about the NCD problem, these diseases tend to reflect interconnectedness, rather than interdependence, between states, in contrast to most communicable diseases that have garnered foreign policy interest. Interconnectedness, even as intensified by globalization, produces weaker common interests and often reflects divergence in foreign policy priorities.

Put differently, U.S. security, economic power, and development objectives are not affected by smoking or obesity prevalence rates in rival powers, other high-income states, or middle- and low-income countries. Many countries have reduced tobacco consumption without needing foreign aid or the WHO Framework Convention on Tobacco Control, illustrating that claims of the necessity of intensified cooperation stretch political and public health realities. Low-income countries often need assistance to grapple with NCDs, but this fact reflects their dependence on aid for health problems—not interdependence between the world's nations on NCDs. Further, the *human dignity* pull of NCDs related to behavior (e.g., smoking, diet) is less than what communicable diseases, maternal and child health, or humanitarian disasters generate. Finally, arguing that increased foreign policy action and aid for NCDs will generate soft-power payoffs for a state will be hard given multi-polarity, fiscal scarcity, and demands from existing inadequately addressed and underfunded global health problems.

Emphasis on health-systems reform and SDH reflects global health policy's tendency to expand when seeking solutions for underlying causes. This proclivity runs into foreign policy processes that ruthlessly winnow complex problems into defined tasks with measurable targets. We see this mismatch in controversies over *horizontal* versus *vertical* health projects. Health-systems reform and SDH are horizontal, which pits them against foreign policy preferences for more limited vertical activities. Despite efforts to ameliorate this problem (e.g., “diagonal” policies²⁵), it remains persistent. The more difficult environment now facing the global health-foreign policy relationship means that the horizontal/vertical tension will continue, which will affect foreign policy action on health-system reform and SDH.

“BLOOD AND TREASURE” FOR GLOBAL HEALTH

The argument that a decline in global health’s foreign policy importance is beginning has to be kept in perspective. The recent rise was unprecedented. Expecting this trajectory to continue without change is not realistic. Some tapering off should be expected, especially as high-profile initiatives become integrated into day-to-day foreign policy operations. Further, arguments about the fall constitute speculation, even if grounded in analysis of unfolding events. The nature and extent of a fall, if any, remains to be determined.

When foreign policy makers debate responses to challenges, they often ask whether their country wants to expend *blood and treasure* on an issue, and, if so, how much. *Blood* typically means commitment of military forces, and *treasure* means expenditure of public money. The more important the issue, the more blood and treasure get committed. The fall in global health’s foreign policy significance will be determined by a health-relevant blood and treasure calculus—whether, and how much, states commit political and economic capital for global health. The blood calculus involves states deciding how much civilian and military time and energy get tasked with supporting global health. The treasure measure focuses on how much public money states appropriate for global health.

States could limit a fall by establishing a *new normal* through embedding global health interests in foreign policy processes in ways that heighten the likelihood that policy makers consider such interests seriously and routinely. Support for this approach appears in recent country-specific foreign policy strategies on global health,²⁶ and UN advocacy for more such strategies.²⁷ These plans could help reduce the foreign policy elasticity health historically has experienced, especially concerning economic power, development, and human dignity. Systematic, operationalized consideration of global health across foreign policy, coupled with increases in “civilian power,”²⁸ could help counteract any leveling off or decline in treasure for global health.

However, this new normal is not assured because a more precipitous fall could occur. The structural, political, economic, and epidemiological factors discussed above signal serious blood and treasure problems—flagging political interest in, and fewer economic resources for, global health that could heighten global health’s elasticity in foreign policy. Pushing foreign policy deeper into NCDs, health-systems reform, and SDH might exacerbate these problems because these areas represent less clear blood and treasure issues, especially for the great powers and high-income countries that would have to lead and provide significant economic resources for these issues. This observation reveals a continuing gap between foreign policy and public health thinking.

Key indicators that will help us discern the nature and extent of any *fall* include:

- How foreign policies of leading states adjust in global health to multi-polarity and the decline in U.S. power and influence;
- How states perceive the political benefits of responding to global health problems and using health as a soft-power tool of foreign policy in this changed geopolitical context;

- How high-income countries allocate foreign aid for health-related purposes;
- Whether leaders of key states stay or become personally committed to global health in foreign policy;
- How all governments appropriate funds and implement programs for national public health because, without action domestically, prospects for foreign policy impact diminish; and
- How states respond to efforts to heighten foreign policy action on NCDs, health-systems reform, and SDH, especially in a context where existing commitments and interest in global health are under increasing scrutiny and stress.

CONCLUSION

Hans Morgenthau once argued that statesmen think and act in terms of interest defined as power.²⁹ Getting statesmen to add public health has typically required health crises that threaten power interests. Ironically, this pattern negates public health's emphasis on prevention, and sustaining adequate surveillance and response capabilities when crises are not occurring. This mismatch is the source of the rise and fall phenomenon and global health's elasticity in foreign policy.

Reducing the zeniths and nadirs of the rise and fall pattern requires more effective conceptual and operational linkages between power and public health, and more efficient application of blood and treasure in an emerging context of greater skepticism about global health in foreign policy and fewer economic resources for foreign policy. These tasks will not prove easy, certainly not as easy as hoping for another crisis that sends foreign policy makers scrambling and global health on another rise to a prominence that betrays its principles.

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