

# Health as foreign policy

The global health arena may appear to be dominated by aid organisations, philanthropists such as Bill Gates and the pharmaceutical industry. What role can the ministries of health and foreign affairs play?

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One late-summer day in 1851, delegates from 12 countries were assembled around a table in the French Ministry of Foreign Affairs. They had gathered to find a solution to prevent the spread of diseases across national boundaries. Cholera, plague and yellow fever were the problem. Each country had two representatives present at the negotiations, one medical doctor and one diplomat (1). This first *International Sanitary Conference* was one of the earliest examples of attempts to establish international agreements. Health was thus a pioneering area for global cooperation.

A number of world challenges related to illness still cannot be addressed within the boundaries of individual countries, but require cooperation regionally and internationally. This cooperation has taken many forms, but more than a century would pass between the signing of the first binding international health agreement in 1892 – regulating matters such as quarantine times for intercontinental shipping – to the second one, the Framework Convention on Tobacco Control in 2003. During the last decade we have seen a completely different level of activity, and the concept of health diplomacy is being used to describe the increasingly frequent international negotiations on matters pertaining to global health (2).

Norway raised its profile in 2006, when Jonas Gahr Støre, Minister of Foreign Affairs, was one of the co-initiators of a new and unique initiative to link health and foreign policy, accompanied by foreign ministers from France, Brazil, Indonesia, Thailand, South Africa and Senegal. This group has become well known as the Oslo Ministerial Group, which in recent years has played a key role in setting a new agenda for the role of foreign policy in the promotion of global health (3).

What impact can international negotiations and agreements have in a world where the volume of health-related development assistance from the richest to the poorest countries has more than quadrupled since the turn of the millennium (4)? In this article we wish to highlight a new foreign-policy landscape, where health has emerged as a subject area. We need more knowledge to demonstrate how foreign policy has an impact on health, but we wish to elucidate how foreign-policy initiatives can play a role. We will illustrate this topic by referring to the efforts associated with the Oslo Ministerial Group in particular.

## A changing world

At the time of the Paris meeting in the 19th century, the challenges related to the spread of diseases were inextricably linked to the increase in intercontinental trade and the swelling tide of migrants. Emigration from Europe to the American continent was a new and decisive factor, as was the opening of the Suez Canal (5).

In 1999, during Gro Harlem Brundtland's directorship of the WHO, the underlying factors remained the same, but with a number of specific challenges. Decades dominated by the security policies of the Cold War and building of alliances were replaced by a far more complex world order. The differences between industrialised and developing countries were no longer as obvious, and the foreign-policy agenda grew: Security remained a key issue for all countries, but economic development, trade, environmental issues and health were having an increasing impact on how the countries expressed their interests on the international stage. Foreign policy was undergoing change.

New challenges related to diseases emerging around the turn of the millennium gave a new impetus to health as a field of foreign policy. The SARS outbreak in 2003 came as a shock to the accustomed and continuous flow of people and goods. However, the issue had been brought to the fore by the problem of HIV/AIDS more than a decade earlier: The matter landed not only on the desk of the health minister, but also in the offices of the foreign minister and the prime minister. How can the population be protected against such threats? Countries such as Norway imagined frightening scenarios of an explosive growth in infections from neighbouring areas to the east, while countries such as South Africa and Brazil found the cost of anti-HIV drugs to be an insurmountable barrier. Not least through pressure from civil society, the matter was put on the UN agenda, which led to a broad mobilisation across boundaries. Health challenges could not be addressed only at the national level, but required a global political commitment.

Some interpret these opportunities for widespread international cooperation as a dream of «a good global order», but how real are these ideas? The fear of a worldwide influenza pandemic in 2009 served as an unpleasant reminder of the challenges involved in balancing national and global concerns: The rich countries, such as Norway, were quick to establish costly contracts with vaccine manufacturers in order to protect their own populations. They had standing orders for most of the global production capacity. Poor countries and the majority of the world's population had little chance to obtain similar quantities during the acute stage, when there was a scarcity of these vaccines (6).

## Health diplomacy

The influenza threat gave an impetus to the international negotiation process Pandemic Influenza Preparedness (PIP) under the auspices of the WHO. This process provides a good illustration of how health overlaps with other areas of international politics, and what health diplomacy really means.

In 2009, it was not only the distribution of vaccines that posed a problem. The negotiations started in 2007, when Indonesia

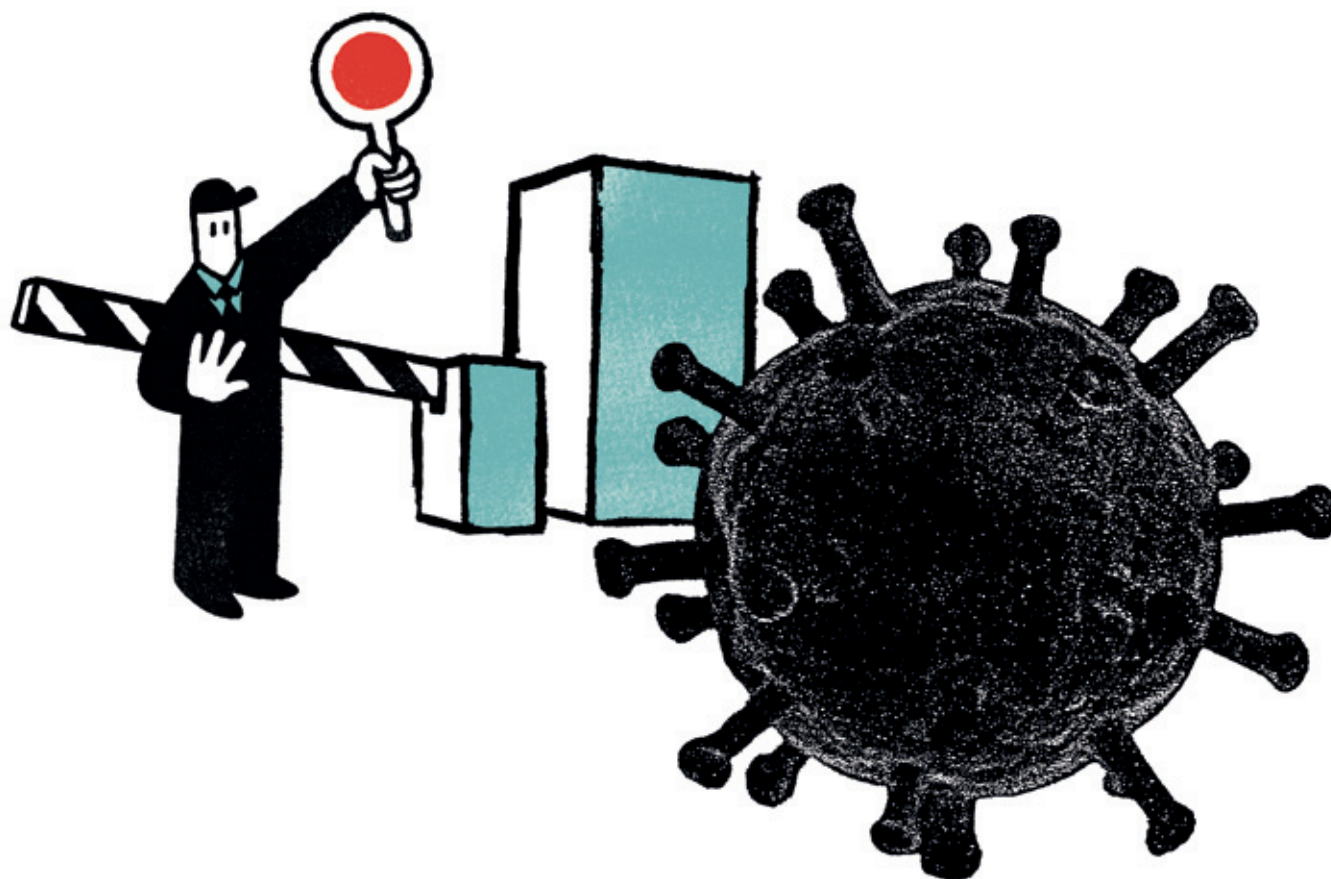


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refused to share an influenza virus with a WHO-based network of laboratories. The network is intended to ensure an optimal sharing of information that can lead to development of vaccines. But, as argued by Indonesia, if the pharmaceutical industry patents vaccines developed on the basis of an Indonesian virus, what will Indonesia receive in return?

As the PIP negotiations progressed, it became increasingly clear that what appeared to be a matter of medical science, concerning the use of a virus with a potential for causing an influenza pandemic, also included a number of topics in which countries from many regions have very differing interests, political ambitions and requirements. The issue of whether manufacturers should be granted patents for vaccines against pandemic influenza had repercussions far beyond the negotiations within the framework of the WHO, reaching into negotiations in the World Trade Organization (WTO) and the World Intellectual Property Organization (WIPO).

It was of decisive importance for a solution that the negotiations were raised from the «technocrats», i.e. the health experts, to the level of ambassadors, i.e. persons who have access to politicians in key positions. Even though the core issue was that of disease and vaccines, the representative delegates could not negotiate in isolation

from actors in civil society or business interests, and political concerns therefore assumed a material importance. During the final year, the negotiations were directed by the Norwegian and Mexican ambassadors to the UN in Geneva, where both enjoyed widespread trust across countries and regions. Here, the path was laid for a final agreement and signature in April 2011.

Health diplomacy requires joint problem-solving. Negotiators from the foreign ministries are trained diplomats, and are knowledgeable in many and diverse fields. The technical-scientific health experts, or those who work with development assistance, are not always in agreement. Often, the ministries of justice and trade may be involved. The cases and processes take their course over several years, while the diplomats move around. Therefore, agreement must be established not only between the delegations from various countries, but also internally within the delegations and across national ministries.

### The Oslo Ministerial Group

Foreign policy has widened its scope to encompass health. Does this mean that countries are now prepared to relate to a new complexity in international politics? In a speech held at the Center for Strategic and International Studies in Washington DC in 2009 (7), Jonas Gahr Støre reflected

on this question. Three years previously, Gahr Støre and his French colleague Philippe Doust Blazy developed the idea for the Oslo Ministerial Group, or The Foreign Policy and Global Health Initiative, which is how the group refers to itself. They asked colleagues from five strategically important countries, who were well known to them, to join.

The Oslo group is heterogeneous and therefore untraditional in international politics, where countries tend to seek each other out on the basis of geographic proximity or similarity of interests (3). The group wrote The Oslo Ministerial Declaration (8), which turned out to be an ambitious consensus document covering topics ranging from migration of health personnel to the threat of climate change. The document is not a plan of action for the group, but rather an argument in favour of establishing a broad agenda for global health, with the goal that increased awareness of health will have an impact on political processes in other sectors of foreign policy, such as UN-based processes on human rights and peace-building (8). The idea is summarised as «common vulnerabilities, shared risk and common responsibilities» (9, p.1).

In 2008 the group established a network of Geneva-based diplomats and created a new space for informal consultations. Such consultations provided a breathing space in

formal international negotiation processes, in which the final document often risks being watered down to the lowest common denominator of agreement. The Oslo group became a place where different political goals and viewpoints could be discussed. There is an implicit agreement between the seven countries that the group is not an arena for negotiations, but rather represents an opportunity to learn from each other and to understand and respect each other's positions. One of the authors of this article (SHS) participated in the PIP negotiations, and experienced how the Oslo group became a decisive resource that helped create a favourable climate for the negotiations.

It is essential for the group that the seven countries not only represent four continents, but also have members in the G8 and G20 and that leading and strong developing countries are in the majority. All the countries in the group have played significant roles. South Africa, for example, played an active role in finalising three resolutions on health and foreign policy in the UN General Assembly. South Africa occupies a strong position in the UN and in the group known as the G77, which includes all the developing countries. This grouping was established as early as 1964, and appears in all settings where global issues are on the agenda. In 2010, Brazil took over the role of coordinator for the Oslo group. Until then, Norway had assumed the main responsibility. Just like Norway, Brazil acts on its ambitions to play key roles in global politics.

### Health and foreign policy, so what?

Measuring the effect of the Oslo Ministerial Group is a demanding task in an age when measurable targets constitute the gold standard for global health initiatives. Insight into how the health diplomacy in Geneva actually works is one of the keys to understanding the Oslo group's function, a group that has neither allocated funds nor defined milestones, but rather has sought to seize opportunities for negotiated solutions wherever they arise. In the longer term the question is whether the group can have an impact in areas where health impinges on other, more traditional fields of foreign policy, such as trade, military interventions and humanitarian aid.

The agreement within the framework of Pandemic Influenza Preparedness may appear specific and technical. Nevertheless, as an example set within a wider political context, the agreement is a victory for global security, international solidarity and the WHO, which is granted a clear, formal leadership role by the member states as a guardian of international norms and rules for pandemic preparedness. The negotiations are evidence that global policies propounding a holistic, humanist perspective are possible in a diverse, although unsettled, world order.

The initiative for health and foreign

policy also influences the Norwegian debate on global health. Until 2006, the focus was on health-related development assistance to the poorest countries and on new global initiatives, such as the GAVI alliance and The Global Fund to Fight AIDS, Tuberculosis, and Malaria. Gahr Store returned from Brundtland's management team in the WHO with experience that extended beyond issues of development assistance, including the importance of taking into account the interconnectedness of all countries with regard to health challenges. The MFA's decision to put health on the foreign-policy agenda raised the discussion on the WHO and its role in the governance of global health policy. This discussion has a far wider scope than the debate on development assistance, since it concerns global health as part of a whole, within a foreign-policy context (3).

If we go back to the first series of International Sanitary Conferences in the 19<sup>th</sup> century, it is interesting to note that the negotiations were characterised by uncertainty about the causes of cholera. This discussion lasted for more than 40 years before the parties could finally agree (1). Since then, there has been a broad development of medical knowledge and of the tools available to doctors. In the present day, we are also aware of the correlation between better living conditions and longer life expectancy. This correlation, known as the social determinants of health, gives rise to questions of how national and global policies impact health. If this new foreign-policy landscape is interpreted as an area where the environment, food supply and turmoil in the financial markets are interconnected, could an emphasis on health possibly be an incitement for untried solutions?

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