

All countries are now dependent on regional and global cooperation to cope with health risks and to secure public health. For Norway to continue its leadership role in global health and health aid, an improved association between money, knowledge and policy is needed.

Global health is the objective – is health aid the answer?

We have heard it often since the turn of the millennium – Norway is in the first division when it comes to health aid. Child vaccines and the battle to secure safe births for women are at the forefront, against a backdrop of solid investment in HIV/AIDS and various global health initiatives. The Prime Minister leads the way in this. In contrast to many controversial issues that divide, health aid in some prioritised areas has become something on which heads of government can safely cooperate. At the same time, there are also health-related areas that are characterised by conflict, where nations and interests oppose one another and limit the effectiveness of leadership and money. In the sphere of development aid this relates to e.g. patents and the cost of drugs, rules of ethical international recruitment of healthcare professionals, issues related to equality, sexual and reproductive health and criminalisation associated with HIV transmission. Aid through financial disbursements, technology and knowledge is important in these contexts, but not sufficient.

In 2011 the Journal of the Norwegian Medical Association published a series on the theme of global health (1), ahead of the Government white paper *Global health in foreign and development policy* (2). The message is that the world is more closely interwoven than it ever was, with the result that great inequalities in health and varying ability to cope renders everyone vulnerable. Nationally and globally, public health depends on all countries acting together to contribute to health-promoting national and international policy, based on the sharing of knowledge and resources. This is a question of both solidarity and self-interest. The health challenges of today exceed the boundaries of what national health authorities can take responsibility for alone; they are linked to the environment, pandemics, migration, trade and the labour market. International negotiations in these areas are demanding, and it is difficult to lend an impact to solutions that allow health concerns to be highly prioritised. This demands a greater investment in alliances and cooperation across regions and borders to find solutions in areas where we are currently at an impasse. Global health is more than health aid.

Many aid-dependent countries still have very weak capacity in their healthcare systems, and are poorly equipped to cope with state responsibility for national public health in the longer term. This entails a significant risk for both national and global public health. Here there is also a particular need for interventions to deal with bottlenecks associated with global policy on trade and markets, access to medicines and healthcare professionals.

There is now great interest over large parts of the world in developing global health as an academic field. A number of universities have established separate units for this discipline, and use it to profile themselves to attract students. A large and committed group of medical students is collaborating internationally to be drivers in questions of global public health, and direct attention towards unsolved challenges that create and maintain vulnerability and health inequality within and across countries. National institutions such as the Norwegian Institute of Public Health are part of a growing worldwide network based on equality and academic collaboration. It is

striking that other Norwegian actors in health have yet to discover this new outline of issues that challenge their profession.

The increasing emphasis on global health will be of importance for Norwegian health aid. Up until the turn of the millennium, support was given to build national and local health services in recipient countries, often with Norwegian personnel. There was room for a multitude of contributors, ranging from specialist consultants and the Peace Corps to large and small voluntary organisations, missionary health services and Doctors Without Borders. International health was to a large extent defined by the cooperation with poorer developing countries. This partly concerned direct professional and economic support from Norway, and partly support through the UN system, without Norwegian health aid being at the centre of either development policy or foreign policy.

Since the turn of the millennium there has been a marked change. The millennium development goals for health provided opportunities for political leadership and profiling. The fight against AIDS, tuberculosis and malaria was given its own goals, together with infant mortality and maternal health. The desire for rapid results led to a number of new global health initiatives, with the WHO as midwife and with heads of government and politicians in the driving seat. In alliance with one another, with UN organisations and leading private actors, it has been possible to mobilise large resources and make great progress. At the same time, direct cooperation with each country, for instance through core investments in national healthcare systems, has received less attention and resources. This change has meant that Norwegian healthcare professionals are less engaged in practical development aid and that the aid competence profile has altered from healthcare studies to aid management and health diplomacy at a global level.

A high-profile political leadership, such as we see today for Norwegian health aid and global health, provides a recognisable Norwegian profile internationally and opens doors for Norwegian health diplomacy. For it to succeed, it needs to be embedded in Norwegian public administration and in professional communities that can contribute with knowledge, experience and networks, and create continuity and a professional basis for a coherent Norwegian policy. Whereas development aid comes under the development aid administration («Norway Aid»), health policy comes under the health administration («Norway Health»). There are no forums for cooperation that regularly bring together these and other governmental and non-governmental actors of importance to both development aid and global health. These challenges are highlighted in White Paper no. 11, but no consequences with regard to a global health policy are drawn from them, either in terms of organisation, funding or knowledge (2).

There is a lack of association between money, knowledge and policy: development aid policy is about financial disbursements to poorer countries, and little about the use of Norwegian knowledge; health policy is primarily concerned with our national interests and priorities and has little association with development aid and

foreign policy. Global health requires that we act on the basis of well-embedded knowledge, both about health in poorer countries and health that concerns everyone. At the moment, the knowledge communities are fragmented and policy is not coherent. For Norway to continue to have a leadership role in global health and development aid, these areas must be better coordinated.

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