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Reflections on the Revolution in Health and Foreign Policy

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Introduction

The papers in this issue of the *Bulletin* reflect increasing interest in, and concern about, the relationship between health and foreign policy. Such intensified attention signals awareness of a transformation in this relationship that is leaving its imprint on the protection and promotion of health nationally and internationally. This transformation remains incompletely understood and raises difficult questions about how the making and implementation of foreign policy will deal with health in the future. These questions suggest that WHO and its members are experiencing a transition in the global politics of public health, a transition perhaps more profound than the one signalled by the establishment of WHO in 1946. The revolution in the relationship between health and foreign policy represents the nascent formation of a new global social contract for health.

Rousseau, Kant and health

Existing literature analysing foreign policy and health often observes that health has long been a foreign policy issue, but one of little importance in the hierarchy of foreign policy objectives. This reality does not support principles informing WHO's establishment, such as the principle that "[t]he health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States".[1] For most of WHO's existence, countries did not behave in their relations with each other as if the health of all peoples was critical to national or international peace and security. Health has not been at the heart of foreign policy theory or practice, and perhaps not even at the margins.

The emergence of health as an important foreign policy issue in the last decade has revealed some consequences of the historical separation of health from foreign policy. In particular, health policy communities have not been well versed in the harsh realities of foreign policy, especially the cold calculations that officials are expected to make in constructing, protecting and promoting national interests. As explored by scholars of politics and international relations, foreign policy dynamics flow from the condition of anarchy in which countries interact. The lack of any recognized common, superior authority means that countries are ultimately responsible for their own sovereignty, security and survival. Diplomats and scholars differ on the dangers and opportunities that international politics create for countries; these differences produce diverse attitudes about the potentialities of foreign policy behaviour. Regardless of these varied perspectives, however, the anarchical nature of international relations forces countries to set political priorities in contingent, uncertain and often dangerous circumstances.

The eminent political scientist Stanley Hoffmann captured the tension in foreign policy-making when he argued that "[w]hoever studies contemporary international relations cannot but hear, behind the clash of interests and ideologies, a kind of permanent dialogue between Rousseau and Kant".[2] When it came to international politics, Rousseau was a deeply pessimistic realist, who could see little more than competition, conflict and enmity in intercourse between countries. By contrast, Kant saw the potential for perpetual peace, achievable through revolutionary transformations of domestic and transnational politics. As Hoffman argued, the diplomat listens to the dialogue between Rousseau and Kant, and realizes that "he *must* play the game of international competition, from which he can escape only exceptionally, and at the same time he *ought* not to lose sight of Kant's ideal. He ought not to give up the hope of a future world community, but he cannot act as if it already existed."

Historically, health has been absent from this permanent foreign policy dialogue in two senses. First, the protection and promotion of population health did not factor into leaders' calculations of what competition in anarchy required of their countries, nor was "health for all" seriously (as opposed to rhetorically) considered a Kantian pathway to a better world. Second, those engaged in public health and health care for the most part did not participate significantly in this permanent dialogue. The establishment of WHO coincided with an unprecedented convergence of traditional but proven public health measures (for example, epidemiological surveillance and urban sanitation) and the potentialities generated by rapid scientific progress in medicine (for example, vaccines, antibiotics). These developments lessened the need for foreign policy-makers to concern themselves with threats to the health of their respective populations.

The detachment of health policy from the permanent dialogue of foreign policy appears most starkly in the 1978 Declaration of Alma Ata, which proclaimed the possibility of health for all by the year 2000. The Declaration expressed the optimism that health advocates developed through their vision of the universal application of epidemiology, technology and an ideology of social justice. Often considered a crowning achievement for WHO, the Declaration emerged, however, in one of the most dangerous and darkest periods of post-World War II international relations; highlighted in 1979 alone by the former Soviet Union's invasion of Afghanistan, an oil crisis that shook the international economic system, and an Islamic revolution in Iran that humiliated a superpower and began a new era of international politics in the Middle East. The gulf between foreign policy and health has perhaps never been more dramatic and obvious than at the moment when health policy unveiled its most ambitious and optimistic global strategy.

The rise of healthcraft in foreign policy

The current attention to the relationship between health and foreign policy indicates that the gulf between these two policy endeavours has disappeared,

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and that this process has changed both in ways that remain enigmatic. Perhaps most significantly for the relationship, health now prominently features in the permanent foreign policy dialogue between Rousseau and Kant. Foreign policy-makers regularly confront issues of population health that relate to national security, economic power, the protection of human dignity and the development of strategically important regions and countries. They must make decisions on these matters by setting priorities that protect national interests without losing sight of the universal aspirations of health policy. For the foreign policy community, the rise of health as an issue did not fundamentally change the permanent dialogue, but it did force foreign policy-makers to rethink, sometimes radically, how they view national interests.

Nowhere is this reality more apparent than in the relationship between national security and public health. Whether discussing biological terrorism, HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) or pandemic influenza, foreign policy makers and public health experts have increasingly framed certain health threats as security challenges. Without question, the major powers of the international system have driven this process with their national interests in mind, which worries many of those involved in protecting and promoting health. Participating in the permanent dialogue of foreign policy does not, however, allow health experts and advocates to avoid the pressures that leaders face to make decisions with scarce resources in volatile contexts of uncertainty, competition and vastly differing national capacities.

Despite the harshness of the foreign policy process, health advocates have found ways to influence the permanent dialogue. Health policy-makers and professionals have experimented with strategies to integrate the empirical powers of epidemiology, the cold calculations of national interests and the ethical filaments that tie health to ideals of human solidarity. The evolution of this healthcraft has not vaulted public health to political primacy in the world of foreign policy, but it has contributed to health gaining political, as opposed to just rhetorical, traction in global politics. In fact, the traction has been such that foreign and health policy-makers now confront dilemmas created by the proliferation of national, intergovernmental and nongovernmental efforts promoting public health.

Tragedies of the global health commons

During the past decade, the explosion in global health activities by governments, international institutions, multinational corporations and nongovernmental organizations is unprecedented and shows the transformation of health as a national and global political endeavour. Commentators have, however, begun to warn of the adverse implications of so many actors engaging in so many health efforts in so many parts of the world.[3] All this activity is producing what can be called two tragedies of the global health commons.

The policy space of global health has developed features resembling Garrett Hardin's famous "pasture open to all".[4] Governments of developed and developing countries, intergovernmental institutions, private corporations, philanthropists, nongovernmental organizations, academics and rock stars have for various reasons embraced global health causes. Political incentives, epidemiological evidence, technological advances, globalization and funding have significantly lowered barriers to entry into global health activities, creating opportunities for more government actors and others to plan and implement projects. This dynamic is producing a global health version of the "tragedy of the commons" as actors' rational, self-interested calculations generate over-exploitation of the global health commons. Critical parts of the global health commons, particularly developing and least-developed countries, cannot adequately support the ongoing proliferation of activities, which tend to fragment already fragile local and national capacities for public health and health care.

But the global health commons experiences as well the tragedy of underexploitation. Critical health issues such as women's health, the global spread of noncommunicable diseases and the building of broad-based local and national public health capacities, receive insufficient attention and suffer from the fragmentation of public health and health-care systems caused by proliferating yet uncoordinated public and private health initiatives.

These two tragedies of the global health commons constitute critical challenges for healthcraft in foreign policy. Technological fixes are not available for these challenges, as they are fundamentally political and governance problems. What these challenges require from healthcraft and foreign policy is the realization that a new global social contract for health is needed. This idea already percolates in different forms in discussions about the future of global health. Some call for new "architecture" for global health governance; others urge more systematic and coordinated approaches to aligning political interests, financial resources and epidemiological needs. Still others have more specific suggestions in mind, from significantly increasing power and resources of WHO to negotiating a comprehensive treaty on global health.

Conclusion

Ultimately, the fate of any new global social contract for health will be determined in the course of the permanent foreign policy dialogue between Rousseau and Kant. This reality is sobering, given the tension between interests and ideals at the heart of the dialogue and the responsibilities still resting with governments. The diplomat cannot act as if the new global social contract for health exists, but cannot fail to see the benefits that such a contract could bring. How the revolution in the relationship between health and foreign policy will play out depends on how skilfully the health community exploits the discretion the dialogue leaves in the hands of those who make foreign policy. ■

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