

GLOBAL HEALTH DIPLOMACY: UNDERSTANDING HOW AND WHY HEALTH
IS INTEGRATED INTO FOREIGN POLICY

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Abstract

This study explores the global health diplomacy phenomenon by focusing on how and why health is integrated into foreign policy. Over the last decade or so, precipitated primarily by a growing concern about the need to strengthen global health security and deliver on the Millennium Development Goals, foreign policymakers have been paying more attention to health as a foreign policy concern and several countries have adopted formal global health policy positions and/or strategies.

To elucidate a deeper and clearer understanding of how and why health is integrated into foreign policy, this thesis used a case study research design that incorporated literature and document review and interviews with twenty informants to conduct an in-depth analysis of the United Kingdom's (UK) *Health is Global: A UK Government Strategy 2008-13*. *Health is Global* represents the first example of a formal national global health strategy developed using a multi-stakeholder process. Briefer background case reviews of three nations that are leaders in global health diplomacy - Brazil, Norway and Switzerland, were also conducted to inform the analysis of the in-depth case. Policy analysis included categorizing data into five areas: context (why?), content (what?), actors (who?), process (how?) and impact (so what?). The Multiple Streams Model of Policymaking and Fidler's health and foreign policy conceptualizations - revolution, remediation and regression - were used to analyze the findings.

Based on this analysis, the primary reason that the countries examined have decided to focus more on global health is self-interest - to protect national and international security and their economic interests. Investing in global health was also seen as a way to enhance a state's international reputation. In terms of self-interest, Brazil was an outlier, however. International solidarity and health as a human right have been the driving forces behind its long-term investment in development cooperation to date. Investing in health for normative reasons was also a prevalent though weaker theme in the UK, Swiss and Norwegian cases. The study highlighted the critical role that policy entrepreneurs who cross the domains of international relations and health play in the global health policymaking process. In regards to advancing a conceptual understanding of global health diplomacy, the findings propose that the whole-of-government global health policymaking process is a form of global health diplomacy. The thesis elucidated factors that underpin this process as well as lessons for other nations, in particular, Canada.

While ascertaining the impact of national global health strategies was not the main objective of this thesis, the study provided an initial look at the impact of these policy instruments and processes. Such impacts include better collaboration across government actors leading to enhanced policy coherence and a more strategic focus on global health.

Finally, some have argued of late that the global health revolution is over due to the current world economic crisis. Considering the level of interest in whole-of-government global health strategies and the ever growing and sophisticated world-wide global health policy community, based on this thesis, the global health revolution is alive and well.

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Acronyms

BRICS	Brazil, Russia, India, China, South Africa
CAHS	Canadian Academy of Health Sciences
DFID	Department for International Development (UK)
DH	Department of Health (UK)
EU	European Union
FCO	Foreign and Commonwealth Office (UK)
FCTC	Framework Convention on Tobacco Control
FDFA	Federal Department of Foreign Affairs (Switzerland)
FDHA	Federal Department of Home Affairs (Switzerland)
FOPH	Federal Office of Public Health (Switzerland)
FPGH	Foreign Policy and Global Health Initiative
GHD	Global Health Diplomacy
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMG	Her Majesty's Government
HPA	Health Protection Agency (UK)
IHP	International Health Partnership
LSHTM	London School of Hygiene and Tropical Medicine
MDGs	Millennium Development Goals
NGO	Non-governmental Organization
NHS	National Health Service (UK)
OECD-DAC	Organization for Economic Cooperation and Development-Development Assistance Committee
PAHO	Pan American Health Organization
SARS	Severe Acute Respiratory Syndrome
SDHs	Social Determinants of Health
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
US	United States
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

Chapter 1: Introduction

1.1 Rationale for the Study

Over the past 10-15 years, global health issues have become more prominent in foreign policies at the national level. (1-6) Events such as the HIV/AIDS¹ pandemic, threats from infectious diseases, fears about bioterrorism and issues related to trade and health have provided an incentive for the makers of foreign policy to focus more attention on health issues. (2;4;7-12) Evidence of such attention includes the quadrupling of health aid disbursements in the past 20 years (13;14) and the establishment of the Millennium Development Goals (MDGs) most of which either directly or indirectly via the social determinants of health (SDH) address critical health inequities. (15) Since 2008, the United Nations General Assembly has adopted three resolutions resolving that governments should pay more attention to global health in their foreign policies thereby heightening the importance of this phenomenon. (16-18) These events have taken place against a backdrop of globalization that is influencing the context in which countries operate. As nations become more interconnected and interdependent and health issues become increasingly global, state actors have more incentives to work together and with a variety of non-state actors on health issues that transcend national boundaries. (7;10) The process of negotiated collective action for global health that can eventually lead to new forms of global health policy and governance has recently come to be referred to as 'global health diplomacy' (GHD). (19) This concept has captured the attention of key global health actors, including the World Health Organization (WHO), foreign ministers and the academic community, and continues to gain momentum despite arguments that

¹ HIV is the acronym for human immunodeficiency virus and AIDS is the acronym for acquired immune deficiency syndrome.

the global health revolution is over due to the world's recent economic situation. (6;7;19-28)

GHD aims to capture the complexity of the multi-level and multi-actor negotiation processes that shape and manage the global health policy environment; however the manner in which this concept is used is highly diverse and the process and intent of this phenomenon poorly understood. (25;29) Little empirical research has been undertaken in this area *per se* leading to strong calls to move beyond rhetoric about GHD and towards more descriptive, analytical, conceptual and practical rigour. (4;19;27;30)

This study contributes to achieving this goal by critically examining the integration of global health (defined on pages 22-23) into foreign policy. (7;12;20;30-33) This project is based on the proposition that one way to better understand the GHD phenomenon is by examining how and why global health is integrated into national foreign policy through rigorous empirical research. As Fidler² writes, health's importance is not self-evident in the world of foreign policy. Therefore, 'more systematic and rigorous understanding and assessment of possibilities and limitations of health in foreign policy has become an imperative.' (11)(p. 25) To contribute to this needed understanding, the overall research question this study explores is: why and how is global health integrated into foreign policy? In other words, what are the motivating and influencing factors that lead state actors to develop foreign policies that integrate global health and the processes by which such integration is undertaken?

² David Fidler is a law professor at Indiana University. His work focuses on international law and global health.

The Foreign Policy and Global Health (FPGH) initiative launched in 2006 by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand and renewed in 2011 (i.e. the *Oslo Ministerial Declaration*) is one manifestation of global health's growing relevance in foreign policy. (24;34;35) FPGH encourages nations to broaden the scope of national foreign policies to integrate global health in a sustainable way and not as a crisis driven 'one-off.' Resolution 63/33 'Global health and foreign policy' adopted by the UN General Assembly in November 2008 further recognizes the 'close relationship between foreign policy and global health and their interdependence' and urges 'member States to consider health in the formulation of foreign policy.' (16) A few nations have been actively pursuing this direction through the development of coherent government strategies. In October 2008 the UK launched *Health is Global: a UK Government Strategy 2008-13*, described by the UK government as an international first. (1) Switzerland's *Swiss Health Foreign Policy*, an internal agreement between relevant services of the Swiss federal administration is another example. (36) Other countries that have rapidly adopted and developed policy statements or introduced initiatives related to GHD include Norway (37) and Brazil. (38-44) The creation of these kinds of 'whole-of-government' coherent policy approaches to global health helps to address the need for focus on this traditionally 'low politics' area of foreign policy ('low politics' is discussed further on p.28). (11)

Increasing understanding of GHD by examining the global health and foreign policy connection is the main objective of this study. Another important and relevant objective is to develop lessons that can be useful to other nations, in particular Canada, as they

consider whether, when and how they might participate in GHD. In light of this objective, this study focuses on an in-depth qualitative case study analysis of the UK's *Health is Global* strategy, from which lessons might be derived for Canada. Since the UK has a parliamentary system similar to Canada's and because both Canada and the UK are G8³ countries (i.e. leading industrialized nations frequently involved in intergovernmental meetings via G8 membership), lessons learned from the UK may have relevance to Canada.⁴ In addition to this in-depth case, the literature review, document analysis and some of the interviews undertaken as background for the in-depth case focus on other countries from which lessons may be derived. Three additional countries (referred to as background cases), Norway, Switzerland and Brazil, were chosen for less detailed analysis for purposes of comparison or contrast to the primary (UK) case. All three countries have demonstrated considerable leadership in moving GHD forward (i.e. Norway played a key role in initiating the *Oslo Ministerial Declaration*; Switzerland has developed a health foreign policy; (36) and Brazil was actively involved in the WHO Commission on Social Determinants of Health (SDH) and hosted the 2011 World Conference on Social Determinants of Health, and as a middle income country can lend a

³ The Group of Eight (G8) is made up of the leaders of eight of the world's most industrialized nations - Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States. It is a mechanism through which these nations discuss and find common ground on key topics and solutions to global issues. The leaders of these countries meet in summit format as the G8 once a year. The G8's origin stems from meetings held in the 1970s between France's Valéry Giscard d'Estaing and Germany's Helmut Schmidt when they were finance ministers. Each subsequently assumed the leadership of their respective countries in the mid-1970s when the oil crisis was taking place. French President Giscard d'Estaing urged the leaders of Germany, Italy, Japan, the United Kingdom and the United States to meet in 1975 to discuss how to respond to the oil crisis. Canada joined the group in 1976 at the Puerto Rico Summit hosted by the United States. Russia became a full-fledged member of the G8 in 1998. (45)

⁴ While Canada may have a similar parliamentary system to that of the UK, it is acknowledged that, unlike the UK, Canada has a federal system of government that impacts on domestic politics and policymaking. Having said this, however, global health in foreign policy is primarily a federal or national government issue in Canada as it is in the UK thereby lending support to the premise that the UK case will be relevant to Canada.

potentially different perspective to this issue), and for practical reasons (i.e. existing contacts in these countries facilitated access to documents and interviewees⁵).

1.2 Research Objectives and Questions

The **main objective** of this study is to explore and better understand what GDH is by focusing on the health and foreign policy nexus. Since little empirical research has been undertaken that focuses on GHD this study aims to break new ground in this area.

Specific objectives are to:

- understand how health as a concept is understood and positioned in the diplomatic and policy discourse at the state level
- build theoretical understanding about global health diplomacy by exploring how and why nations integrate global health into foreign policy (e.g. what factors influence this process and what is the process itself that leads to this integration)
- build understanding about what the connection between health and foreign policy means for the craft of foreign policy and global health diplomacy
- begin exploring whether whole-of-government strategies that aim to promote this integration make or have the potential to make a relevant difference to government policy, structures and processes and what that difference is or could be as perceived by the stakeholders involved
- derive policy and decision making lessons for other nations that are potentially interested in developing similar policy coherence mechanisms (e.g. Canada)

⁵ In this thesis 'interviewee' and 'informant' are used interchangeably to refer to individuals who were interviewed as part of the project.

The **central research question** explored is: how and why is global health integrated into foreign policy? Sub-questions include: how is global health defined and understood in the diplomatic and policymaking processes? Which global health issue(s) have the most saliency with state actors and why? Who are the actors involved and what role and influence do they exert in the process? How and why does global health attract the attention of state actors and remain on the policy agenda? How have government diplomatic strategies or practices changed with respect to the adoption of a broad policy framework that embodies GHD? How are state foreign policy interests in global health understood by state actors?

1.3 Summary of the Knowledge Gap and Tentative Hypotheses

While secondary research, as well as theoretical analysis and conceptual framing relevant to the integration of health into foreign policy has been undertaken, the literature review highlights that minimal primary research has been conducted in this area. In particular, there is a gap in research that draws on the perspectives and experiences of informants who are directly involved in the development of global health and foreign policy strategies. The main purpose of this study is to contribute to filling this gap. Moreover, since states play a key role in facilitating the development of policies directed at improving global health, (46) understanding the motivations behind these policies and how they are developed will significantly contribute to an understanding of GHD.

This study aims to help strengthen GHD's theoretical foundations from which research hypotheses and questions can be more confidently drawn, however, it is not an entirely inductive inquiry as sufficient theory exists to make some tentative hypotheses at the

outset of the study to guide and inform the research process. The literature review supports the premise that the primary reason state actors have chosen to integrate health into foreign policy is to protect national security and the material interests of the state. Therefore, one tentative hypothesis is that the integration of health into foreign policy does not mean that health is an overriding normative value and the ultimate goal of foreign policy; rather it is an instrument of foreign policy that can be used to achieve other foreign policy goals. As such, it is defined in a narrow way in the policy process as the absence of disease only and does not encompass the social determinants of health. This hypothesis is consistent with Fidler's 'remediation' theory. Another tentative hypothesis pertains to the influencing role that different actors assume in the policymaking process. Since health is a highly technical and scientific domain and states cannot ignore the epidemiological reality of many health crises, it can be hypothesized that the health research community and scientific research evidence play a powerful influencing role in the policy development process. See Chapter 6 for discussion and conclusions about these hypotheses.

1.4 Research Design and Methodology

1.4.1 Case study design

This thesis research adopted a case study design. The case study is an ideal methodology for in-depth investigation that aims to build understanding about a phenomenon or issue. (47;48) According to Yin, it is a highly appropriate research method when 'how' or 'why' questions are being asked about a contemporary set of events over which the investigator has little or no control, as is the case in this study. (47) The criteria outlined

by Curtis et al. for purposive case study selection were used to guide the case selection. These criteria include: relevance to the conceptual framework and research questions; potential to generate rich information about the phenomenon being studied; ability to derive lessons learned for other contexts; and feasibility. (49)

The major element of the study consists of an in-depth investigation and analysis of the UK global health strategy launched in 2008. This UK case was chosen because it represents the first instance in which a G8 country has articulated a national global health strategy that purports to integrate global health into foreign policy. Of the countries presently engaged formally in some form of GHD initiative, the UK global health strategy is also the most detailed and comprehensive.

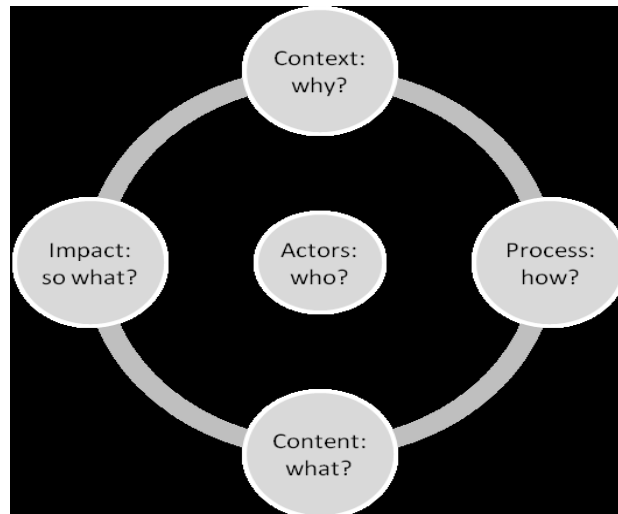
Case studies look at individuals or organizations from the multiple perspectives of key actors that help to build a detailed understanding of the experience and outcomes in a specific case. (50) A key strength of the case study method is that it can incorporate the triangulation of data from multiple sources using multiple data collection methods as an ongoing part of the research process. (51) Triangulation is one way to enhance the rigor of the research results and achieve a more complete representation of context through the use of multiple methods and data sources. (52) Triangulation is incorporated into this study by using techniques such as gathering and comparing data from more than one source (from both documents and informants) and using more than one potential theoretical perspective to analyze and understand the data (described later). In addition to

the UK case, document analysis and interviews were conducted for three other background case reviews, Norway, Switzerland and Brazil.

Literature review, document analysis and semi-structured interviews were used to conduct the UK case and the background case studies. To structure data review and subsequent analysis as described on pages 13-14, an adapted version of Walt and Gilson's policy analysis triangle was used as an heuristic device⁶ to gather and organize a comprehensive and relevant set of data in five areas (see Figure 1): the policy **context** within which the policy was developed (i.e. context for and reasons why the policy was developed); the policy **processes** (i.e. how the policy was developed and how it is being implemented); the policy **content** (i.e. the global health issues to be addressed through the policy and how health is positioned in the policy discourse); and the **actors** involved (i.e. who and what role they played in the process). (53;54) A fifth important category that was arguably missing from the triangle, '**indications of impact**' was added to the heuristic device as a way to capture data that focused on potential and actual impact of the policy. Categorizing data in these five areas provided a more thorough and comprehensive approach to subsequent interpretation and analysis using the theoretical frameworks.

⁶ Since first published in 1994, Walt and Gilson's approach to policy analysis has been used in a diverse array of countries to analyze a large number of health issues. (53;54) It provides a reputable and convenient analytical model for capturing and organizing data. As an adaptation of the 'stages' model of the policy process, its usefulness as a theoretical framework to guide more in-depth interpretation and analysis of findings is weak, however. (55) Therefore, it is not being used in this study as a component of the theoretical framework, but rather as a heuristic device only. Kingdon's Multiple Streams Model of Policymaking is the theoretical framework used in this thesis to analyze and interpret the findings pertinent to the policymaking process. (56)

Figure 1: Policy analysis circle



After data was categorized using this heuristic device it was then analyzed, interpreted and explained using the conclusions drawn from the literature and document review, Fidler's health and foreign policy conceptualizations (7;19;57) and political scientist, John W. Kingdon's Multiple Streams Model of the policymaking process. (56;58;59)

1.4.2 Literature and document review

A literature review was conducted focused on GHD and the integration of health into foreign policy with a focus on supporting and informing the main research question in this study: how and why is health integrated into foreign policy. Documents relevant to the main case study and each of the three background cases were reviewed and their content categorized systematically using the expanded Walt and Gilson heuristic categories. Documents included policy statements, historical material, government reports, website materials, media releases, scholarly articles and grey literature.

Document analysis (60;61) aimed to uncover initial insights into both the process (how) and motivations (why) behind the integration of global health into foreign policy and how

these have evolved over time. It also helped to identify potential informants to interview as part of the semi-structured interview phase of the research and provided information used in the further refinement of the interview guide (see Appendix A).

The literature review was conducted with library based and web-based search engines (e.g. Google, Google Scholar, PubMed, MEDLINE) using the key words ‘global health diplomacy’ and ‘health and foreign policy.’ Since GHD is a relatively new phenomenon, the search was confined to literature from the last 10-12 years. Only about 20 relevant articles (those directly addressing global health diplomacy and/or the relationship between health and foreign policy) were found using this method while a larger number was found through contacts at the WHO, documents produced for the new Canadian GHD Network⁷ and through discussions with a small number of academics who are currently interested or involved in GHD and/or related areas. Articles and special journal issues summarizing current issues and ideas related to GHD and the integration of health into foreign policy were particularly informative. (4;63-66) Through the course of the project, newly published literature was incorporated into the review where appropriate.

1.4.3 Semi-structured interviews

Purposive sampling, a sampling method by which ‘information rich’ study participants are chosen in order to ‘learn a great deal about issues of central importance to the purpose of the inquiry’ (61)(p.230) was used to identify and recruit informants for semi-structured interviews . In keeping with the objective of the study and to help answer the main

⁷ The Canadian GHD Network was established in 2008 through the leadership of the Munk Centre for International Studies at the University of Toronto. The network supports the ‘individual, collaborative and interdisciplinary work on health diplomacy being carried out by scholars within Canada and their colleagues around the world.’ (62)

research question, state and non-state actors⁸ who had been directly involved in the process of the integration of health into foreign policy in each of the four countries were targeted for interviews. A total of twenty interviews were conducted, 14 for the UK case (seven with state actors and seven with non-state actors) and two each for the background cases (Norway: one state, one non-state; Brazil: two state; and Switzerland: one state and one non-state)(see Table 1).

Table 1: Summary description of sample

Country	Description of sample of interviewees
UK	--Seven participants who worked within Her Majesty's Government (HMG) including the Department of Health (DH), the Foreign and Commonwealth Office (FCO), the Department for International Development (DFID), the Ministry of Defense, the Health Protection Agency and the UK Collaborative on Development Sciences --One participant from the journal publishing sector --Three participants from academia --Two participants from research and policy think tanks --One participant from an NGO (Medact)
Switzerland	--One participant from academia and private consulting --One participant from the Swiss Division of International Affairs, Federal Office of Public Health
Norway	--One participant from academia --One participant from the Secretariat for Foreign Policy and Global Health Initiative, Ministry of Foreign Affairs
Brazil	--Two participants from FIOCRUZ Centre for Global Health, Brazilian Ministry of Health

The identification and selection of informants for each case began with preliminary discussions with pre-existing contacts in the international academic community of experts who focus on global health, globalization and health and global health diplomacy from which a list of potential informants was derived. Those who had been most closely and

⁸ In this project the term 'actors' is used to refer to both organizations and individuals.

directly involved in the development of the country level policies that integrate global health into foreign policy were recruited and interviewed first. Snowball sampling was used to identify additional interviewees. Overall, access to interviewees was not an issue; however repeated attempts to recruit politicians who had been involved in the endorsement and approval of the UK strategy for an interview were not successful.

Interviews took place between August 27, 2009 and March 24, 2010. Six of the interviews with UK informants were conducted in person in London and the rest of the interviews were conducted by telephone. Interviews lasted anywhere from 30 minutes to 1.5 hours. Interviewees were recruited using the recruitment letter (see Appendix B). Once a mutually convenient time for the interviews was established, interviewees were provided with the consent form (see Appendix C) and interview guide prior to the interview. Consent was obtained before the interview began. Interviews were audio-taped and then transcribed verbatim by a hired transcriber. Interviewees who had requested a copy of their verbatim transcripts were provided with a copy by e-mail and invited to comment and provide edits although none of the informants provided such feedback.

1.4.4 Data analysis

Overall, I followed a general inductive approach as described by Thomas to analyze the interview data. (67) In this approach, both the research objectives and questions (deductive) and multiple readings and interpretations of the raw data (inductive) guide data analysis. The main mode of analysis is the development of categories from the raw data into a framework or model that captures key themes and processes. (67)

Within the context of this overall method and in keeping with conventional approaches to systematic qualitative data analysis, interview data analysis encompassed three concurrent and iterative flows of activities: data reduction, data display and conclusion drawing/verification. (50;67-71)

First, I read the interview transcripts several times in detail making comments and notes in the margins that helped me to conduct a high level iterative comparison of the content across interviewees and to better understand how the data could be coded and categorized for further analysis. I then created a matrix to help display and categorize the interview data by using the main themes in the interview questions as descriptive, high level theme categories. In the matrix, the interviews were further categorized by country and then by type of interviewee. I then returned to the verbatim transcripts and cut and pasted responses falling within each theme area into the matrix, keeping track of any themes that had emerged from my initial careful reading of the transcripts that did not fit well within the matrix categories derived from the interview guide. Having reduced the data into the matrix format, I then created sub-codes of data within each general theme area and further synthesized data within these sub-codes and the main theme areas, resulting in a hierarchy of theme areas within each broad theme area. The policy analysis circle was used to help categorize the main themes into context, content, process, actors and indications of impact categories leading to a systematic presentation, discussion and analysis of both document review and interview findings within the heuristic device categories. Throughout the data analysis process, I remained very close to the data revisiting it frequently to validate and re-validate coding assumptions and interpretations.

I also used interviewee quotations extensively to support findings, analysis and conclusions.

As part of this process, I discussed and refined my approach in consultation with my thesis supervisor and with other researchers with expertise in qualitative interview data analysis. I also shared and received feedback on my approach and on the synthesized emerging interview findings with my thesis advisory committee. The interview findings from the UK case were also presented at two conferences⁹ to international audiences and feedback and perspectives on the findings sought as part of those presentations. Advice and viewpoints were incorporated where relevant considering the objectives and conceptual framework of this study to further refine the analysis and to help verify conclusions that I was drawing from the data. Throughout this process, I also iteratively triangulated the data with findings and conclusions drawn from the document analysis. As a final step in the analytical process, I analyzed the interview findings using the conceptual framework for the thesis and the arguments and evidence for the integration of health and foreign policy, both of which are detailed in the next chapter.

1.4.5 Ethics

I received ethics approval for this study from the University of Ottawa on May 21, 2009 (certificate number H03-09-04), which was renewed on an annual basis until the study was completed. The study was undertaken in full accordance with the University's ethical guidelines, including obtaining informed consent from each study participant, protecting the participants' anonymity and confidentiality through the assignment of unique

⁹ These conferences were the Canadian Conference on Global Health held from October 31 to November 3, 2010 in Ottawa (I presented on November 2) and the International Studies Association (ISA) Annual Conference held in Montreal from March 16-19, 2011 (I presented on March 16).

identifying numbers and by storing data (audio-taped and transcribed) in a locked cabinet and on computer backup files. Only my thesis advisor and I had access to the names of the study participants and the data.

1.5 Limitations

Limitations relevant to this project may include the following:

- Using interviews to gather data may have drawbacks. For example, the researcher's presence may bias responses and not all interviewees will be equally articulate, perceptive (50) or truthful. However, triangulation using both data from other interviews and from documentary sources aims to minimize the significance of these dynamics.
- Some might argue that the case study method is potentially limited because it might not lead to generalizable findings. (47) However, looking for multiple and rich sources of data and integrating triangulation strategies into the case study design can help ensure transferability¹⁰ of findings. Including almost equal numbers of state and non-state informants meant that multiple perspectives were obtained. This was particularly important as state actors tend to not be critical of government positions. This non-critical approach was balanced by input from non-state actors (e.g. academics, representatives of NGOs) who are in a position to speak more freely about government positions and provide critical feedback.
- Despite repeated attempts to do so, politicians who had been involved in the UK strategy and were ultimately responsible for approving it did not agree to be interviewed. Therefore, their perspectives are drawn from publicly available

¹⁰ In qualitative research it is argued that extrapolation or transferability of findings from one specific case to another is possible. Case to case transfer can be accomplished if the researcher provides sufficient detail about the circumstances of the situation or case that was studied so that users of the research can speculate about whether the findings are applicable to other cases with similar circumstances. (60;72)

documents including media releases and through information that interviewees provided.

- Despite repeated attempts to do so over several months, none of the policy specialists from the Department for International Development (DFID) would agree to be interviewed; however I was able to interview an individual from DFID's research division. This individual had been peripherally involved in the strategy process but was not one of the key/lead persons from DFID who had been involved in all discussions. Therefore, my knowledge of DFID's perspective was primarily based on this one informant's contributions, on perspectives from non-DFID interviewees and on relevant policy documents.
- Coding effectively can be challenging. Limitations include the tendency to think of coding as a mechanical, straight forward algorithmic process that ignores prior conceptual and theoretical underpinnings and the tendency to regard categories as fixed and unchanging. (60) To address these challenges, I frequently revisited the interview data in an iterative manner throughout the entire research process to arrive at a final set of themes and ways to categorize and analyze the themes in alignment with the study's theoretical framework and research questions. I aimed to do this as systematically as possible while remaining as open and flexible as possible to what the data was saying and meaning. I deliberately chose to manually code the data rather than using qualitative software to help me remain immersed in the interview data.

1.6 Reflexivity

Reflexivity refers to the process of critical self-reflection on the biases, theoretical predispositions, preferences and so on that a researcher brings to the research process.

(60)

Throughout the research process and particularly while interacting with interviewees I aimed to be fully self-aware and reflect on my role as a researcher in the process. I was also aware that my decade plus long experience with public sector policymaking processes as a public servant in a Canadian health research funding organization could influence the way in which I approached the interview process and could encompass both benefits and possible risks. For example, to a certain extent it could be like interacting with colleagues rather than conducting interviews. Moreover, there could be other professional knowledge and experience outside the scope of the research study *per se* that could inappropriately enter into the discussions. To address these possibilities, I consistently reminded myself that I was undertaking this study as a doctoral student and not as a professional public servant. This is also how I positioned myself with the interviewees. While my professional experience might have led to a greater degree of comfort in interacting with and understanding informant perspectives, it was secondary to my role as a researcher. This type of self-reflection helped me remain solidly in this role. It also led to my personal realization that in a way I was, to a certain degree, like an insider in the research process with pre-existing knowledge of the social world in which the actors came from. Rather than a detached spectator looking for cause and effect relationships, I was actually part of the social construction process and was playing a role through my interactions with informants in further elucidating the phenomenon of GHD.

1.7 Knowledge Translation Plan

Beyond sharing the final results of this research with the interviewees who were involved in the process, and over and above the research outputs that have already stemmed from

this work, (73;74), and in future academic publications, there could be other ways to share and discuss the findings with other potentially interested stakeholders. Fortunately, GHD related networks of academics, policy-decision makers and non-state actors have flourished over the last few years providing ideal mechanisms for sharing and disseminating the results. Therefore, part of the knowledge translation plan will include connecting with these networks for purposes of exploring their interest in the results (e.g. GHD-NET,¹¹ Chatham House,¹² Consortium for Global Health Diplomacy¹³). Building on recent GHD studies undertaken in Canada, sharing the results with Canadian stakeholders will also be timely and relevant. (78;79) Connections with potentially interested public servants in the Health Portfolio have already been established through related work that Ronald Labonté and I did for Health Canada in 2010. (80) Also, in light of the recently released Canadian Academy of Health Sciences (CAHS) report, *Canadians Making a Difference: The Expert Panel on Canada's Strategic Role in Global Health*, (28) I intend to share the results with CAHS. Students and trainees in interdisciplinary population and global health programs could be another potentially

¹¹As interest in global health diplomacy has grown over the last 20 years, networks such as Global Health Diplomacy (GHD)-NET coordinated through the Centre for Trade Policy and Law at Carleton University in Ottawa, Canada have emerged to link the academic community, health experts, foreign policy experts and practicing diplomats. GHD-NET's mission is 'to increase knowledge about GHD, improve training and education for those who engage in GHD, and innovate in the provision of advice into GHD processes.' (75)

¹² Chatham House, also known as the Royal Institute of International Affairs, was established in the 1920s and is based in London. It is an independent international affairs think-tank and membership organization. It was a partner in the creation of the UK strategy and is helping to implement it through its initiatives focused on global health security. (76)

¹³ The Consortium for Global Health Diplomacy, coordinated by the Graduate Institute in Geneva, Switzerland, links institutes and programs that work to develop an interdisciplinary approach to the interface of global health and foreign policy. The consortium aims to be a catalyst for the development and growth of such centres, institutes and programs, and networks around the world, in particular in developing countries and emerging economies. Members include the University of Ottawa's, Globalization and Health Equity Research Unit that Professor Ronald Labonté leads. (77)

interested audience. An important component of the knowledge translation plan will be to customize the way in which the results are presented and packaged for these different audiences so they are communicated based on audience preferences.

1.8 Overview of Chapters

Chapter two presents the conceptual framework used in this study for helping to understand how and why health is integrated into foreign policy. Chapter three summarizes evidence and arguments about health and foreign policy and global health diplomacy derived from the literature and document review.

Chapter four presents and discusses the three background country cases, Switzerland, Norway and Brazil, and concludes with a summary and analysis of findings to compare and contrast with those from the in-depth UK *Health is Global* case that follows in chapter five. Chapter six presents a discussion and analysis of the UK case as informed by the background cases, literature and document review and conceptual framework. This analysis leads to conclusions about the global health diplomacy process at the state level that aim to inform the practice of whole-of-government global health policymaking.

Chapter seven presents a summary of the contributions that this thesis makes to the global health diplomacy knowledge base, recommendations for future research directions in this area, and for policy and policymaking, with a focus on Canada, along with concluding perspectives on the study's theoretical frameworks.

Chapter 2: A conceptual framework for understanding how and why health is integrated into foreign policy

2.1 Introduction

This chapter presents the conceptual framework¹⁴ that underpins the objectives and research questions for this study and will also be used to analyze and interpret the findings. It begins with a review of key definitions and assumptions and then describes the two main theoretical frameworks, Fidler's health and foreign policy conceptualizations and Kingdon's Multiple Streams Model of the policy process that have been deemed to be most relevant to the elucidation of the central research question - how and why is health integrated into foreign policy.

2.2 Key Definitions and Assumptions

Globalization: As the literature highlights, contemporary globalization is a driving force behind the rise of global health as a foreign policy issue. Several informants also emphasized this point. *Health is Global* defines globalization as the 'widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life. These global processes are changing the nature of human interaction across a wide range of social sphere including the economic, political, cultural and environmental.'

(1)(p. 5) While multidimensional, contemporary globalization is fundamentally an economic process, characterized by the emergence of a global marketplace. (81)

Schrecker and Labonté identify the early 1970s as the beginning of contemporary globalization, when the 'world economic and geopolitical environment changed

¹⁴ The conceptual framework encompasses the key definitions and assumptions that underpin this study as well as the theoretical frameworks. This term is not being used interchangeably with 'theoretical framework' but rather is an umbrella term that includes the theoretical frameworks.

decisively’ as a result of the first oil crisis. (82;83) Globalization is driving a world system comprising national economies and societies that are increasingly influenced by factors outside their borders. (81) While potentially beneficial for some, in its current form globalization is a force that can exacerbate global health inequities. (81;84)

Global health governance: The Globalization and Health Network of the WHO Commission on SDH’s definition of global governance has been adopted for this study: global governance is the ‘complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens and organizations, both inter-and non-governmental, through which collective interests on the global plane are articulated, rights and obligations are established, and differences are mediated.’ (83)(p. 74) States hold formal power in international relations; however, globalization is creating changes in the number and importance of state, private sector and civil society actors involved in global governance. (83;85) Global health governance and global health diplomacy are closely linked phenomena. (22) Diplomacy is a process through which actors in international relations distill, articulate and negotiate their interests. It provides a way for common interests to be translated and sustained into and through governance strategies and mechanism. (19) Governance ‘settles’ diplomacy in an area into agreed patterns and provides for more consistency and predictability in how actors work together on global health issues. (19)

Global health: Global health refers to health issues that transcend the territorial boundaries of states and are therefore beyond the capacity of individual countries to

address through domestic policies alone: ‘Global health recognizes that health is determined by problems, issues and concerns that transcend national boundaries.’ (1)(p. 5) Global health ‘places a priority on improving health and achieving equity in health for people worldwide’ and emphasizes ‘transnational health issues, determinants, and solutions; involves many disciplines beyond health sciences and promotes interdisciplinary collaboration.’ (86)

Definitions and understandings about global health from informants ranged from global health as primarily about diseases that cross borders and “all about global health security”¹⁵ to those who argued that global health was “more than global health security” and included social determinants of health. One described global health as broader than “just the health sector” and “more than health services.” In line with Koplan’s definition, some informants also described global health as a “collective responsibility” starting with “health needs and not thinking about borders” and “the single uniting force globally.” A few others emphasized that perspectives on global health depend on “where you are situated” (i.e. in which government department) and on shifting government priorities. Several acknowledged that global health is often used as a tool or a means to achieve other foreign policy objectives. In their recent paper, Feldbaum and Michaud highlight this point. They argue that foreign policy interests drive global health issues and that state and non-state actors alike are increasingly using health interventions as a way to achieve non-health goals. (29) Finally, several interviewees raised the idea that global health now involves a diverse array of state and non-state actors.

¹⁵ Interview data used throughout this thesis are distinguished from literature citations through use of double quotes, or italicized and indented for longer passages.

Global health diplomacy (GHD): In this study, and following Fidler, (19) GHD is defined for descriptive and analytical purposes by breaking down this concept into its three component parts. Using this approach ‘global’ involves actors from across the public, private and civil society sectors who engage in international or multilateral policy processes, ‘health’ encompasses problems that involve the protection or promotion of human health (i.e. public health) and also the SDH or the ‘links between the social determinants of health anywhere in the world,’ (87) and ‘diplomacy’ refers to the process in which state and non-state actors interact in articulating, advocating for and defending their interests on health-related matters. As one informant put it, GHD is “about ways of working together” that should focus on “doing less bad and more good.” As Fidler writes, ‘how health gets configured into existing interests and advanced vis-à-vis other actors in global politics is the very stuff of diplomacy traditionally understood.’ (19)(p.7) As a whole, ‘global health diplomacy’ aims to capture the ‘multi-level and multi actor negotiation processes that shape and manage the global policy environment for health.’ (22)(p.1) More specifically, GHD refers to ‘policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives.’ (25)(p. 10) (88) Several interviewees reflected on this notion that GHD is used to help achieve other objectives and not necessarily global health itself. As one said, “there will always be tensions within government policy about promoting health using health for diplomatic ends and other short-term and economic gains, which may, in fact even damage health.” Another asserted that GHD is the:

integration of health into foreign policy where countries use global health as an instrument to not just achieve development ends, but also to advance their own political agendas, which may involve getting trade-offs on certain health initiatives. For example, the Cubans have used health for many years as a way of achieving some political ends.

A few other noteworthy perspectives on GHD from informants provided insight into how GHD works in practice. Some noted that diplomacy is still largely regarded as an “official activity” and part of nation states “being strategic.” As one academic observed, nation states are still the main players and diplomacy is driven by “state-centric drivers” (e.g. trade, migration). Another noted that GHD is “not necessarily cooperative” and is primarily a way to further individual actors’ own agendas. Some state actors focused on GHD within the government context and reflected that GHD is “a way to understand interdependencies within government” and “a process to bring different departments together all with widely differing incentives to be involved.”

Fidler highlights that GHD often becomes an interchangeable term for global health governance or global health politics, which leads to confusion, particularly when trying to conduct research and analysis focused on GHD. (19) As already noted, diplomacy is a process through which actors negotiate their interests in political interactions and when interests converge, collective action may result. Through governance, politics and diplomacy settle into agreed patterns and structures (19) that govern how actors work together both diplomatically and politically. The boundaries between these entities are porous reflecting their mutual relationships and interdependency. ‘Politics continues simultaneously with diplomacy and governance, and diplomacy continues to support the functioning of governance mechanisms once established.’ (19)(p.5)

Actors in global health diplomacy: This study defines state actors as elected officials and senior public servants who make policy decisions and determine government strategy, as well as individuals who are involved in the policy process but are not necessarily responsible for making policy decisions, such as government policy analysts and advisors. Several informants highlighted that government actors primarily include those from departments of foreign affairs, development and health, though others also acknowledged that the focus on security has brought departments of defense into the GHD arena. A distinguishing feature of GHD, as compared to more traditional forms of international health diplomacy (described in the next chapter), is that in addition to state actors it involves a diverse array of non-state actors, including national and international non-governmental organizations, international institutions (e.g. WHO), transnational corporations and networks that link actors such as epistemic communities. (38) Several informants commented on their governments' engagement with WHO as a key part of their GHD processes. One, in particular, noted that as the power shifts in global health, "with the G20¹⁶ and the rest" the agenda is being "pushed by actors other than traditional representatives of health ministries or traditional diplomats from foreign ministries." Such powerful actors now include philanthropic foundations though, interestingly, informants made minimal reference to such foundations *per se* (e.g. The Bill and Melinda Gates Foundation) or to their increasingly powerful role in global health. Fidler describes

¹⁶ The Group of Twenty, or G20, brings together the world's major advanced and emerging economies and is a forum for international cooperation on the important aspects of the international economic and financial agenda. The G20 includes 19 country members and the European Union, that all together represent around 90% of global GDP, 80% of global trade, and two thirds of the world's population. The objectives of the G20 are: policy coordination between its members in order to achieve global economic stability, sustainable growth; to promote financial regulations that reduce risks and prevent future financial crises; and to create a new international financial architecture. (89)

the impact of such organizations on global health and GHD as ‘profound’ because of the new financial resources they have contributed to multiple health problems. (4;14)

The role of epistemic communities as policy influencers appears to be particularly relevant in the context of this study since global health knowledge is often highly technical and specialized. According to Haas, an epistemic community is a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain. (90) These experts share common norms, beliefs and notions of what makes knowledge valid. As providers of expert information and advice within the context of increasing demands for such information, these communities of actors can become influential and sought after players in the global health policymaking process. As recognized authorities in a knowledge area, they may also circumscribe the limits of permissible discourse to that which they believe to be legitimate and scientific to the exclusion of other possible points of view. (90) As described in upcoming chapters, an emerging epistemic community was first germinated by the UK’s Nuffield Trust¹⁷ in the late 90s and played a significant role in catalyzing attention to GHD. As GHD gained momentum, several networks of members of the global health epistemic community have emerged including the Consortium for Global Health Diplomacy (77) and the Global Health Diplomacy Network (GHD-NET). (75) Of

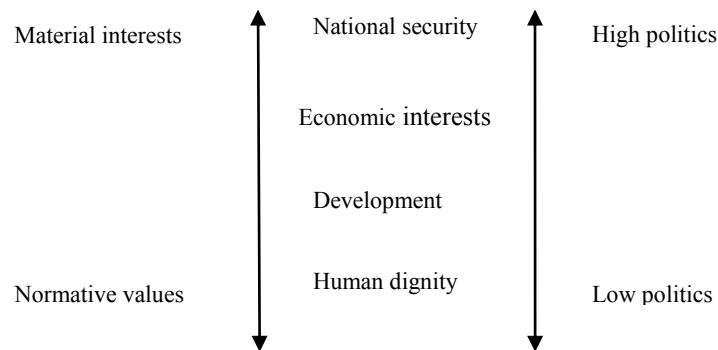
¹⁷ Viscount Nuffield (William Morris) the founder of Morris Motors established the Nuffield Trust in 1940. The Nuffield Trust is described as an independent source of evidence-based research and policy analysis for improving health care in the UK. It conducts research and analysis, informs and generates debate, supports leaders, and examines international best practice. (91) Just over half (~53%) of its annual budget is funded through income generated from an endowment set up in 1940. The bulk of the remaining budget is generated through projects funded primarily by public sector organizations such as the UK’s Department of Health and the National Institute for Health Research Services Delivery and Organization programme. About 2% of the budget is generated from private, public and civil sector sponsors. The Nuffield Trust will only engage in work that aligns with its primarily charitable purpose in accordance with its policy on ethical collaboration. (91)

note, none of the interviewees referred to epistemic communities *per se* in their responses but a few used the term “policy community”¹⁸ to describe networks of stakeholders focused on global health.

Foreign policy: As previously noted, foreign policy involves a variety of government departments with direct interest in global policy and frames how a nation will interact with other nations and non-state actors in the global community. The four basic functions of foreign policy are generally defined as: ensure national security; contribute to economic power and prosperity by promoting international trade and investment; support order and stability in countries and regions important to a nation’s security and economic interests; and promote and protect human dignity (human rights and humanitarian assistance). (57;92) According to Fidler, experts in foreign policy and international relations frequently discuss these functions within a hierarchy of objectives for foreign policy from high politics to low politics as depicted in Figure 2. Traditionally health has been categorized as low politics because health activities were perceived as technical, scientific, non-political and humanitarian endeavours not connected to the high politics of foreign policy. Health was perceived as gravitating toward normative values concerned with human dignity, and having less relevance to the state’s pursuit of its material interests, power and security. (57) This positioning appears to have changed recently, as discussed in more detail in the section on theoretical frameworks.

¹⁸ Members of epistemic communities may be part of what Kingdon refers to as policy communities. Policy communities are composed of specialists in a given policy area, such as health. Such specialists are scattered both in and outside government and include public servants, academics, consultants, think tanks, etc. Often they are well connected with each other through networks. (56) A common focus on one policy area defines a policy community. Within such communities it is possible, as the interview data analysis highlights, that there may be members of two or more epistemic communities with competing, even conflicting world views, e.g. those who think of global health primarily as an investment opportunity and others who define it within a health equity paradigm.

Figure 2: Hierarchy of foreign policy objectives (92)



Policy coherence/whole-of-government approach: The proposal that argued for the development of the UK's *Health is Global* strategy describes this strategy as a government wide or whole-of-government global strategy (also referred to by some as 'joined-up-government'). (93) Such strategies aim to achieve horizontal and vertical coordination in order to reduce situations in which government policies undermine each other. They promote policy coherence across government priorities, particularly in policy areas that straddle the boundaries of different government departments, agencies and policy foci such as health. (94) Another whole-of-government policy objective is to make better use of scarce resources and create synergies by bringing together different stakeholders in a particular policy area. (94) The whole-of-government approach has been popular in the UK and Australia for some time. (94;95) More recently, a United States (US) committee examining that country's commitment to global health has recommended a similarly government-wide coherent strategy for global health in that country. (3;96;97) Another example of a call for 'joined-up leadership' across government when it comes to health is embodied in the Adelaide Statement on Health in All Policies released by the WHO in 2010 at the International Meeting on Health in All

Policies held in Adelaide, Australia. (98) This statement emphasizes the ‘need for joined-up government’ to effectively develop and implement interdependent public policy across government departments through mechanisms such as ‘strategic plans that set out common goals, integrated responses and increased accountability.’ (98) These processes, it is argued, should ideally be undertaken in partnership with civil society and the private sector. (98) The WHO background report for the October 2011 World Conference on the Social Determinants of Health also refers to the whole-of- government approach as an important way in which health can be integrated across relevant government departments and priorities areas. (99) Kickbusch argues strongly for such an approach stating that ‘health ministers should insist on intersectoral mechanisms that create coherent policy between government departments. National strategies...set out the values and priorities for global health action and establish mechanisms for cooperation.’ (100) (p. 2)

Public policy and the policy process: The UK *Health is Global* strategy is a government policy (i.e. a public policy) that aims to guide the UK’s strategic actions, investments, programs and diplomatic activities and processes related to global health. (1) As one interviewee put it, “it is partly policy, partly strategy, partly statement of intent.”

Klein and Marmor define *public policy* as ‘what governments do and neglect to do. It is about politics, resolving (or at least attenuating) conflicts about resources, rights and morals.’ (101)(p. 890) The *public policy process*, in turn, is usually considered to include the following stages: agenda setting and specification of alternatives from which a policy choice is to be made; policy formulation; policy implementation and policy evaluation.

(53;56;102;103) While the linearity assumed in this model does not necessarily exist in reality, the model provides a useful way of conceptualizing the entire process. This study is primarily concerned with the first two components of this process: agenda setting and specification of policy alternatives, and policy formulation. Agenda setting is described as the issue sorting stage when issues rise to the attention of state actors. At the policy formulation stage, state actors design policies. (53;56;58;103)

2.3 Theoretical Frameworks

Two main theoretical frameworks underpin this research project: Fidler's health and foreign policy conceptualizations (the term that Fidler uses to describe them) and Kingdon's Multiple Streams Model of Policymaking. Taken together, these frameworks provide a useful mechanism for analyzing and interpreting the study findings and arriving at conclusions in light of the main research question: how and why is health integrated into foreign policy? As a starting point for the descriptions of the frameworks that follow, it is important to bear in mind that little theoretical work has been undertaken in terms of health as an issue in international relations. Fidler highlights that historically international relations theorists have shown little interest in health and health scholars and practitioners have not been engaged with international relations theory, concluding that there is scant theoretical literature to draw on in thinking about the conceptual and theoretical aspects of GHD. (57) This observation lends support for the importance of undertaking this particular research study, which aims to contribute to a conceptual and theoretical understanding of GHD.

2.3.1 Fidler's health and foreign policy conceptualizations: revolution, remediation, regression

Of the literature reviewed for this proposal, Fidler provides the most extensive and in-depth discussion of the conceptual and theoretical underpinnings of global health diplomacy and the relationship between health and foreign policy. The usefulness of these conceptualizations as analytical and explanatory devices is reflected in their recent application by scholars writing on GHD and the integration of health and foreign policy. In two papers published in 2010, Feldbaum and colleagues used Fidler's three concepts to help elucidate why states incorporate global health into their foreign policy agendas and the relationship between global health and foreign policy. (29;65) Similarly, Labonté and Gagnon refer to the three conceptualizations to help clarify global health's rise in foreign policy prominence. (73)

International relations theory¹⁹

Fidler's conceptualizations are grounded in international relations theory. (19) The discipline of international relations is concerned with the interaction and role of state and non-state actors in international politics. (19;104;105) According to some, the concept of anarchy is central to understanding international relations and the diplomatic process. In the international political context anarchy means that the players in the system do not recognize any common superior authority. (19;104) The main international relations theories - realism, institutionalism, liberalism and social constructivism - aim to help explain the impact of anarchy on state and non-state actors and thereby shed light on the

¹⁹ This thesis is not designed to shed any light on the merits of the different broad theories of international relations briefly presented here; rather this description has been included in the conceptual framework because the theories underpin Fidler's conceptualizations, and as such, implicitly inform a deeper understanding of this project's findings based on Fidler's model. In particular, Fidler argues that 'revolution' can be loosely aligned with social constructivism and 'remediation' with realism. Moreover, institutionalism can potentially shed light on the role of institutional actors, such as the WHO, in GHD, and liberalism on the importance of economic globalization as a contextual variable.

behaviours of state actors when considering the integration of health into foreign policy.
(59;104;105)

Realists argue that in anarchy states are necessarily the primary actors, which forces them to act in a calculating, self-interested way. (104) Anarchy creates an environment in which mistrust undermines inter-state cooperation and is governed through the balance of power between and amongst state actors. Diplomacy is an instrument in pursuit of power, survival and self-interest. (19) Like realists, institutionalists accept that anarchy makes states the primary actors. (9) However, international institutions can help states cooperate to achieve better outcomes. Diplomacy may be primarily an instrument in the pursuit of power and self-interest but it also involves institutional actors that can modify anarchy sufficiently to allow states to better cooperate. (105) Neither of these theories considers non-state actors as relevant to international relations. (19)

In contrast to both realism and institutionalism, liberalism holds that individuals and non-state groups are the primary actors in international relations. (105) For liberals, two issues dominate: the protection of individual rights and the existence of democratic governments. Individual and non-state actors are seen as driving state behaviour in anarchy to achieve the proliferation of economically interdependent democracies. (19;104;105) Common interests articulated through diplomatic processes are only undertaken and considered if they help achieve this goal.

The fourth theory, social constructivism, appears highly relevant to the collective action element that underpins the GHD ideal and the importance of including a multiplicity of actors in the process. This theory argues that reality is socially constructed and therefore anarchy is what state and non-state actors make of it. (19) The very process of interacting and sharing ideas can influence how state and non-state actors formulate their political preferences and self-interests. There is no objective international world outside the practices and institutions that states and non-state actors arrange for themselves. (104) Therefore, diplomatic processes become the means by which actors intersubjectively construct and express their ideas, interests and identities.

Health and foreign policy conceptualizations

The distinction between high and low politics in foreign policy has already been referred to, along with a description of the four functions of foreign policy. According to Fidler, these four functions can be used to analyze health's rise as a foreign policy issue. (57;92)

Overall, health's new prominence in foreign policy as demonstrated in the UK strategy and that of other countries reflects the movement of health from the margins of low politics into a situation in which health features significantly in all four foreign policy functions. The discursive framing of global health (i.e. health as security, development, human right, commodity and global public good, described later), and other bodies of literature that analyze health's relation to national security, globalization and the protection and promotion of human dignity, support the claim that health is figuring more prominently across foreign policy priority areas. (38;73;81) These developments signify the movement of health from low to high politics, but understanding what this means for

health and foreign policy, and how health is positioned and understood within foreign policy, remains unclear. Fidler proposes three conceptualizations to clarify and explain this phenomenon further that can be applied as a framework to help understand why the UK and other countries' global health strategies were developed, and how health is positioned within these strategies.

The first conceptualization is 'revolution.' This perspective argues that health's increasing role in foreign policy is transformative of the health-foreign policy nexus. Health collapses the traditional distinction between high and low politics and provides new political space in which health is an overriding normative value and the ultimate goal of foreign policy. (21;57;106) Health is broadly perceived as more than the absence of disease, encompassing as well the social determinants of health. (92)

The scope of foreign policy is argued to extend beyond traditional preoccupations with military and economic power. Health and health equity become pre-eminent political values for the 21st century. (92) This theory is consistent with health discourses that focus on health as a human right and the 'health for all' ideal. (107-109)

The second conceptualization 'remediation' asserts that health's rise as a foreign policy issue reflects the continued persistence of the traditional hierarchy of foreign policy functions. (92) Health has become another issue that needs to be addressed through traditional approaches to foreign policy, or as a strategic vehicle through which traditional foreign policy 'high politics' goals can be achieved. As Fidler notes, foreign

policy's attention on health actions is highly elastic, focused when disease crises appear and fading when crises drop from the political spotlight. Such elasticity makes health-centred issues highly vulnerable to subordination or marginalization by other non-health problems or crises that flare up.(11;27) Within this context, health is not a factor that transforms thinking and is not an overriding norm that states believe in and desire to adhere to. It has risen as a foreign policy issue because it impacts on the high politics of foreign policy and threatens the material interest and capabilities of the state. (57) Health is only about communicable diseases and attention paid to it is primarily crisis driven. (11) It is not about upstream determinants of health; and the target of foreign policy is not health but mitigating risks and costs of certain infectious disease burdens in other countries. (57) As Fidler notes, 'but for the global ravages of HIV/AIDS, the fear produced by SARS,²⁰ the framing of tobacco-and obesity-related diseases as pandemics, and the panic associated with the emergence of pandemic influenza, health would not have its present foreign policy prominence.' (7)(p. 11) When improving health or health systems in foreign countries is an intended consequence of foreign policy action, the strategic objective is usually something other than health in keeping with the traditionally narrow view of foreign policy. Health is merely a tool, an instrument of statecraft that serves the material interests of the state. The remediation perspective may acknowledge health's 'escape' from the domain of low politics but interprets this as health becoming another issue like others that foreign policymakers need to grapple with. (92) The continued application of the traditional framework for foreign policy remedies the mistaken notion that health has a special place in international relations. (92) This conceptualization appears to resonate with health discourses that focus on health as

²⁰ SARS is the acronym for severe acute respiratory syndrome.

security, the dominant global health discourse of the past decade, and health as a commodity, which focuses on the potential economic impacts of investments in health products and services. It is also consistent with the realist theory of international relations in which states necessarily act in their own self-interest in the international arena in keeping with the traditional functions of foreign policy. Of the three models, Feldbaum et al. and Labonté and Gagnon argue that remediation provides the strongest explanation for why health has risen as a foreign policy issue. (29;65;73)

‘Regression’ is the third of Fidler’s models. This model views health’s integration into foreign policy as a regressive development; in other words, as an indicator that health problems are getting worse. (92) The increasing attention paid to health across the functions of foreign policy signifies the failure of public health efforts and ‘regression.’ Connecting health to high politics threatens to tarnish long-standing associations of health with normative values. (92) So public health’s wish for health to become more politically prominent may have come true but in a way that threatens what was special about health in international relations in the first place. For example, while the inclusion of health across several of the Millennium Development Goals (MDGs) vindicates the rise of health in the development agenda, (15) a failure to meet these health equity goals could signify the failure of the effective integration of health into foreign policy or another sign of regression.

An important issue that Fidler raises is the role of science and epidemiological evidence in GHD. Regardless of political and economic considerations and which of his three

conceptualizations resonates best in reality, foreign policy decision makers are also often confronted with scientific evidence about health threats when making policy decisions, which may require public acceptance, rejection or avoidance of engaging with such evidence, and the potential political risks this might entail. Such evidence was instrumental in the development of the MDGs and other policy statements that apply globally, such as the Framework Convention on Tobacco Control. (110;111) Scientific evidence also appears to have played a key role in the development of the UK *Health is Global* strategy, which includes a discussion of the evidence base behind the strategy and which involved stakeholders from the scientific community, such as those from the London School of Hygiene and Tropical Medicine. (1) As Feldbaum et al. write, an emphasis on health scientific evidence in global health policymaking does not discount that state interest drives foreign policy, but it does recognize that the influence can run both ways. (57;65) The role of science in the development of policy related to global health means that the disparate worlds of policy and science need to interact, understand each other and speak the same language, which is a key challenge underpinning the development of evidence-based (or what is now more aptly called evidence-informed) policy. (103;112;113) Therefore, another factor that this study explores is the potential influencing role that scientific evidence and the health research community play in the development of the state level policies.

2.3.2 The Multiple Streams Model of Policymaking

Health as a foreign policy issue competes for attention among many other such issues including prominent global issues such as climate change and economic crisis. (7) While there is no shortage of theories of the policy process that can help explain how and why health might rise on the policy agenda at any given time, Kingdon's Multiple Streams Model will be used in this study to analyze this phenomenon, for a number of reasons (see Figure 3).²¹ (58;59) First, this is an evidence-informed model grounded in hundreds of interviews conducted over several years with both state and non state actors involved in policymaking in the United States (US). (56) Second, the model focuses on understanding why some topics become prominent on the policy agenda and others do not, and why some alternatives for choice are seriously considered while others are neglected (i.e. on the agenda setting and policy formulation stages of the policy process that are the foci of this study). Third, with a focus on actors, process, policy content and contextual factors, the model coheres well with the other frameworks used in this study (Fidler's conceptualizations and the adapted Walt and Gilson policy analysis triangle), both of which have been applied in empirical studies similar to the one undertaken for this thesis. Fourth, the model provides a framework within which theories, frameworks and concepts related to the importance of the framing of issues in policy discourse and the role of influential actors in the process (73;114-119) can be incorporated, in particular, as elements within the model's policy stream. Fifth, the model is consistent with my own personal experience with the policymaking process at the federal level in Canada. Finally, Tomlin, Hillmer and Hampson have adopted Kingdon's model for their

²¹ In particular, Kingdon's model is used in this study to emphasize the importance of framing, timing and especially leadership in the policymaking process.

analysis of Canada's international policies because it is more comprehensive than others (e.g. advocacy coalition and punctuated equilibrium models)²² and subsumes the concepts of these other two models in its theoretical structure. (59)

According to Kingdon the policy selection process resembles biological natural selection.

(59) Ideas float around in policy communities, are softened up and may be combined with others in various ways. The 'soup' of ideas changes through the appearance of wholly new elements and also by the recombination of existing elements. (59) While ideas float around, systematic indicators (e.g. surveillance data about the growing incidence and prevalence of a disease in a population), 'focusing events' such as crises and disasters and/or feedback pertaining to the implementation of current government programs, allow some to attract the attention of policy and decision makers. (56) In this 'evolutionary' process, completely new ideas do not suddenly appear and get adopted; rather ideas float freely and are debated and framed by the community of specialists (i.e. policy community) who attempt to persuade one another while advocates of particular solutions act as policy entrepreneurs, attempting to soften up who needs to be persuaded. (59) Policy entrepreneurs are not necessarily found in any one location in a policy community. They could be inside or outside of government, in elected or appointed positions, in interest groups or research organizations. But, like business entrepreneurs

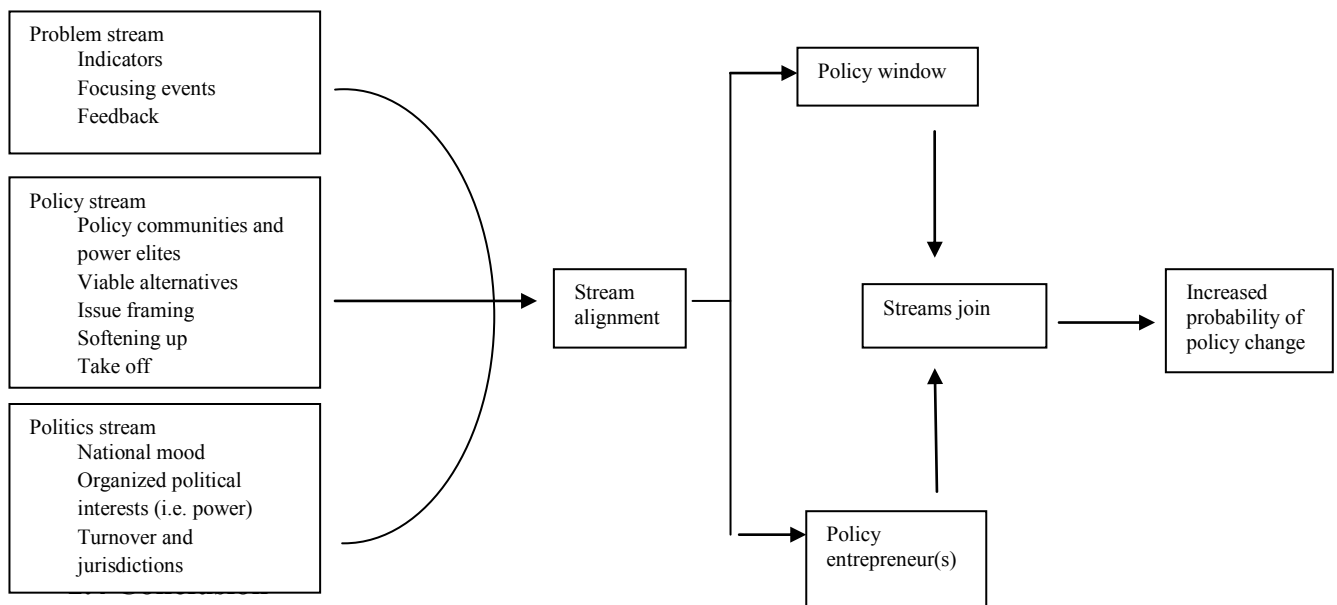
²² In the advocacy coalition model, actors in policy subsystems join together in advocacy coalitions based on their shared knowledge of a problem and their common interest in pursuing certain solutions. (59) In Kingdon's model, such coalitions would be examples of policy entrepreneurs. The punctuated equilibrium model of agenda change is based on the premise that rather than changing gradually over time substantive policy shifts occur rapidly from one stable point to another. Many policy ideas circulate in policy subsystems competing for attention but once an idea gets attention, policy change is rapid. This occurs more frequently in response to external events that disturb the equilibrium of the political system. (59) This idea of rapid change fits within Kingdon's model as a part of the explanation behind rapid change that can occur when streams align and policy windows open.

their one defining characteristic is that they are willing to invest their resources - time, energy, reputation - in the hope for a future return, such as a policy that they support. Kingdon describes them as central figures in the policy process with three sets of qualities: 1) some 'claim to a hearing' such as expertise or an authoritative decision-making position; 2) is known for his/her political connection or negotiating skill; and 3) is tenacious and persistence. (56)

Through the efforts and influence of policy communities and entrepreneurs, when a particular idea catches on, a tipping point is reached, the idea takes off and a bandwagon effect secures its adoption. (59) This process is conceived of consisting of three separate streams of activity - problem identification or recognition (i.e. the problem stream), policy alternatives generation (i.e. the policy stream), and politics (i.e. the politics stream that includes swings in national mood, administration or legislative turnover, interest group pressure etc.) - that flow through and around decision structures, largely independent of one another. (56;59) At a certain time the three streams come together and at that juncture major policy change can occur. At these points policy windows (defined as opportunities for policy entrepreneurs to advocate for particular proposals or conceptions of problems) are opened either by the appearance of compelling problems or because of political will (e.g. strong and organized political interests all pointing in the same direction). (59) The importance of time and timing in the policymaking process are critically important elements of Kingdon's model. 'Who pays attention to what and when' (120) and how time is managed is fundamental to the policymaking process and underpins the model.

Research questions that can be derived from this framework include those focused on the actors involved in the policy process, among others. This framework also promotes the exploration of other problems and alternative solutions that may have confronted policymakers and influenced their decision to focus on global health in foreign policy. Understanding how a focus on health was weighed and positioned in this process can strengthen the understanding of how and why it received attention in the first place and what tactics policy entrepreneurs used to attract such attention. This knowledge could be useful to state actors in other contexts who are attempting to derive similar policy directions. A focus on politics is also highly important.

**Figure 3: A Multiple Streams Model of Policymaking
(adapted from Tomlin, Hillmer & Hampson, 2008)(59)**



2.4 Conclusion

This chapter presented the key definitions, assumptions and theoretical frameworks that underpin the interpretation of findings, discussion, analysis and conclusions. The incorporation of both Fidler's conceptualizations and Kingdon's Multiple Streams Model aims to add theoretical richness to the thesis, as well as a theoretical approach that could potentially be used in similar GHD-related research studies.

Chapter 3: Health and Foreign Policy - The Arguments and the Evidence

3.1 Introduction

This chapter presents a summary of current understandings of the phenomenon of global health diplomacy and then a summary of the literature pertinent to the main research question - how and why health is integrated into foreign policy. In addition to the conceptual framework, main conclusions drawn from this review underpin the interpretation, analysis and discussion of the findings.

3.2 Global Health Diplomacy

Health diplomacy is not a new phenomenon. International cooperation directed at controlling global risks to health began in the mid-19th century when European nations gathered for the first International European Conference to discuss cooperation on cholera, plague and yellow fever. (121) At that time, national policies were insufficient to prevent the spread of transborder diseases and caught European nations off-guard. (121) Cooperation with other nations and the development of agreed upon international policies to govern the spread of infectious diseases were required. Over the next 100 years international cooperation directed at preventing and controlling disease evolved significantly culminating in the establishment of the World Health Organization (WHO) and the International Sanitary Regulations in 1951. (121;122) Since that time, coinciding with contemporary globalization and what some refer to as a revolution in global health, particularly over the last decade or so, discussions have evolved from those about international health and international health diplomacy to those about global health and global health diplomacy. (9;123-127)

This new policy realm is characterized by not only the involvement of state actors, but also the complex interplay of state and non-state actors from public, private and civil society sectors as well as combinations thereof, such as private-public partnerships. (38;83;84;125) The involvement of multiple actors and a focus on understanding and addressing the SDH at the global level to improve health outcomes has led to calls for new forms of global health governance. (10;31;38;46;83-85;125;128-131)

Global health diplomacy, which can potentially lead to these new forms of governance or even be understood as one of these new forms, has emerged within the context just described. It is receiving significant attention from the WHO and a growing number of scholars from across disciplines including health, international relations and law (19;21-23;132), many of whom are now part of global networks, such as Global Health Diplomacy Network (75) and the Consortium for Global Health Diplomacy. (4;77) A few academic training programs that focus on GHD have also been established. (21;22;133) One of the main catalysts for this increasing attention has been what Fidler refers to as the global health political revolution that has taken place over the last 15 years. (9;57) This revolution, albeit one that may now be attracting less attention in the fallout of the 2008 global financial crisis, (27;134) was driven largely by the increasing threat of global infectious diseases and bioterrorism, has given health a more prominent position in foreign policy and diplomatic processes. However, other normative and political forces have also moved health further up global policy agendas, including efforts framed variously as health as a means to development (embodied in the MDGs), strengthening global public goods for health or promoting health as a human right, the latter frequently

forming the advocacy positions of global civil society organizations. (93;107;135) The growing interest in the SDH and the WHO's strong evidence-based call for global action to address the SDH to improve global health equity also appears to be strengthening the focus on health in international relations. (9;10;38;83;136)

While a clear and consistent definition of GHD is difficult to find in the literature and little empirical research has been undertaken that focuses on this phenomenon *per se*, the concept is closely linked to the integration of health into foreign policy. (7;23) Foreign policy is the mechanism that outlines how and why a nation will interact with others in the international arena and diplomacy provides the means by which actors translate and sustain their common interests through governance strategies and mechanisms. (19;104) In this sense, diplomacy is a mechanism that facilitates the development and implementation of a nation's foreign policy. As well, once established, a nation's foreign policy frames diplomatic discussion and practices. Health in foreign policy is an example of a country level outcome that can result from global health diplomacy processes and, once in place, guide and frame such processes and resulting country level policy directions.

3.3 The Integration of Health and Foreign Policy: Background and Overview of the Evidence

Health's rise as a foreign policy issue has been apparent in the proliferation of literature published in this area over the last decade and in particular, over the last few years. In 2007 an issue of the *Bulletin of the World Health Organization* focused on GHD and health and foreign policy (64) and a new publication of Carleton University's Norman

Paterson School of International Affairs entitled *Health and Foreign Policy Bulletin* was launched the same year. (33) In late 2009 a special issue of Canadian Foreign Policy was published focusing on global health and foreign policy (66) and in spring 2010 a series of articles in PLoS Medicine were devoted to this issue (63) and the Centre for Trade Policy and Law located at Carleton University in Ottawa launched the Health Diplomacy Monitor ‘to help policymakers keep pace,’ with the ‘multiplication of international negotiations related to global health.’ (137) As well, upon the UN’s request following acceptance of resolution 63/33, the WHO prepared a comprehensive report discussing challenges, activities and initiatives related to foreign policy and global health. (4) These publications add to the literature of the last decade devoted to debating and analyzing the integration of health into foreign policy as a phenomenon *per se* and also on substantive issues within this context such as health systems, health impact assessment and infectious disease. (32;33;38;64;100;105;135;138-142)

While scholarly writing focused on this issue is increasing in volume, very little of it has been based on primary empirical research. The synthesis and critical analysis of important arguments, ideas and concepts in the existing literature nonetheless sheds significant light on how and why health is integrated into foreign policy.

A few relevant health and foreign policy country case studies in the literature appeared to incorporate primarily secondary data and historical analysis as research methods. One study that focused on Malaysia aimed to elucidate how health is positioned in foreign policies in that country. (143) In a second noteworthy study commissioned by the

Nuffield Trust, three policy areas in the UK from 1997-2005 were examined: infectious disease, HIV/AIDS and tobacco control. (138) Through these case studies, McInnes found that public health was not a dominant driver in the policymaking process, that the role of non-state actors did not figure prominently in the process and where a clear national interest could be articulated, this tended to take precedence over other concerns. (138) Nixon's doctoral thesis, which examined Canada's international response to HIV/AIDS, used primary research methods to gauge Canadian policymakers' attitudes towards Canada's role in addressing this global health issue. (144) Through interviews, Nixon found that policymakers' attitudes included both the need to 'do the right thing' and the need to act in Canada's self-interest, with little indication of how decisions would be made if or when a conflict between the two arose. (144) These findings highlight the potentially contradictory motivations behind integrating health into foreign policymaking and the challenges that this aim might pose for state actors. (107) On the one hand, as conveyed by the Canadians in Nixon's study, the duty of the state is seen as acting in its own self-interest to protect its citizens from harm, while on the other, engaging in what is now referred to as GHD calls for a broader framing of interests with respect to global health equity. Feldbaum's doctoral thesis incorporated similar methods to Nixon's, including interviews with policymakers, to construct a history of the HIV/AIDS-national security nexus. In his study, Feldbaum found that where policymakers framed HIV/AIDS as a direct threat to national security and prioritized the disease as an issue of high politics, high-level political attention and resources for HIV/AIDS followed. (145) Feldbaum's work is also relevant to this thesis as Feldbaum uses his findings to assess the relevance of Fidler's conceptualizations. His study concludes that the evidence gathered

strongly supports the remediation and not the revolution or regression models. HIV/AIDS received attention because it was perceived as a threat to the security and strategic interests of the states that were included in the study as case examples. (145)

Another area of literature that is relevant to this discussion addresses trade and health. Blouin, Heymann and Drager's edited book, *Trade and Health: Seeking Common Ground*, provides a descriptive, analytical and conceptual look at actors, experiences, policies and processes related to the integration of health into trade policy. (146) This global issue has risen in saliency over the last decade and in May 2006 the WHO's World Health Assembly adopted a resolution calling for coherence in trade and health policies. (146) Using primarily secondary data analysis, individual chapters cover topics such as trade and the SDH and efforts to achieve coherence between trade and health policies at the country level. (146) The book's summary of tactical lessons learned from efforts to integrate health into trade policy is potentially relevant to understanding the health and foreign policy connection. (7;23;126) Such lessons include exploiting existing common principles that various actors in the process hold to achieve policy coherency, engaging in training and education, valuing individual leadership and maintaining political buy-in. (7;11)

3.4 A Focus on How and Why and Global Health Policy Frames

A growing awareness of the potential importance of the integration of global health in foreign policy and international relations as a phenomenon worthy of further attention, particularly in the Western world, can be traced back to the late 1990s and early

millennium. Growing interest at the state level, largely driven by globalization, was apparent in the United States (US) Institute of Medicine report released in 1997, *America's Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy and Advancing Our International Interests*. The report argued that 'America has a vital and direct stake in the health of people around the globe, and that this interest derives from both America's long and enduring humanitarian concern and compelling reasons of enlightened self-interest.' (96)(p. v) It recommended 'leadership and coordination' as one of the ways in which the country could better engage in global health, including cooperation across relevant government departments and agencies and 'stronger collaboration with the nongovernmental and corporate sectors.' (96)(pp. 6-7) In the late 1990s, the UK's Nuffield Trust was also turning its attention to better understanding the links between globalization and health that eventually dovetailed into a research programme focused on global health and the integration of health in foreign policy in 2003. (147) The Institute of Medicine report and the Nuffield Trust's early work with partners, appear to mark the beginning of more focused efforts to elucidate the 'how' and 'why' behind the emerging phenomenon of global health in foreign policy, laying the ground work for future scholarly work in this area.

Stemming largely from the Nuffield Trust's interest in this phenomenon and leadership role in global health research, a number of conferences and events took place between 2002 and 2006 in Australia, Canada, the UK and the US that focused on health and foreign policy, in particular its link with the high politics of security-related policy in the post SARS and 9/11 world. (148) These events began in 2002 when the Ditchley

Foundation²³ hosted a joint conference with the Nuffield Trust and Rand Corporation²⁴ that brought together government representatives, academics and leaders of non-governmental organizations from Canada, the Netherlands, New Zealand, United Kingdom, and the US, together with executive members of the WHO, including Dr. Gro Harlem Brundtland. The conference theme was ‘to examine the links between health issues and national foreign policy interests and the synergies to be obtained through the coordination at both the national and international levels of health policies with foreign security and development policies.’ (151)(p. 1) The role of health in global development, the link between security and health, which the participants acknowledged may be driven primarily by state self-interest, and the importance of focusing on health in foreign policy for moral and ethical reason emerged at that meeting. (151) Conference participants cautioned against politicizing health as a way to achieve other foreign policy goals since this could threaten the ‘neutrality of health’ as a worthy foreign policy goal in its own right. (151)(p. 2) In the context of sharing current practices, the deliberations also highlighted possible ways in which state governments could integrate health into foreign policies, including better policy coherence (i.e. whole-of-government approaches), earmarking funds for global health and development projects, and exchanging health, foreign and security experts between the different parts of government to achieve greater mutual understanding and a shared language. Finally, leadership from the top was seen to be one of the most important ways of achieving strong and sustained interest in global

²³ The Ditchley Foundation was established by Sir David Wills in 1958 to advance international learning and to bring transatlantic and other experts together to discuss international issues. (149)

²⁴ RAND focuses on issues such as health, education, national security, international affairs, law, business, and the environment. It has been conducting research in these areas for more than 60 years. It is a nonpartisan, independent organization. (150)

health across government, along with the acknowledgment of the expanding role, number and diversity of non-government actors in the process. (151)

In the same year as the Ditchley conference, two participants in the conference affiliated with RAND published related work from a US perspective that focused on the role that health and health professions should play in domestic and foreign policy, particularly in the aftermath of 9/11. This paper links health with security and global economic development and positions health as a tool or instrument for foreign policy in the sense that it can be unifying force for engagement. (152) It also highlights the role that health professionals can play in dealing with health challenges abroad for humanitarian reasons, but also to dampen US security threats and to enhance America's faltering global reputation through their work. '...the US health community can also "do well by doing good," in helping to foster, for legitimate reason, a far better reputation for the United States in many parts of the world than, regrettably, it has today.' (152)(p.71) These perspectives appear to support those expressed by the Canadian policymakers in Nixon's study. State actors will consider health as important in foreign policy both as a way 'to do the right thing' but also to protect the interests and reputation of the state.

The RAND and Nuffield Trust Conference also attracted the attention of a few Canadian scholars in 2002 that referred to the conference's role in placing health as a central element of 21st century foreign policy in their paper prepared for the Commission on the Future of Health Care in Canada. (139) In that paper, Blouin et al. contributed to the discussion of why health should be a foreign policy concern (i.e. to support development,

to enhance security, and explicitly for reasons of self interest) by highlighting the relationship between trade and health and the importance of focusing on ‘health as a human right.’ (139)

A new research collaboration that Norway is leading stemming from the FPGH initiative is a concrete demonstration of how this issue continues to attract attention and gain momentum. (26) More recently, efforts have been made to consolidate and synthesize arguments and perspectives from academic literature and existing policy statements into a limited number of frames or theme areas. These syntheses aim to advance understanding, research and analysis in this area and also assist health diplomats in their efforts to strategically frame or position global health in policy discourse and take coherent action to improve global health. (1;4;4;24;30;36;73;107;153-156)

Labonté and Gagnon’s 2010 review article is the most comprehensive attempt to date to identify and synthesize arguments for health in foreign policy to inform global health diplomacy. (73) The article consolidates the arguments into six policy frames: security, development, global public goods, trade, human rights and ethical/moral reasoning. The authors argue that each frame has important implications for how global health as a foreign policy issue is conceptualized and propose that differing arguments within and between these policy frames, while overlapping, can also be contradictory. (73) For example, investing in global health to advance state economic interests may conflict with providing development aid to countries in greatest need with no strings attached. Through analysis of policy and policy-related documents and academic literature pertinent to each

policy framing the authors explore which arguments prevail in actual state decision-making. The reference point for the analysis is the 'explicit goal of improving health equity,' which, the paper argues, has increasing national traction within national public health discourse and decision-making through the MDGs and other multilateral reports and declarations. (73)(p.1) Overall the findings show that states, even when committed to health as a foreign policy goal, appear to make policy decisions based on priority areas that foreign policymakers traditionally focus on - national security and economic interests. Development, human rights and ethical/moral arguments, while not ignored in the process, do not appear to be top priorities in practice. The authors propose that the analysis offered may prove helpful to those engaged in global health diplomacy or in efforts to have global governance across a range of sectoral interests pay more attention to health equity impacts. Following is a summary of each of the key arguments for health in foreign policy from the article. (73)

Table 2: Summary of the arguments for integrating health into foreign policy (73)(p. 15)

Security, by far the dominant argument, gives global health interventions greater traction across a range of political classes than a rights-based argument alone. To the extent that this strengthens a base of public health expansion, securitization of health may be a prerequisite to its eventual de-securitization. But vigilance is needed to avoid national security from trumping human security.	Trade can improve health through global market integration, economic growth and positive health externalities. However, present trade rules skew benefits towards more economically and politically powerful countries; and evidence of negative health externalities demands careful <i>a priori</i> assessments of trade treaties for health, development and human rights implications.
Development remains the invitation to global governance debates. It provides a seat at the table. Risks inherent in its ‘investing in health’ instrumentalism can be tempered by continuously reminding decision makers to distinguish which one is the objective (human development) and which one the tool (economic growth).	Human rights, though weak in global enforcement, have advocacy traction and legal potential within national boundaries. Such rights do not resolve embedded tensions between the individual and the collective, an issue to which human rights experts are now attending.
Global public goods provides a language by which economists of one market persuasion can convince economists of another that there is a sound rationale for a system of shared global financing and regulation.	Moral/ethical reasoning is suggested as a necessary addendum to the legalistic nature of human rights treaties. This need, in turn, has created scholarly momentum to articulate more rigorous argument for a global health ethic based on moral reasoning. Competitors for such an ethic range from a liberal theory of assistive duties based on ‘burdened societies’ in need, to cosmopolitan arguments that emphasize minimum capabilities needed for people to lead valued live, to more recent arguments for a new ethic of relational justice based on cosmopolitan and human rights theories.

3.5 Conclusion

This review highlights the proliferation of interest and involvement by a variety of stakeholders in continuing to work towards achieving a stronger and deeper understanding of global health diplomacy and its role in improving global health through initiatives such as country level global health strategies. More specifically, it provides evidence to support the conclusion that health’s rise as foreign policy issue has been primarily crisis driven and it continues to be highly vulnerable to being usurped by other

more traditional foreign policy priorities (e.g. security, trade) and/or to being used instrumentally to advance such priorities. The adoption of strategic approaches to state level involvement in global health through the development of explicit, whole-of-government global health strategies may lead to more sustained attention on this issue. Balancing ‘high’ and ‘low’ political interests as part of the global health policy process appears to create challenges for those developing these initiatives, however. Significant negotiation and trade-offs are required to arrive at cross government agreements. The scholarly work undertaken to date to synthesize and analyze possible global health frames provides important insights for health diplomats into the benefits and risks of using various arguments for the integration of health into foreign policy. This work, along with the theoretical frameworks, informs the analysis of the following background country case study findings.

Chapter 4: Background Country Cases

4.1 Introduction

In this section, themes in the findings from the background case studies are categorized and described within the policy analysis circle categories: **context (why)** - background to and reasons why the policy was developed; **content (what)** - the priority areas that are included in the policy; **process (how)** - how the policy was developed, including how differences were reconciled and how it is being implemented; **actors (who)** - who was involved in the policymaking process; and, **indications of impact (so what)** - how the impact of the policy will be assessed and perspectives on potential and actual impacts to date. The findings are analyzed and discussed in the final section of the chapter.

4.2 Switzerland: *Swiss Health Foreign Policy*

4.2.1 Introduction

As one of the world's major centres for diplomacy, international and humanitarian affairs, Switzerland plays an important role in global health policy development and has demonstrated significant leadership in global health diplomacy. (157) Key actors involved in Swiss global health related activities assert that support for global health 'begins at home' (158;159)(p. 564) through coordinated national global health policy, such as the *Swiss Health Foreign Policy*. (36) As Gaudenz Silberschmidt, chairperson of the Graduate Institute's Advisory Board of the Global Health Programme and Vice-Director of the Swiss Federal Office of Public Health states, Switzerland was the first country to formally adopt a global health policy. (158) This policy is the focus of the Switzerland background country case study.

4.2.2 Context

The *Swiss Health Foreign Policy* is an internal agreement between the Federal Department of Home Affairs (FDHA) and the Federal Department of Foreign Affairs (FDFA).²⁵ The head of the Federal Department of Home Affairs, Pascal Couchepin, and the head of the Federal Department of Foreign Affairs, Micheline Calmy-Rey, signed and submitted it to the Federal Council in October 2006. (161) The Federal Council is the seven-member executive council of the federal government of Switzerland and serves as the Swiss collective head of state. Each Councilor heads one of the seven federal executive departments: Defense; Economic Affairs; Finance; Foreign Affairs; Home Affairs; Justice and Police; and Transport, Communication and Energy. (160)

About a year and a half prior to its publication (in May 2005), the Swiss Federal Council had decided ‘to improve the coordination and coherence of Switzerland’s foreign policy, and to enhance interdepartmental collaboration in sectors that the FDFA does not lead by concluding agreements on shared objectives between the FDFA and the federal department responsible for the sector in question.’ (36)(p. 5) The policy is a fulfillment of ‘the Federal Council’s mandate concerning foreign policy in the area of health.’ (36)(p.5) A focus on health is described as the ‘first application’ of such an interdepartmental

²⁵ The Federal Department of Home Affairs (FDHA) (i.e. interior ministry) is composed of a General Secretariat, several Federal Offices, including the Federal Office for Public Health, and a number of other affiliated administrative entities. (160) The Federal Department for Foreign Affairs (FDFA) formulates and coordinates Swiss foreign policy with a focus on cross government policy coherence. ‘A coherent foreign policy is a precondition for the effective protection of Swiss interests vis-à-vis foreign countries.’ (160) (p.52) The FDFA is composed of a General Secretariat and several Federal Offices including the Swiss Agency for Development and Cooperation and is responsible for the Swiss diplomatic and consular missions abroad. (160)

agreement. (161) The reasons that the policy was developed and key influencing factors follow.

Improving policy coherence and coordination

The main stated motivation behind the development of the Swiss policy was clearly to improve policy coordination and coherence across government departments responsible for foreign policy and global health.

‘Until now, we have tended to address health issues in our foreign policy in an indirect manner, and to consider them primarily as part of health and development policies. However, greater global interdependence calls for a more comprehensive and more coherent approach, as well as for solutions that are coordinated at both the national and international levels.’ (36)(p. 7)

One way to achieve this goal is through mechanisms such as the health foreign policy that integrates all policy areas directly or indirectly involved in health into a single framework. (36) As indicated in the policy, before the policy agreement was established, cooperation between FDHA’s Federal Office of Public Health (FOPH) and FDFA was ad hoc. Systematic coordination through the International Health Policy Steering Committee and the Interdepartmental WHO Working Group only occurred in the context of the World Health Assembly and the other meetings centered on relations with the WHO.

(160) The policy agreement aims to support a systematic approach to coordination and coherence across the FDFA and FDHA. It is not meant, however, to ‘infringe on the existing competencies of the federal offices,’ but rather to ‘give overall foreign policy a more specific direction.’(36)(p. 17) ‘Coherence in foreign policy and more efficient safeguarding of interests are its overriding objectives; coordination between the players in the administration is the instrument.’ (36)(p. 17)

Health security, economic prosperity, development

Other factors that led to the development of the policy summarized in the background/context setting section entitled, ‘Solving problems together’ include (in the order in which they are presented): the 2003 SARS epidemic and the 2005 spread of avian influenza that ‘showed that the growing interdependence of countries and societies has also increased their vulnerability’ (36)(p. 6); the mutually beneficial and potentially reciprocal nature of the relationship between health and economic development; the rising importance of health of populations and investments in the health sector as considerations for the economy and competitiveness; acknowledgement of the importance of international cooperation on health and its determinants, through global public goods, such as the WHO Framework Convention on Tobacco Control (FCTC); (36)(p. 8) and the MDGs - ‘development is not possible without health.’(36)(p. 8) An informant described the three aspects of the policy as a triangle that includes “health, foreign affairs and development cooperation.” This concept is further elaborated on in a presentation that Dr. Silberschmidt gave at the Geneva Health Forum in 2008 in which he summarizes the three main aspects of the *Swiss Health Foreign Policy* as: a tool to improve health in Switzerland; health as a pillar of development policy; and coherence with general foreign policy. (161)

Leadership within the bureaucracy

The interviews with Swiss informants helped to further elucidate factors that contributed to the establishment of the policy. According to one informant, leadership within the Federal Office of Public Health (FOPH) was central to the adoption of the policy.

Gaudenz Silberschmidt, a medical doctor with a graduate degree in international relations

assumed the position of the Director of the Federal Office of Public Health in 2003. He played a key influencing role in raising awareness of the increasingly interrelated aspects of health and foreign policy and collaborated with the FDFA to eventually put the policy in place. As an informant put it, he:

came to understand that based on his experience and the experience of his director, who'd been very active in the WHO, that it was important to make other parts of government understand in what way international health negotiations actually impacted on Swiss policy overall.

Timing: A window of opportunity

Coinciding with this leadership role or potentially resulting from it, an interviewee indicated that there was a “window of opportunity” at the senior administrative level coupled with political will. “There was an overall will of having sectoral foreign policies” which was “accepted by government.” Interestingly, an informant commented that “SARS contributed but this did not lead immediately to the process.” Political will and leadership were also needed.

A way to communicate Switzerland's position on global health

Finally, another driver behind the policy that aligns with the desire for policy coherence was the need to develop a more strategic, transparent and articulated approach to Switzerland's contributions to global health grounded in its longstanding reputation and role as a leader in this area. One informant reflected on questions that were asked at the outset of the process, such as:

Where do we invest? How do we invest? And what are our responsibilities globally? What kind of document do we need to work more efficiently and be able to explain to others why we are active in global health? How do we express our value base? How do we honestly express the tensions we have between being a country that very committed to human rights on the one hand but on the other hand also has a major pharmaceutical industry?

The policy was seen as a way to debate and reconcile these issues across government players but also to communicate and make them more transparent for outside government actors too, such as the NGO community. One interviewee summed up the overall purpose of the document:

They are an incredibly pragmatic bunch. So, it's really you know what kind of working mechanism, what kind of document they need to work more efficiently and to get to be able to explain to others why we are doing this.

4.2.3 Content

The *Swiss Health Foreign Policy* outlines five main health foreign policy interests and medium-term goals for each (18 in total) to guide Switzerland's work in this area over the five year period, 2006 to 2011. The policy is limited to identifying medium-term goals and a government department lead(s) for each one that is responsible for defining and implementing the goals further. No explanation is provided in the policy as to why only medium-term goals have been included though one informant indicated that health was put forward as a "pilot for elaborating an explicit sectoral foreign policy document." The pilot nature of the policy may explain its five year horizon. Moreover, the overall intent behind the policy was to create a mechanism to catalyze and guide, as one interviewee said, a more "automatized" approach to global health policy coordination and coherence across government. Following the initial five-year course of the policy, informants indicated that the need for a formal agreement across departments over the long run would be assessed based on the five year experience.

Table 3 summarizes the policy's five main interests and medium-term goals. (36) Of note, protecting the health interest of the Swiss population is the first main interest followed by

two interests that focus on improving Swiss government coordination and policy coherence. Improving the global health situation in the world is the fourth interest followed by a final interest to safeguard Switzerland's role and reputation as the home of important global health actors, including NGOs and private companies (e.g. pharmaceutical companies).

Table 3: *Swiss Health Foreign Policy* - Summary of main interests and goals (36)

Interests	Description	Medium-term goals
1. Protect the health interests of the Swiss population	- emphasizes protection against communicable and non-communicable diseases as well as general health and consumer protection issues - can only be tackled efficiently in cooperation with international organizations and Switzerland's neighbors	- Strengthen international monitoring networks for communicable diseases - Maintain a high level of protection for Switzerland through international cooperation using measures that are as business friendly as possible - Maintain the health and productivity of the Swiss population by adapting international strategies and targets to fight non-communicable disease, particularly obesity
2. Harmonise national and international health policy	focuses on: adapting national policy as effectively as possible to the new international and regional framework (includes developments such as the increasingly international dimensions of healthcare provision and the migration of patients and workforce) and learning from international experiences to further develop Switzerland's health system and improve its cost-effectiveness	- Use multilateral and bilateral comparisons to inform healthcare system improvements - Cooperate more closely with the EU in areas such as European Centre for Disease Prevention and Control, European Food Safety Authority, various early warning systems etc - Manage migration of health professionals to ensure the needs of the labour markets in industrialized countries and emerging economies are satisfied, without depriving developing countries of the health workforce they need
3. Improve international collaboration on health issues	- Switzerland has a major interest in shaping international health policy because of the health sector's important status in the Swiss economy and development - careful harmonisation with foreign policy objectives and national interest in general are essential	- Strengthen the normative role of the WHO - Support cooperation between WHO, OECD and EU on normative issues to promote greater synergies - Improve international access to essential drugs - Improve efficiency of multilateral players in health, development cooperation and humanitarian aid - Actively support the definition and

		implementation of international health standards to be applied in humanitarian crisis and emergency situations 12. Promote research to strengthen the empirical basis for effective health interventions to reduce the disproportionate burden of disease in the southern hemisphere
4. Improve the global health situation	• Switzerland has a major economic and political interest in improving the situation of the world's health, especially in developing countries and countries in transition • A main objective is to strengthen the global partnership for development, security and human rights that has been agreed upon and implemented with the UN. Switzerland would like to make a credible and acknowledged contribution.	13. Health system reform in developing and emerging countries and those in transition or in crisis, focusing on efficient and non-discriminatory access to health services and drugs 14. Make appropriate contributions to eliminating the three significant poverty-related diseases – AIDS, TB and malaria, paying particular attention to gender issues 15. Contribute to global strategies and programmes to combat non-communicable diseases 16. Cooperate bilaterally and multilaterally to save lives, deliver aid to victims of natural disasters and armed conflicts and restore health living conditions
5. Safeguard our role as host country to international organizations and a base for major companies working in the health sector	• Geneva is the host city to 25 UN and other international organizations and as such plays a pivotal role in international health policy. It also hosts permanent missions of 154 nations and offices of over 200 NGOs. • Switzerland seeks to maintain and expand its important role as a host country and conference venue. • Switzerland must also represent the interest of the pharmaceutical industry, a major player in its economy and safeguard the industry's base. Issues involved include the impact of health policy on national and international trade policy.	17. Consolidate and strengthen Geneva's position as an international centre of excellence for public and humanitarian health 18. Ensure appropriate protection for intellectual property as an essential incentive for research into, and development of new drugs and vaccines

4.2.4 Process

Policy development process

According to the informants, the *Swiss Health Foreign Policy* took about two and half years to develop using a “within government” process. They described the process as an intergovernmental approach that did not involve non-governmental actors or consultation on drafts of the document beyond the federal government players. Through the leadership of key government actors, the process began in about 2003 involving discussions and negotiations between the Ministry of Health and the Ministry of Development. As described in more detail below this initial interaction was very competitive and little progress in reaching an agreement on health and foreign policy was made. Eventually the foreign office became involved and “really became a broker” that facilitated agreement to draft the health foreign policy.

Reconciling different interests

One of the interviewees highlighted that the need to acknowledge and articulate the potential tensions between policy goals was raised during early policy formulation discussions. An acknowledgment of the challenges associated with ‘reconciling different interests’ is included as a separate section of the policy, where it states that ‘it is not possible to avoid conflicts of interest.’ (36)(p. 13) One of its goals is to carefully ‘weigh up’ different interests and ‘to reconcile national priorities with international developments, in order, as far as possible, to avoid an inefficient or incoherent approach.’ (36)(p.13) In other words, the policy should facilitate the adoption of congruent and coherent positions across government players so Switzerland is speaking with one voice when it comes to global health.

Two specific areas are presented as examples of those in which different interests may be difficult to reconcile. The first is Switzerland's commitment to adequate protection of intellectual property rights for 'its major pharmaceutical industry' while at that same time upholding a commitment to 'access to essential drugs for the world's poorest countries.' (36)(p. 13) No details are provided as to how such reconciliation is to take place, however, the policy indicates that the private sector's increasing awareness of its social and global responsibilities in the area of health should present new opportunities for cooperation. (36) The second area is trade policy. The policy acknowledges that policies to protect health may restrict the free movement of goods or individuals, while trade policy measures can have, indirectly, both negative and positive effects on population health. The policy refers to the major exceptions to the World Trade Organization's basic principle of unrestricted market access as a way to reconcile this potential conflict of interest. It can be assumed that by including this in the Swiss policy, Switzerland agrees with these exceptions - that 'measures essential to protecting health are permitted in principle, provided they are not discriminatory or used as a covert means of restricting international trade.' (36)(p. 13)

The informant from government provided additional perspectives that further elucidate how differences were reconciled as part of the policy process. First, the interviewee noted that because of the integrated nature of interdepartmental work established through mechanisms such as the interministerial group on intellectual property, as a baseline, positions are "closer together than average" compared to other countries.

You have rather consistent positions in the sense that I with the number two of the Swiss IP (intellectual property) office co-chair an interministerial group where we go through topics in which every for it comes up, in the sense that when you ask Switzerland what's our position in the WTO (World Trade Organization) or you ask us in the WHO or in the Human Rights Council or in the UN General Assembly, probably our different position in the different fora are closer together than average. We move forward and it's not at all in the sense that just we would have to give in and it's only trade interests, it's really common positions, if you look at our role in that process, in WHO, over time, we have been among the more progressive industrialized countries and especially among the more progressive pharmaceutical location countries.

Second, despite this common front, the interviewee noted that differences that did exist were most pronounced between the development and health communities.

We realized later on that the Swiss Society of Public Health organized their annual conference around global health, which was the first time the public health community and the Swiss health development community came together in the same conference. It was amazing to see what extent they speak different language and to what extent they don't know each other. So here again, it's a long-term work.

While this comment related to outside government players, both informants, as previously noted, commented that initial work to develop the policy was done together with representatives of the Swiss Development Agency “which is a very strong agency under the responsibility of the ministry of foreign affairs but at that point lived a life of its own more or less with a very strong director” and the FOPH. Significant differences appeared to exist between the two in regards to global health and Switzerland's position. Attempts were made to reconcile differences by trying to identify common goals and values (e.g. human rights) and how the two parts of government could work together on global health. These attempts were not successful, however. As one informant said, the process “dragged on for quite a while and was actually very, very competitive.” The other interviewee stated that this tension that existed between the two was not unique to

Switzerland - “in most countries this is a collaboration with quite a lot of tension.”

Finally, the:

foreign office started to get more involved because the foreign office had decided because there was more and more interface between foreign affairs and domestic policy, the border is becoming porous and they would like exemplary agreements with other policy arenas.

Both informants described the foreign office as a “broker” that was instrumental in helping the FOPH and the development agency reach an agreement related to global health.

Policy implementation process

In addition to the five main interests and accompanying goals, the policy outlines six measures focused on improving coordination and coherence that will help achieve the goals ‘with maximum efficiency and minimum policy conflict.’ (36)(p. 14)(See Table 4) ‘Coherence in foreign policy and more efficient safeguarding of interests’ (36)(p. 17) are the policy’s overriding objectives and ‘coordination between players in the administration is the instrument.’ (36)(p. 17) Two measures have been assigned to each of the main parties to the agreement, the FDFA and the FDHA, and two are identified as joint measures under the shared responsibility of both. Of note, the policy does not include any additional human or financial resources dedicated to its implementation. This means that it is to be implemented with existing resources ‘that will be more clearly targeted and coordinated in the newly planned health foreign policy.’ (36)(p. 13) This clear articulation of roles and responsibilities, including those that are shared and serve to breakdown department silos may be contributing to how cross government integration of health in foreign policy has become “automatized” as one informant put it.

Table 4: *Swiss Health Foreign Policy* - Measures to improve coordination and coherence (36)(pp.18-19)

Measures undertaken by the FDFA	
Measure 1: Establishment of a coordinating office for health foreign policy	• Contact point for all relevant inquiries from across government • Responsible for coordinating all health matters within FDFA • Responsible for collecting and forwarding relevant information from the FDFA to other offices across government • Ensures the coherence of health foreign policy as part of overall Swiss foreign policy
Measure 2: Creation of an information platform for health foreign policy	• Platform contains all important basic documents and background information, as well as an agenda showing the most important issues, meetings and events in health foreign policy • Involved offices can upload documents directly to the system • FDFA uses the information to ensure that all offices involved in health foreign policy have the same background information and planning documents at their disposal
Measures undertaken by the FDHA	
Measure 3: Produce policy papers on subjects arising in health foreign policy and strengthen academic competence	• The Federal Office of Public Health (FOPH) develops papers on specific aspects of health foreign policy in consultation with other departments • Aims to strengthen 'International Geneva' by establishing scientific competence in international health issues through approaches such as including international health in the target agreement with the government-funded academic institutions in Geneva and Lausanne
Measure 4: Harmonisation with general foreign policy and other sectoral policies	• Regularly briefs and consults with the FDFA and other relevant offices on important developments in health foreign policy
Joint Measures	
Measure 5: Creation of an Interdepartmental Conference on Health Foreign Policy (IK GAP)	• Headed jointly by FDHA- FOPH and FDFA and includes members of the Swiss Conference of the Cantonal Ministers of Public Health • Defines current priorities and joint projects and is supported by the Interdepartmental Working Group on Health Foreign Policy
Measure 6: Staff exchange and foreign missions	• Includes mechanisms such as a senior position in the FOPH International Affairs section held by a member of the diplomatic staff from the FDFA • One staff at each of the Missions to Geneva and Brussels are assigned to the health dossier • Health-related goals included in the annual goals of the FDFA's foreign missions

4.2.5 Actors

The major players in the Swiss administration who were involved in the development of the policy and are responsible for its implementation are the FDHA (FOPH), for the international health policy, and the FDFA. Other key players include the Swiss Agency for Development and Cooperation (SDC) responsible for development and humanitarian policy relating to health and the Directorate of Political Affairs (DP) responsible for general foreign policy issues. Other offices within the auspices of the FDHA and the FDFA play important roles too, including the Federal Department of Economic Affairs (FDEA) and the Federal Department of Justice and Policy (FDJP) intellectual property rights division. (36)

Being an interdepartmental agreement, the main players involved were within government, however, the informant from academia had a significant relationship with government players focused on global health diplomacy and governance, in particular from the FOPH, prior to and since the policy was adopted. Moreover, the Swiss government and the Graduate Institute in Geneva jointly support the Graduate Institute's global health diplomacy program.

The Federal Office of Public Health is also a financial supporter of our program and has a very close link with the academic community. We organize events and invite them to present their views which are questioned, challenged and supported as need be.

NGOs were not involved in the policy development process, but as interviewees communicated, the policy has been presented to the NGO community, including at meetings of the Swiss Public Health Association: “there's great awareness of it and something new has happened.” The informant from academia stated that in Switzerland

because the government does not need to be convinced of the importance of global health, NGOs don't need to fight for attention on global health *per se*. Therefore, they can focus on specific health issues and try to move them forward. "There's a great openness so people from government are at a lot of meetings of these bodies with academics and the like." Interestingly, however, the other informant from government indicated that the interaction with NGOs as part of the policy process was not necessarily positive.

It was deliberately not together with civil society. Then we involved Medicus Mundi (the network of Swiss organizations working in the field of international health) and then realized how difficult it would have been with civil society for the following reasons: they were saying, that's unacceptable, we haven't been involved. Asking what should be different they couldn't give an example. It was just, we need to be involved and later on I got a request we want to be involved on topic 6,8 etc. Then our answer was, either you are topic-wise, no problem of involvement or you are on all topics... but they wanted to be involved only in the development topics, and there they can speak directly to colleagues in the Swiss Development Corporation. So it's very hard to get their involvement. It's very long-term work. There are not many NGOs that focus on global health in that broad sense.

4.2.6 Indications of impact

One of the main purposes of the *Swiss Health Foreign Policy* was to create a mechanism that would lead to greater collaboration and coordination across FDHA and FDFA so health would become better integrated into foreign policy. According to the interviewees, this goal is indeed being achieved in a number of ways.

First, as a result of the agreement, and the implementation of the various measures it includes, working together has become "everyday business." "It's how we do the business of global health, we do it together." Through measures such as having dedicated staff in the foreign affairs department who focus on health and including those staff in "intensive day to day collaboration" with the FOPH, "health is the business of foreign

policy....it's on the foreign policy agenda and its part of everyday work.” In a report written for the US Centre for Strategic and International Studies (CSIS) and also in a background paper prepared for the 2009 Prince Mahidol Award Conference about global health diplomacy, Gaudenz Silberschmidt reported that the measures to improve coordination and coherence summarized in Table 4 using existing financial and human resources are indeed underway and working well. For example, a coordination office for health in the ministry of foreign affairs has been created, a joint electronic information platform where all government entities working on global health consult one another has been developed and an inter-ministerial coordination meeting of senior officials is held annually with meetings of working level staff held five times per year. (153;162)

Second, through this collaboration, people know each other better, “are talking” and different departments have a “much better understanding” of what each other do and why it is important to global health. This had led to a “greater interest and willingness to do certain things.” One example given was the agreement obtained from Swiss parliament to make 10% of its vaccines it purchased “for the new influenza” available to the WHO for developing countries. It was the first country to obtain such agreement. The agreement was:

made possible because of the long-standing two year constant dialogue within government...five years ago, a national health ministry wouldn't have – when it bought a vaccine – had the idea to say, let's at the same time make and also buy some for the rest of the world. The strict division between national and global health is starting to weaken and that's very good.

Third, planning related to health and foreign policy has become more proactive. Established working groups and committees work together to prioritize issues and “what is really interesting is they don’t do that in a sort of knee-jerk reaction.” They identify what future issues will likely be and how to prepare for them. And, fourth, one informant stated that the policy has “created more transparency for the NGO community to get back to representatives of the various government agencies” with feedback on whether the government is “living up to this...so, the government is very proud of that.”

On a more critical note, the *Swiss Health Foreign Policy* commits to improving the global health situation including the ‘efficiency of multilateral players in the fields of health, development cooperation and humanitarian aid,’ (36)(p. 15) but not aid volumes noting that ‘no additional human or financial resources are planned for the implementation of this agreement.’ (36)(p. 13) This undermines at least one component of its policy’s stated objective that is to strengthen the ‘global partnership for development, security and human rights to make a credible and acknowledged contribution.’ (36)(p. 12) It is not clear if a country like Switzerland’s commitment to a cross-government global health policy equates to increasing its volume for aid but it is questionable if the objectives of the Swiss policy can be fully achieved given its contributions to aid. As the Organization for Economic Co-operation and Development (OECD) reported (see Figure 4) Switzerland’s overseas development aid (ODA) fell by 4.5% in 2010 due to a reduction in the amount contributed to debt relief, however, Switzerland has now set a firm ODA target of 0.5% of gross national income (GNI) by 2015. While setting a firm target is laudable it is still below the 0.7% target first proposed and accepted as a long-

term objective in 1969 by the majority of OECD Development Co-operation Directorate (DAC) members with the exception of Switzerland and the United States. (163) It is also below that of other countries that are leading in global health diplomacy efforts, including the UK and Norway (in 2010 the UK's ODA rose by 19.4% reflecting the continuing scaling up of its aid programme and Norway's by 3.6% mainly due to increasing efforts to promote clean energy and reduce deforestation). (164) Of note, based on the data reported in Figure 4, Switzerland's aid appears to be directed at a somewhat balanced mix of low and middle income countries that are not in conflict. This is an indication that the aid is not being allocated strategically for security reasons but rather to those in need, and for health, education and social infrastructure; although a significant portion is unallocated so it is unclear what this aid is contributing to.

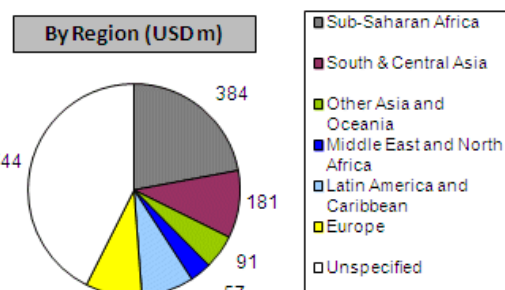
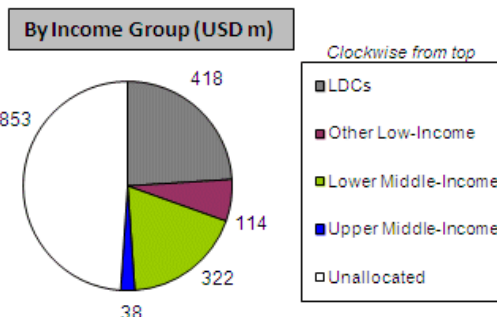
Figure 4: Switzerland Aid Statistics 2009, 2010 (165)

SWITZERLAND

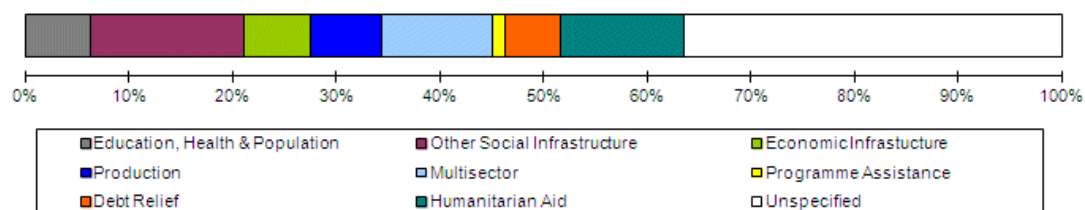
Net ODA	2009	2010	Change 2009/10
Current (USD m)	2 310	2 300	-0.4%
Constant (2009 USD m)	2 310	2 210	-4.3%
In Swiss Francs (million)	2 504	2 398	-4.2%
ODA/GNI	0.45%	0.40%	
Bilateral share	76%	74%	

Top Ten Recipients of Gross ODA (USD million)	
1 Togo	80
2 Kosovo	49
3 Mozambique	27
4 Nepal	26
5 Burkina Faso	26
6 Vietnam	24
7 Tanzania	23
8 Bangladesh	22
9 Peru	22
10 Pakistan	21
Memo: Share of gross bilateral ODA	
Top 5 recipients	12%
Top 10 recipients	18%
Top 20 recipients	29%

Gross Bilateral ODA, 2009-10 average, unless otherwise shown



By Sector



Source: OECD - DAC ; www.oecd.org/dac/stats

4.2.7 Conclusion

The findings from the Swiss case lead to a few main conclusions.

First, in regards to the reason that the cross government policy was developed, the main reason was to improve coordination and coherence across government. The policy was developed by government actors only, without outside involvement or consultation, to help them better work together in a coherent and efficient way and not duplicate efforts. The feedback that this has broken down silos and made working together on health and foreign policy more automatic is an indication that this aim is likely being achieved. As highlighted in the policy, the SARS epidemic was an important precipitating event, or ‘focusing event,’ that led to the realization that better coordination and coherence in preparation for future such global health crises was needed. This may help explain why protecting the health interest of the Swiss population is the first priority of the policy. Overall, the policy appears to have been driven largely by self-interest in a time of crisis, which is consistent with conclusions drawn from the literature review pertaining to why foreign policymakers have tended to pay attention to health. Other motivations that fall within the traditional ‘high politics’ domains of foreign policy include safeguarding Switzerland’s relationship and reputation with the pharmaceutical industry and investing in health for economic reasons. While these motivations dominate, contributing to improving global health and collaborating with others, in particular the WHO, are also priorities though appear to be secondary to the main driving force, protecting Swiss interests.

Second, leadership within the bureaucracy was essential to raising the importance of the need to develop such a policy and then to ensure that it was implemented as planned. This policy entrepreneur, to use Kingdon's language, seized the window of opportunity that led to the development and acceptance of the policy. An important player in this process was the foreign office. The foreign office acted as a "broker" to help reconcile differences such as ensuring that Swiss pharmaceutical companies were not going to be disadvantaged by any aspects of the policy (i.e. protecting trade and business interests) while at the same time, committing to the achievement of equally important 'low politics' goals (e.g. MDGs). In this way, the cross government process can be described as a form of global health diplomacy. Negotiations involving a broker (i.e. diplomat) needed to take place among government actors with widely different perspectives and positions to arrive at collective global health priorities.

One potential weakness in this process is that it did not involve non-state actors, or at least NGOs, which, as the literature review and conceptual framework for this study show, are now recognized as key actors in global health diplomacy that should be included in multi-stakeholder global health processes. (It is not known whether private sector actors had been consulted.) Moreover Dr. Silberschmidt indicated in 2009, albeit after the Swiss policy was developed, that governments are called upon to collaborate with these partners. (162) Perhaps it can be argued that not including NGOs may have been appropriate considering the primary aim of the *Swiss Health Foreign Policy* was to improve coordination and coherence across government. Excluding NGOs from the foreign policymaking process is consistent with an approach to international relations that

argues that non-state actors are not relevant to such relations, which underpins Fidler's 'remediation' conceptualization. However, the policy's strong focus on the importance of the WHO's contributions to global health, in particular as a mechanism to develop and govern global health policies (e.g. FCTC) and the necessity to collaborate with WHO to achieve collective global health goals, is consistent with an approach to foreign policy that acknowledges that international institutions have a role to play. In this way, the policy acknowledges that the WHO helps states cooperate in the area of global health to achieve collective global health goals.

Third, another important theme in the Switzerland data pertains to the role that temporal issues played in the policy process. The importance of timing underpins the Multiple Streams Model of the policy process. When the time is right, the problem, policy and politics streams align, a policy window opens with the help of a policy entrepreneur (s) and policy change takes place. This indeed appears to have been the case with the *Swiss Health Foreign Policy*. SARS was a focusing event that activated political will within a context in which global policy entrepreneurs (e.g. academics, policymakers) had already been actively drawing attention to global health as a foreign policy concern. The streams aligned in large part because of leadership in the Swiss bureaucracy and the policy was born. An important factor to bear in mind related to timing is what one Swiss interviewee referred to as "long-term work." It took several years to frame and 'soften up' (Kingdon's term) the policy community before the SARS epidemic took place and then it took two and a half years for the policy to be developed. This is an important finding for health diplomats who aim to keep health on the foreign policy agenda while other issues

compete for attention. Even when such attention shifts, as Kingdon's model highlights, it is important to continue to frame and debate the issues, 'soften up' the policymakers and be ready as policy entrepreneurs to help open policy windows.

Fourth, it can be concluded that the policy has had a positive impact on improving coherence and coordination across government; but some of its substantive objectives that pertain to improving global health may be undermined by the level of aid that Switzerland contributes compared to the level provided by other wealthy nations.

4.3 Norway: *Oslo Ministerial Declaration*

4.3.1 Introduction

Unlike Switzerland, Norway does not have a whole-of-government global health strategy *per se*.²⁶ However, one of the interviewees from Norway stated that the best example of a statement that articulates the country's perspective on health and foreign policy is the *Oslo Ministerial Declaration (the Declaration)* issued on March 20, 2007 by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand. (24) Norwegian Foreign Minister, Jonas Gahr Støre co-initiated the Foreign Policy and Global Health Initiative (FPGH) made up of these countries with French Minister of Foreign Affairs, (and former Minister of Health), Philippe Douste-Blazy in 2006. Because of the leadership that Norway demonstrated in initiating the FPGH, which is 'quite in line with Norway's general approach to foreign affairs,' (167;168) in the absence of an explicit Norwegian whole-of-government global health

²⁶ When this thesis was being prepared for final submission and examination, Norway launched such a whole-of-government strategy as briefly mentioned in Chapter 7. (166)

strategy, this description and analysis will focus on the *Oslo Ministerial Declaration* as the Norway country case example.

4.3.2 Context

In their analysis of the evolution of Norway's perspective on and investments in global health over the last decade or so, Sandberg and Andresen use the picture of Norway as an idealistic regime of 'goodness' as a starting point. (169) This regime of goodness has grown over the years to be a national symbol that shapes Norwegians' self-image and identify. (169) The phenomenon of 'goodness' coupled with the revision and broadening of the concept of national interests as outlined in recent Norwegian foreign policy (170) along with a reorientation of Norwegian engagement from 'where the need is greatest to where Norway can make a difference in world affairs' (169)(p. 307) is the context within which Norway initiated FPGH. While global health in Norway had previously been confined to development aid and public health specialists, it has changed to 'become part of new and broader conceptualizations of Norwegian interests in a globalized world.' (169) This change is evident in Norway's efforts to seek a higher profile on global health issues through initiatives such as the FPGH. In this context, the main rationales or motivating factors that led to the development of the FPGH and the *Oslo Ministerial Declaration* follow.

Leadership in Global Health - "Norway's ambition to make a difference in global health"

As one interviewee noted, "for Norway, there's been a long, long interest and engagement with the WHO."

Sandberg and Andresen trace Norway's role with WHO back to when Karl Evang, former surgeon general of the Norwegian Public Health Service, was one of 16 people who helped craft the WHO's 1948 constitution. Evang was regarded as a visionary in international health collaboration. (169) In 1998, Gro Harlem Brundtland, the previous long-standing prime minister of Norway (a medical doctor and former Minister of Health), became the Director-General of the WHO. In 1983, just before becoming Norway's Prime Minister, she had been asked by the UN to establish and chair the World Commission on Environment and Development (WCED). While at WHO, Dr. Brundtland is credited with raising the profile of health on the international political agenda through facilitating initiatives such as the Tobacco Convention, serving as the inaugural chair of the Global Alliance for Vaccines and Immunisation (GAVI Alliance) and establishing the WHO's Commission of Macroeconomics and Health, which generated a new discourse focused on the significance of health for development and economic growth. (169) Dr. Brundtland's role in the WHO was "instrumental in triggering the interest in global health" among other key Norwegian political figures, most notably Jonas Gahr Støre, who initiated FPGH in 2006. Mr. Støre had been head of the prime minister's office during Dr. Brundtland mandate and assisted with her transition to the WHO. He credits his time at WHO for raising his awareness of global health, 'I discovered how much more there is to health - and global health - than the strict medical side of the issue....and learned how much global health matters to foreign and security policy.' (171)(p.1-2) He later became Norway's foreign minister, a position he continues to hold at time of writing (2012). Norway's Prime Minister since 2005, Jens Stoltenberg, an economist, also became strongly engaged and interested in global health

issues such as GAVI from a cost-effectiveness perspective. (169) Sandberg and Andresen describe Norway's participation in GAVI as 'a key junction in the Norwegian global health relations as it engaged both the political leadership and the development establishment in Norway' and was 'the starting point for the broadening of the Norwegian global health portfolio.' (169)(p. 310) While the Norwegian Agency for Development Cooperation (Norad) was the main implementer of Norway's activities in GAVI and other global health initiatives, 'its core resided in the Ministry of Foreign Affairs' (169)(p. 315) where the minister Jonas Gahr Støre created 'his own initiative,' the FPGH in 2006. This deliberate move to place health on the foreign policy agenda was seen as a continuation of Støre's engagement with health at the WHO and 'an initiative to place the new language of global health, that which spoke to health as part of a whole, into a coherent foreign policy context.' (169)(p. 315) Støre promoted reaching out to partners beyond health and seeing foreign policy more broadly. (169;171;172)

Interviewees emphasized that political leaders outside the health ministry *per se* in Norway have played an instrumental role in raising the profile of health in foreign policy in Norway. Leadership from foreign affairs and the PM's office was particularly critical. "It hasn't only been driven by national health policies....but it has been driven by the Foreign Affairs, Development and the PM so it's health driven by others than the traditional health people" said one. "We also have a Prime Minister who is very, very engaged in global health," said another. "When you read different speeches they include health in the messages they would like to convey. This is a highly personal commitment from the Ministers," the interviewee continued. "Thinking outside the box," and in non-

traditional ways appears to be what the political leadership brought to the table. It is also noteworthy that the political leaders who drove Norway's profile and investment in global health, Stoltenberg and Støre, were from the same political party as Dr Brundtland (the Labour Party), presumably shared the same political ideology and enjoyed her strong mentorship in global health and in politics. Moreover, one of the interviewees described Mr. Støre as "the most popular politician in office," which is likely the main reason that an interest in health and foreign policy "has survived."

Sustaining foreign policy attention on global health

Closely related to this idea of health and foreign policy "surviving" on the political and policy agenda is the second main motivation behind the FPGH and *Oslo Ministerial Declaration* - the need to sustain foreign policy attention on global health not only when global health crises occur. Historically, global health has received foreign policy attention only when it was associated with a direct health threat usually from a communicable disease. As Fidler writes, 'it was subject to brief bursts of foreign policy attention, followed by sustained marginalization and neglect.' (141)(p.4) The *Oslo Ministerial Declaration* argues that 'in today's era of globalization and interdependence there is an urgent need to broaden the scope of foreign policy.' (24)(p. 1373) The erratic attention of the past is no longer acceptable as states face 'a number of pressing challenges that require concerted responses and collaborative efforts.' (24)(p. 1373) The Ministers assert that 'health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time.' (24)(p.1373)

‘We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make impact on health a point of departure and a defining lens that our countries will use to examine key elements of foreign policy and development strategies and to engage in a dialogue on how to deal with policy options from this perspective.’ (24)(p. 1373)

In her speech at the Prince Mahidol Conference in Bangkok in 2009, Inga Myhamar, Deputy Director General from the Norwegian Ministry of Foreign Affairs emphasized the role that the FPGH plays in attracting attention on health. ‘The main thrust of the initiative has been political advocacy... the point has been to increase awareness of health as a cross-cutting foreign policy issue, and of the importance of raising health issues in all arenas where foreign policy issues are discussed - from the UN General Assembly to bilateral talks.’ (167)(p. 1)

The premise behind the FPGH and the *Oslo Ministerial Declaration* is that leadership from foreign policymakers is critical if health is to become a strategic foreign policy issue that does not wax and wane as crises occur. As one interviewee expressed, “health is too important to leave to health people alone,” re-iterating the point made by Mr. Støre in a 2009 speech in Washington: ‘Health is simply too important to be left to health ministers alone. I am not saying this because I underestimate health ministers, but to highlight that finance ministers, prime ministers, presidents, and foreign ministers, are needed as well.’ (171)(p. 5) Based on this premise, the FPGH and the *Oslo Ministerial Declaration* were developed by foreign ministers without involvement from health ministers to raise the political profile of health. As the background to the *Declaration* states:

‘There are both technical and political dimensions to protecting and promoting global health and human security. This means that health issues do not only belong to ministries of health and the WHO, especially when they are cross-cutting in nature. New mechanisms in addition to the traditional development model are required...a focus on people’s health and wellbeing must become part of the collective consciousness of policymakers at the highest level...’ (24)(p. 1374)

To attract the attention of high level policymakers beyond the ‘technical’ health arena, the rationale for why the initiative is needed and what it will aim to achieve are framed to ‘sustain traction’ within the politics of foreign policy. (141) The *Oslo Ministerial Declaration* focuses on ‘global health security’ as a key concept, presumably because it resonates with foreign policymakers since it falls within the traditional high politics domain. What exactly it means within the context of the *Declaration* is not clear, however. The *Declaration* states that the concept has yet to be defined and that the Ministers expect that a definition would be agreed to at the World Health Assembly. The Ministers nonetheless assert that global health security refers to ‘protection against public health risks and threats that by their very nature do not respect borders. Global health security depends on critical capacity in all countries, combined with a commitment to collaborate.’ (24)(p. 1375) This definition seems to be in keeping with narrow notions of global health security rather than the broader concept of human security, for example. (73) However, global health security also appears to be used in the *Declaration* as an umbrella concept to ‘to connect health concerns with numerous foreign policy interests,’ (141)(p. 5) including economic growth, development and the MDGs, human rights and dignity, all of which are included in the *Declaration* in some way. Interestingly, neither of the interviewees for the Norway case study thought that global health security was a driving force behind the FPGH. As one stated:

In terms of health as security, that has never been a strong sort of argument although in relation to pandemic influenza of course, the issue of health and foreign policy has been highlighted, but it hasn't been a main driver of the initiative. What I see as an observer is what characterizes this coalition of countries is the very, very broad agenda that includes almost everything as opposed to a focus on sort of terminology like global health security.

Sandberg et al. reiterated the idea that the *Declaration* is a broad agenda in their recent commentary on the FPGH. They write, 'the document is...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.' (173)(p. 1785) The 'global health security' framing thus appears to have been used as a strategy to enhance sustained political attention on the importance in foreign policy of global health, broadly defined.

An urgent need for change

The third and final major motivating factor behind the creation of the FPGH and the *Oslo Ministerial Declaration* was an 'urgent need' to change and try 'non-traditional' approaches to broadening the scope of foreign policy beyond 'pure self-interest' which could undermine 'the solutions that respond to challenges of growing interdependence.' (24) (p. 1373;1375) The Ministers argued that globalization and its various impacts, be they economic, technological or social, were driving the need to broaden the scope of foreign policy, and that globalization-driven impacts could only be managed successfully if nations worked together to embrace new ideas, new approaches, and new alliances (the Ministers used the word 'new' at least 25 times in the declaration while words such as 'partnerships,' 'alliances,' 'cooperation,' 'collaboration,' 'together,' and 'shared' appear up to 10 times each in the text). Within the 'need for change' falls the idea of applying the foreign policy lens when looking at health issues and applying the health lens when

looking at the motivations and consequences of foreign policy. Applying the foreign policy lens implies looking at health issues through foreign policy interests, such as security and economic power. This is part of the new or non-traditional approach to foreign policy that the Ministers are espousing. Another component of the new approach is making ‘ “impact on health” ’ a point of departure and a defining lens’ to be used when examining key elements of foreign policy. (24)(p. 1375) The *Declaration* argues that using health impact assessments would advance the cause of health across governments and lead to a much needed ‘long-term, forward-looking view.’(24)(p. 1375)

The interviewees supported the notion that the need for change was a key factor behind the creation of the FPGH.

There were many new challenges that you couldn't fix by doing it in the traditional ways, and you needed what has been referred to so often as a new collective action to find solutions to problems together.

It doesn't work if you do it on your own. I mean the motivation is global solidarity. I think another motivation is that we need to think outside the box by building new alliances. Thinking strategically and trying to find solutions was also a huge motivation for countries to join this group and also to focus on this area.

4.3.3 Content

The *Oslo Ministerial Declaration* consists of an agenda for action organized around three main themes - ‘capacity for global health security,’ ‘facing threats to global health security’ and ‘making globalization work for all.’ (See Table 5 for a summary of the agenda for action). It contains ten priority areas within these themes with specific action points for each. The action plan is high level with no further details about how the FPGH members intend to deliver on it. The ten priority areas were chosen because the Ministers

deemed that these were the areas in which ‘a stronger, more direct involvement of foreign policy could make a tangible contribution to protecting and promoting health, as well as offer new scope for foreign policy.’ (24)(p.1373). The agenda for action is described as ‘ambitious and progressive.’ (24)(p.1373) A close examination of the content of the action agenda highlights that health security is at its core based on the premise that all nations share a ‘common vulnerability’ to health threats. (24)(p.1373) ‘Global health security is only as strong as its weakest link.’ (24)(p.1374) Eight references to the links between health and the MDGs are included as well as references to the key role that UN institutions play in global health, in particular, global health security. Almost every priority action area refers to actions countries should take in collaboration with UN agencies. The agenda for action also refers to the link between health and human rights (makes three references to human rights) and in so doing refers to both the ‘high politics’ and ‘low politics’ areas of foreign policy, although the ‘high politics’ areas clearly dominate (e.g. the word ‘security’ appears in the agenda for action 25 times, and ‘trade,’ 14). The agenda for action also includes several references to the need to build health research capacity and to support researchers in the FPGH member countries as part of efforts to strengthen health systems overall.

Table 5: Oslo Ministerial Declaration Agenda for Action (24;141)

Action areas within themes	Examples of actions
Capacity for global health security 1) Preparedness and foreign policy 2) Control of emerging infectious diseases and foreign policy 3) Human resources for health and foreign policy	Strengthen the capacity of the UN Secretary General to assume a coordinating role in facilitating action related to foreign policy in preparedness, planning, and action for global health security. Identify gaps in implementation ensuring the availability of essential medicines, vaccines, and equipment, not only domestically but also within countries that need assistance, including failing states and countries in conflict and crisis. Support and facilitate WHO's leadership role. Support the development of a global framework for tackling the global shortage of health workers, with monitoring and accountability mechanisms, including tracking recruitment from countries with weak capacity.
Facing threats to global health security 4) Conflict (pre, during, and post conflict, and as peace is being built) 5) Natural disasters and other crises 6) Response to HIV/AIDS 7) Health and the environment	Further develop the case for a health focus in post-conflict reconstruction in cooperation with the WHO. Ensure that priority is given to restoring a functioning health system (workforce, infrastructure and supplies) in the aftermath of a crisis. Take up the challenge that HIV/AIDS presents to trade, human rights, peace building and humanitarian action through a health lens to drive forward a broader agenda for change. Make the links between environment policies and global health visible in foreign policy engagements and exploit the synergistic potential of related policy processes.
Making globalization work for all 8) Health and development 9) Trade policies and measures to implement and monitor agreements 10) Governance of global health security	Engage with WHO and the UN Environment Programme on their joint health and environment initiatives. Affirm the interconnectedness of trade, health and development, including both trade and health policies in the formulation of all bilateral, regional, and multilateral trade agreements. Support policies for global health security in the various foreign policy dialogue and action areas, such as the UN, G8, arenas for economics and trade issues, and within regional and bilateral arenas.

4.3.4 Process

The role that Norway played in developing the FPGH and the *Oslo Ministerial Declaration* has already been described. To elaborate further, Jonas Gahr Støre first approached French Minister of Foreign Affairs, Phillipe Douste Blazy about the possibility of creating the initiative in summer 2006. Blazy was a medical doctor who had previously been a Minister of Health. They agreed on the initiative and decided which additional countries to invite to join. These countries were chosen for different reasons. Norway was interested in strengthening bonds with some of them and had already cooperated on international health issues with others. Other countries represented key states in different regions of the world, including the emerging economies of Brazil and South Africa. (174) Interviewees from Norway described the process as “elite driven” and clearly stated that the initiative “was not developed with health people.”

Once formed, the FPGH initiated a dialogue amongst its members on the inter-linkages between health and foreign policy, which eventually led to the *Oslo Ministerial Declaration* published in The Lancet in 2007. (175) After the *Declaration*, one of the interviewees explained, in 2008 the FPGH “established a network of Geneva based diplomats and created a new space for informal consultations.”

Norway was the FPGH’s initial secretariat and in 2010 this role was passed on to Brazil. South Africa led the initiative’s involvement in finalizing three resolutions on health and foreign policy at the General Assembly. (173) Work of the experts from each country (“the expert group” made up of the Geneva-based diplomatic staff of the FPGH countries

(169)) appeared to have informed the Ministers' efforts. The expert group "develops evidence in order to feed into the Oslo group in these areas but also working with research institutes and others." The FPGH functions quite informally. No funds are allocated for its work nor are milestones defined. (173) Rather it has sought to 'seize opportunities for negotiated solutions wherever they arise.' (173)(p. 1786)

4.3.5 Actors

Although the *Oslo Ministerial Declaration* states that Ministers of Foreign Affairs from all regions were invited the 'join us in further exploring ways and means to achieve our objectives,' (24)(p. 1373) the FPGH is in fact a club with closed membership. (174) Membership has not changed since it was initially formed, although according to one informant other countries (including Canada) were invited to at least one FPGH meeting that took place in October 2009. More recently at a global health diplomacy conference at Chatham House, London, a representative of FPGH from Brazil explained that the expansion of the original group of members had been debated and other countries have sought membership, but in the interest of balance, the group has not sought to grow. Moreover, the informality of the group was credited with fostering trust among its members. (176) At the Prince Mahidol Conference in 2009, Minister Støre explained the rationale for the small group and membership further:

'the group is a small one, but it represents a range of different perspectives in geographical as well as political terms. It is this well equipped to promote the foreign policy and global health agenda in a wide range of regional and global contexts.'(168)(p. 1)

Since it was Norway's leadership that led to the FPGH, one of the informants provided insights into the actors involved in global health in Norway that might help shed further light on FPGH's approach to membership, as well.

Global health involvement in Norway has been elite driven. So it's been driven by these few individuals, sort of policymakers that are extremely well placed internationally. It's not something that has been driven by university engagement and NGOs. It's sort of gone the other way. I don't think that people have necessarily seen that as a problem because you have very little public attention to the fact that Norway has been involved in this. Health related NGOs are mostly interested in health and development. On the academic side we are just starting in this area-looking at climate change governance issues that are relevant to health too. In IR²⁷ we are finding ourselves this little niche that hasn't really existed before.

In their paper analyzing the evolution of Norway's role in global health, Sandberg and Andresen provide additional insight into the key global health actors in Norway. They note that the Ministry of Foreign Affairs' broadening health agenda brings it closer to 'the realm of the Ministry of Health's relations to the WHO.' (169)(p. 316) Despite the significance of the FPGH, the WHO remains central to Norwegian global health policy and it is Norway's Minister of Health and not the Minister of Foreign Affairs that is ultimately responsible for WHO issues. (169) As the Ministry of Foreign Affairs becomes increasingly interested and engaged in the traditional responsibilities of the Ministry, Sandberg and Andresen point out that challenges in coordination have arisen along with the question: 'who represents Norway on health issues in international arenas?' (169)(p. 318) With the WHO this question appears to have been answered through the new Norwegian WHO Strategy released in 2010 and coinciding with Norway being granted a three-year seat on the WHO's Executive Board. (177) The Ministers of Foreign Affairs, Health and Care Services and Environment and International Development co-signed the strategy agreeing to 'join forces on a Norwegian strategy that will apply for the duration of the Norwegian term of office and to the end of 2013.' (177)(p. 9) The WHO strategy is 'in keeping with' both Norway's foreign policy and

²⁷ IR is short for the academic discipline of international relations.

development policy. (177) (p. 9) In this way, the WHO strategy appears to be Norway's version of a whole-of-government agreement on global health, at least when it comes to its relationship with the WHO.

4.3.6 Indicators of impact

The *Oslo Ministerial Declaration* is silent about how its action agenda will be achieved and how its impact assessed and understood. However, the interviewees provided some insight into what they regarded as impacts of the initiative at the time of the interviews. One described the initiative as a “catalyst in getting the issue of health and foreign policy on the UN General Assembly agenda” and a way to “build alliances on topics where it is not always easy to find consensus.” The other talked about how the initiative has catalyzed interest in “coupling up research in this area more actively to foreign policy.” These accomplishments also appear in the statement the FPGH members released in 2010 renewing their commitment to the 2007 *Oslo Ministerial Declaration*.

‘Together with the UN Secretary-General and the WHO Director-General, our initiative has contributed to set a global foreign policy and global health agenda, anchored in annual General Assembly debates and resolutions. The growing interest and engagement of countries as well as the increasing academic work related to the interface between foreign policy and global health underpins the relevance of this agenda.’ (34)(p.1)

In terms of academic collaboration stemming from the FPGH, in December 2010, Norway's Foreign Minister, Jønas Gahr Støre launched a new international collaborative research project that will explore the links between foreign policy and global health. Collaborating countries include the US, Norway, Indonesia, Brazil and South Africa. The first phase of the research project will include interactions with diplomats and ministries of foreign affairs culminating in four reports (not available at time of writing) that seek to map and review existing knowledge of the interlinkages of health and foreign policy. The

reports will provide the basis for a longer term research agenda. (26;178) This research collaboration is regarded as a concrete example of an outcome stemming from the FPGH. (176) A component of the collaboration announced in November 2011 includes the creation of the independent academic Oslo Commission on Global Governance for Health led by the University of Oslo's Rector Ole Petter Ottersen in partnership with the Harvard Global Health Institute. (179) To augment currently sparse empirical knowledge on how health can be better promoted through foreign policymaking and other governance processes, this Commission will analyze the inter-relations between health and other governance sectors. It will assess how policies and actions in these areas affect global health objectives and then identify and make recommendations pertaining to how targeted actions outside institutions of health governance may contribute to global health. (179) The FPGH has committed to taking recommendations stemming from the Commission to the highest political levels as part of the next stage of its work.²⁸ (35)

In regards to other impacts, when the interviewees were asked if policy and diplomatic practice had changed as a result of the initiative, one responded by saying:

Yes and no- ministries have to cooperate within one delegation, so it started and people that were part of that delegation have sort of expressed that it really had people think through what it meant to be part of negotiations where you had multiple sort of objectives and multiple states within a common field– an example of how diplomacy is changing. On the no side, the difficulty policymakers are having in terms of sort of educating and informing their staff involved in the UN to try to sort of make those bridges or those interlinkages where the issues such as trade or climate has a health impact sort of maximize in other issue areas. I mean, this has been difficult. And it also has to do with sort of reaching out and communicating within our own ministry, but I don't know if that depends on the issues or if that depends on the people. But here is an effort to change diplomatic

²⁸ The Commission's work, including new research and analysis, will be published in an extensive report in The Lancet in August 2013 and the recommendations will also be presented at the United Nations General Assembly in 2013. (180)

practice, but it's small. It's hard to implement intersectoral coordination, easier said than done.

Since the interviews for this thesis project were first undertaken there has been significant interest in understanding the Oslo process and assessing its impact. As already mentioned, the founding countries renewed their commitment to the 2007 declaration with a more prioritized focus on the MDGs, global governance for health, the global workforce market, protecting peoples' health in situations of crises, establishing the evidence base and contributing to the WHO Conference on Social Determinants of Health that took place in Rio de Janeiro in Fall 2011. Amongst these priorities, the Ministers supported the creation of the new Oslo Commission on Global Governance for Health. This support aligns with their decision to make governance the overarching theme for their next phase of collaboration 'in recognition that the world needs more functional and coherent global governance for health.' (35)(p. 2) Foreign policy areas such as security and peace building, trade and human rights continue to be the rubric within which these new priorities fall. No additional countries were added to the FPGH membership as part of this renewal. (34)

In June 2011, the inaugural conference of the Global Health Diplomacy Network took place at Chatham House in London. One of the main topics of discussion was the current influence and future of the FPGH. (176) Fidler wrote a briefing paper to inform discussions in which he concluded that assessing the initiative is difficult because information about its activities is not readily available nor has its performance been critically analyzed. He concludes that FPGH's impact has been limited and that it does not appear to be a 'promising venue in which to address the increasingly difficult

environment health faces within foreign policy processes because of fiscal crises on many countries and geopolitical shifts in the distribution of power.’ (141) (p. 1) The group of Norwegian academics who have been focusing on health and foreign policy and the FPGH also assert that the FPGH should be strengthened as an institution if Norway truly believes in the concept and practice of health as foreign policy. However they also argue that the initiative has had a significant impact on building relationships between the country members, raising the profile of health and foreign policy at the UN and galvanizing a new epistemic community focused on strengthening the knowledge base in this area in collaboration with policymakers. (169;173-175)

A few observations and conclusions can be made when applying a ‘health as development’ lens to the *Oslo Ministerial Declaration* and more generally to Norway’s leadership in improving global health as reflected in aid contributions. Supporting international development for normative and ethical reasons appears to be important to Norway and to the FPGH. Norway has highlighted the importance of assistance to countries to reach MGD 4 (reduce child mortality by two thirds) and MDG 5 (reduce maternal mortality by three-quarters). (73) As Minister Støre stated at the 2009 Prince Mahidol Awards Conference, ‘contributing to international development is a key goal of the Norwegian government. One per cent of Norway’s GDP has been allocated to ODA (overseas development assistance), and 1-13 (0.87%) per cent of these funds is earmarked for health purposes.’ (168)(p.2) Figure 5 summaries Norway’s ODA contributions for 2009 and 2010. Of note, Afghanistan, the West Bank and Gaza Strip and Sudan, countries in conflict, are amongst the top five recipients of aid from Norway,

leading to the conclusion that Norway's aid is also potentially related to security interests and not only needs based.

The *Oslo Ministerial Declaration* also asserts that development cooperation models that allocate aid based on need and not on national interests are needed and indicates that countries should honour existing aid financial commitments (24) most of which appear to lag behind proclaimed intent. (73) The International Health Partnership (IHP) is one example of a development approach to global health policy anticipated by the *Oslo Ministerial Declaration*. Launched in September 2007, with leadership from the UK and Norway, the IHP intends to improve aid effectiveness within the health sector. (73) Whether it will deliver more health aid or only improve efficiency and effectiveness of what is currently offered is not clear. The initiative's progress so far has been described as slow indicating that at least at this point in time this type of initiative may not lead to the impacts that FPGH is looking for. (73)

Figure 5: Norway Aid Statistics 2009, 2010 (165)

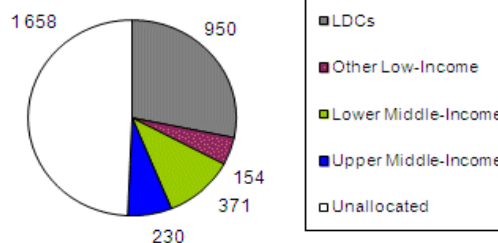
NORWAY

Gross Bilateral ODA, 2009-10 average, unless otherwise shown

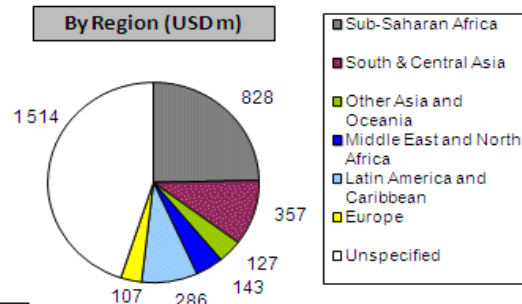
Net ODA	2009	2010	Change 2009/10
Current (USD m)	4 081	4 580	12.2%
Constant (2009 USD m)	4 081	4 231	3.7%
In Norwegian Kroner (million)	25 624	27 681	8.0%
ODA/GNI	1.06%	1.10%	
Bilateral share	78%	78%	

Top Ten Recipients of Gross ODA (USD million)	
1 Brazil	137
2 Tanzania	120
3 Afghanistan	118
4 West Bank & Gaza Strip	105
5 Sudan	104
6 Mozambique	77
7 Uganda	69
8 Pakistan	65
9 Malawi	64
10 Zambia	58
Memo: Share of gross bilateral ODA	
Top 5 recipients	17%
Top 10 recipients	27%
Top 20 recipients	37%

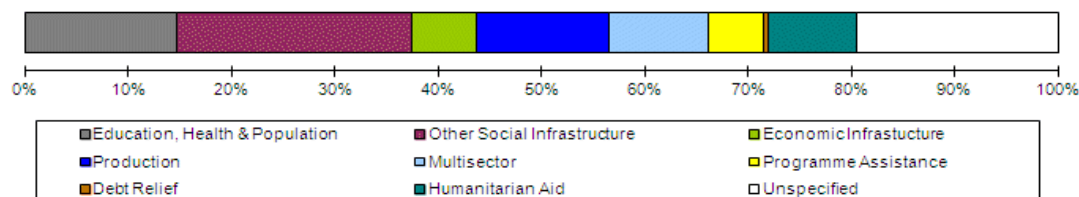
By Income Group (USD m)



By Region (USD m)



By Sector



Source: OECD - DAC ; www.oecd.org/dac/stats

4.3.7 Conclusion

The findings from the Norway case lead to a few main conclusions.

First, as in the Swiss case, the leadership of a key individual (i.e. policy entrepreneur), played a major role in catalyzing policy action. In the Norwegian case, the leader was a politician with a political science background who had experience working at the WHO, Jonas Gahr Støre, Minister of Foreign Affairs, and in the Swiss case, catalytic leadership came from a senior public servant working in the health division, Gaudenz Silberschmidt, a medical doctor with an advanced degree in international relations. The nature of the leadership and its impact is likely related in part to the differences in the intent of the policy statements that were developed in each case. In the Swiss case, the policy was developed as an internal document to guide coordination primarily between those parts of the Swiss government responsible for health and those responsible for foreign relations. A senior and seasoned public servant like Dr. Silberschmidt, steeped in the culture of efficiency and effectiveness within the Swiss government who could bridge the worlds of health and foreign policy, was arguably an ideal change agent in this case. In the Norwegian case, since the intent of the *Declaration* and FPGH was to raise the profile of health as foreign policy concern, leadership from a credible foreign policy expert and practitioner was highly appropriate. Minister Støre's experience with the WHO also likely contributed to his impact as a leader. His reputation as Norway's "most popular politician" has helped him sustain attention on global health and foreign policy, but also potentially implies that his leadership could be politically motivated and shift to other priorities if voter attention shifts.

In addition to leadership at the individual level, the motivation to build on and strengthen national reputation as leaders in global health was also a strong influencing factor in both the Swiss and Norwegian cases, albeit more prominent in the latter. In the Swiss case, safeguarding and strengthening Switzerland's reputation as a host country to international organizations (Geneva is the host city to 25 United Nations (UN) and other international organizations and hosts permanent missions of over 200 NGOs) and a base for major companies working in the health sector is described as one of the main interests underpinning the *Swiss Health Foreign Policy*. (36) In Norway's case, building on and strengthening Norway's reputation for 'goodness' as demonstrated through its long history of leadership in global health at the WHO was described as one of the main reasons why the Norwegian Minister of Foreign Affairs decided to establish the FPGH. Norway's investments in ODA also demonstrates its commitment to improving the global health situation though it appears that its traditional focus on 'goodness' is now being coupled with stronger self-interest as Norway shifts focus from where the need is greatest to where it can make a difference in world affairs.

Second, because the intent of the *Declaration* and the FPGH was to attract the attention of foreign policymakers to health as a foreign policy issue and sustain such attention, it appears that health was framed strategically in the *Declaration* as 'global health security.' This traditional 'high politics' approach to framing health as a foreign policy is not surprising as it is the dominant rationale underpinning health's rise as a foreign policy issue. It is also consistent with Fidler's 'remediation' conceptualization which asserts that increasing attention to health as a foreign policy issue reflects the continued reality of the

traditional hierarchy of foreign policy functions in which protecting national security is at the top. Such framing can be problematic for those aiming to collectively advance global health, however, as the term ‘global health security’ is not well defined and inconsistently used. (181) For some, global health security is primarily about protecting the security and self-interests of the state (i.e. traditional foreign policy framing), while for others it may be defined more broadly to also encompass ‘human security,’ which is people-rather than state-centred with a focus on vulnerable populations. (73;182) As Labonté and Gagnon and others have argued, global health security traditionally conceived can pose significant threats to global health equity and to global health as a humanitarian endeavour. (73;183) Treating global health issues as security threats may focus attention disproportionately on countries and diseases that pose security threats to wealthy nations, rather than on those in greatest need. (183) While the Ministers may have decided to use this framing to attract the attention foreign policymakers, they potentially took a risk in doing so. As Fidler argues in his ‘regression’ conceptualization, connecting health to high politics in this way threatens long-standing associations of health as a normative value and what was special about health in international relations in the first place. (57) While a focus on ‘global health security,’ permeates the *Declaration*, it also makes two references to protecting and promoting ‘human security,’ (24) a concept more in keeping with the more traditional normative nature of providing aid for health. (73)

Third, under Norway’s leadership, the establishment of FPGH and the *Declaration* was “elite-driven” and not undertaken in collaboration “with health.” The FPGH argued that this approach was part of the urgent change that was needed to draw foreign policy

attention on global health. Health could not stay within the domain of health leaders only, if global health issues were to attract the attention of the most elite stakeholders in the process, the participating nations' foreign policy ministers and the UN General Assembly. Based on the assessments of the FPGH done to date, it appears that this approach has led to a number of important outcomes including the three UN General Assembly resolutions on health and foreign policy²⁹ and the new Commission on Governance for Health. While the group of Ministers appears to have been an effective advocacy group for health and foreign policy, if FPGH becomes a more formalized actor in global health governance perhaps it would be advisable for it to revisit its membership and consider adding representatives from health and development. As Switzerland's Dr. Silberschmidt argued, advancing health as a foreign policy concern should ideally involve at least actors from these three entities - health, development and international relations. Debates and analysis about the pros and cons of closed versus open clubs in the context of global governance could inform this process. (184) At the country level, Norway has established such collaboration across Norwegian ministries as part of its new WHO strategy. To achieve greater impact, perhaps this approach could also be expanded at the international level through Norwegian leadership in the next phase of FPGH. It does appear, however that as the FPGH enters its next phase, it is engaging to a greater extent in collaborations with the health community, or at least with the academic community that focuses on global health, as part of the Oslo Commission on Global Governance for Health. (179) It will be important to assess the success and impact of

²⁹ In his assessment of FPGH, Fidler argues that while these resolutions are evidence of heightened awareness, their impact on why and how countries approach health issues in their foreign policy is difficult to assess. (141)

such engagement to inform what appears to be an evolving role for FPGH in the global health landscape.

Finally, there are two additional observations that can be made from the Norwegian case. First, as in the Swiss case, timing was critically important. As Kingdon's model illuminates, the FPGH leaders recognized the window of opportunity for country level collaboration that had opened as a result of problem, policy and political stream alignment in the mid-2000s. SARS was arguably a focusing event (i.e. the problem) that led to growing attention on global health in foreign policy in the context of globalization. Health as part of foreign policy was a policy idea that had been attracting attention for several years and when political will, largely Norway's, was present, the streams aligned and the FPGH was created and the *Oslo Ministerial Declaration*, released. And, second, as in the Swiss case, the WHO was regarded as a key actor in global health that nations must collaborate with to achieve global health objectives. The WHO played a prominent role in profiling and collaborating on the FPGH (30) and is also figured prominently as an important partner in the *Declaration*. This highlights FPGH countries' acceptance of the WHO as an international institution that helps countries work together to achieve collective global health objectives at the population level.

4.4 Brazil: Global solidarity

4.4.1 Introduction

Brazil's role as an emerging, important global leader continues to garner attention. (185)

One area in which Brazil has demonstrated considerable leadership is in global health and

global health diplomacy. Its role in a number of global health initiatives has been regarded as instrumental in effectively moving them forward. (39-44;186-192)

Brazil has not developed a whole-of-government global health policy *per se* (though it is a member in the FPGH and presumably supports that initiative's policy directions) therefore Brazil's overall role and perspective on global health diplomacy will be discussed as it has been portrayed by the two informants from Brazil (interviewed simultaneously), and from examples drawn from the literature.

4.4.2 Context

Brazil's constitution: Health is a human right

As the interviewees explained, Brazil's current constitution promulgated in 1988 in reaction to a twenty plus year military dictatorship in Brazil sought to guarantee individual rights and limit restriction on freedom, including health as a human right: "First of all, Brazil, in its constitution in 1988 established that health is a right of the people and the duty of the State, and this gave rise to the health reform in Brazil." In addition to underpinning health reforms within the country itself, the interviewees explained that health as a human right is also the main motivation behind Brazil's focus on global health and influences how it goes about engaging in global health diplomacy. This main motivation was grounded in former President Luiz Inácio Lula da Silva's (2003- 2010) Workers' Party ideological and political position,³⁰ which they referred to as "international solidarity." The need for greater international solidarity, they highlighted, is particularly poignant in the context of globalization that is bringing

³⁰ Brazil's new President, Dilma Rousseff, assumed office in January 2011. She has been referred to as outgoing President Lula's anointed successor. Therefore, it is assumed that her policy positions will be the same or similar to what President Lula's were. (193)

nations even closer together. Advancing health equity in this context requires international “cooperation,” (in particular, South-South cooperation) a fundamental cornerstone of Brazilian foreign policy ‘inspired in common interest and mutual help’ (190)(p. 38) that drives its role and leadership in health as well as other areas.³¹

In global health, our main thrust is not necessarily assistance but cooperation, and the difference we make between assistance and cooperation is that it's a two-way process in which both sides-Brazil and the other countries involved-participate. The base mechanism that we have been utilizing in most of the cooperation with developed or mostly Africa and Latin America is the establishment of networks in which we have several initiatives in different countries, in Brazil, in Angola, Mozambique, in Colombia, in Chile, in which they interact in a network format in which all of them take advantage of the important development that each one can operate. This is a different approach to cooperation and to global health itself.

Dr. José Gomes Temporão’s remarks at a 2009 Chatham House event align with those from the interviewees and sum up Brazil’s main motivations for focusing on global health in foreign policy. (191) He expressed these perspectives, for example, when referring to Brazil’s role in mitigating the impact of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) on public health stating that, ‘Brazil defends, in an unequivocal manner, the primacy of Public Health over trade issues, a principle that is recorded in the Doha Declaration on the TRIPS³² Agreement and Public Health.’

(191)(p. 6)

³¹ Brazil’s principles of health cooperation include: “commitment to life; health as a universal right and the State’s obligation; equality between the States; cooperation between nations for the progress of humanity; respect for national sovereignty, economic independence, equal rights and non-intervention in the nations’ domestic affairs; actions based on horizontality; respect for cultural diversity; autonomy of the countries and sustainability of action; integration/articulation; ability to resolve and efficiency; teamwork; development of partnerships; organization and modernization; protagonism of the countries; institutionalization and recovery of local history; social participation and control.” (194)(p. 3)

³² In 2001, the World Trade Organization (WTO) Members adopted a Ministerial Declaration at the WTO Ministerial Conference in Doha to clarify ambiguities between the need for governments to apply the principles of public health and the terms of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The Declaration responds to developing countries’ concerns about the obstacles they face when seeking to implement measures to promote access to affordable medicines in the interest of

Of note, one of the interviewees explicitly stated that health security and economic gain for Brazil “are not the main motivations of the Brazilian government” when it comes to paying attention to global health. However, both interviewees acknowledged that Brazil’s role as an increasingly influential global economic player may also eventually permeate more deeply its main reasons for integrating health in foreign policy.

There are a lot of companies, private companies in Brazil, very important now, and very important players in the international trade, international economy like mining companies and also building companies.. construction companies working a lot in countries where Brazil is helping. That is, I think there are economic interests of Brazil, but not so clearly linked. I think the main motivation is international solidarity.

While Brazilian self-interest is not or has not been a primary motivating factor for its focus on global health, there are some indications that self-interest may play a role, nonetheless. Bliss’ Center for Strategic and International Studies (CSIS) reports refer to this motivation. She writes that Brazil’s reasons for focusing on global health are at least in part informed by the concept that health activities can serve as an engine of domestic industrial development. This viewpoint manifests itself in two ways: first, in the belief that a healthy population is a more productive population; and second, in the conviction that Brazil should develop its health industry and increase its activities in biotechnology research, vaccine and pharmaceutical production and the dissemination of products internationally, to create jobs and promote economic growth. (186;187)

public health in general, without limitation to certain diseases. The Doha Declaration affirms that the TRIPS Agreement does not and should not prevent WTO members from taking measures to protect public health. (195;196)

4.4.3 Content

Health in all policies

The interviewees indicated that “health is very well accepted as part of our foreign policy,” and provided examples of Brazil’s global health priorities. These include what Minister Gomes referred to during his Chatham House speech as ‘global conventions’ (i.e. global public goods) such as the WHO Framework Convention on Tobacco Control, which Brazil strongly supported, as well as other international conventions, in particular those related to addressing climate change.³³ (191)

Ensuring equitable access to medicines is another global health priority for Brazil. Brazil played a key role in negotiating the 2001 Doha Declaration on the TRIPS Agreement and Public Health and has adopted a ‘a successful policy of permanent negotiation with the pharmaceutical industry,’ to keep its own costs of drugs low. (191)(p.6) As Bliss writes, it was Brazil’s achievements in HIV/AIDS prevention and treatment beginning in the 1990s that helped lead to its successful negotiation of flexibilities within TRIPS. Brazil’s decision in the 1990s to ensure universal access to antiretroviral medications along with prevention campaigns helped the country to avoid up to 1.2 million HIV/AIDS cases that had been projected to develop. (187)

Action to address social determinants of health and by so doing also working towards achieving the MDGs are a third global health priority for Brazil. (191) Brazil played an active role in the WHO Commission on Social Determinants of Health (2005-2008) and hosted the 2011 World Conference on Social Determinants of Health. (136)

³³ E.g. Convention on Biological Diversity, Stockholm Convention on Persistent Organic Pollutants

4.4.4 Process

Brazil has enjoyed considerable success as an influential player in global health diplomacy processes that have led to significant advancements in global health. As the interviewees explained, this success can be attributed to the approach that Brazil takes in such negotiations and to how internal government operations and relationships have been set up to achieve greater integration of health into foreign policy and policy coherence.

Soft power

According to one of the interviewees, President Lula decided that:

health would be part of our foreign affairs policy and the ministers of health were very committed to his governing position that we are calling diplomatic soft power, and health is one of his soft power tools the Brazilian government is putting ahead in its foreign policy.

This statement highlights the role that political commitment from the very top has played in Brazil's leadership in global health and GHD, and the importance of its soft power approach. Celso Amorim, Foreign Minister under President Lula and now Brazil's Minister of Defense, defines soft power as 'The use of culture and civilization, not threat. It is a belief in dialogue, not force.' (197) In contrast to 'hard power' that is based on force and coercion, soft power is grounded in the ability to frame issues, set the agenda through attraction to shared values, 'and to the justness and duty of contributing to the achievement of those values.' (198)(p.2) Some argue that in the context of globalization characterized by greater interconnectedness and interdependency, soft power is a more favourable approach than hard.³⁴ An analysis of Brazil's role in the process to develop the WHO Framework Convention on Tobacco Control (FCTC) demonstrated that the

³⁴ More recently, global leaders have also started to talk about 'smart power,' an approach through which hard and soft power is combined in ways that are 'mutually reinforcing.' (43) Brazil's increasing economic clout coupled with its soft power approach to diplomacy has also been referred to as 'smart power.' (43)

country's effective use of soft power contributed significantly to achieving this particular global health outcome. (42) Brazil's ability to grapple with a diversity of interests at the national level to establish a national tobacco control program received significant WHO attention in the early millennium. (43) A Brazilian medical doctor who led the Brazil process was recruited to lead the WHO Tobacco Free Initiative (TFI) and a skilled and experienced diplomat from Brazil was appointed as chair of the Intergovernmental Negotiating Body (INB) for the FCTC. (42) Brazil's status as one of the biggest producers and exporters of tobacco, while at the same time achieving high visibility in tobacco control, provided credibility to its leadership role in the WHO process. (42) Through diplomatic leadership and coalition building, Brazil played a key role in building support in the developing world for the FCTC which resulted in 'effective expanded participation by developing countries in negotiations.' (42)(p. 4)

Collaboration across government

As the informants explained, Brazil's Ministries of Health and Foreign Affairs work closely together on global health policy development and implementation.

We have joint missions in which the Foreign Affairs Minister and the Minister of Health work together in establishing relations with several different countries...very concentrated in Africa, in South America.

This interviewee went on to explain that the ability and capacity to work so closely together as ministries is largely a result of how the Brazilian federal government is structured to ensure that health is integrated into all policies.

I would like to remind you of a special situation in Brazil. It is that each ministry has a representative from the Foreign Affairs Ministry. The first ministry to have this representative was the Ministry of Health. So the Foreign Affairs Ministry defined that the Ministry of Health must have a representative, a diplomat working together with several divisions of the Ministry of Health to define the policy linked to health on behalf of the Ministry of Health and Ministry of Foreign Affairs.

To facilitate this linkage and disburse aid, the Ministry of Foreign Affairs established an entity called the Brazilian Cooperation Agency (ABC-Agencia Brasileira da Cooperação) in 1987³⁵ that works with the Ministry of Health to carry out technical assistance projects, nearly half of which are health-related. Nearly 16% of the ABC's total budget of \$30 million in 2010 is allocated to health projects. (187) However, this is only a portion of what Brazil's annual aid is estimated to be. While there is no official figure for Brazil's aggregate development assistance, a study by the Brazilian Institute for Applied Economic Research estimates that it is close to \$1 billion per year which includes: about \$480 million for technical cooperation projects, including the \$30 million for health projects; an estimated \$450 million for in-kind expertise provided by the many Brazilian institutions involved in technical cooperation; Brazil's peacekeeping mission in Haiti of about \$350 million per year; and in-kind contributions to the World Food Programme of about \$300 million per year. (200) If this estimate is correct, it puts Brazil, described as an emerging aid donor along with China and India, slightly ahead of smaller OECD-DAC donors in terms of value of aid but not on a per capita basis. (200) In addition to development projects *per se*, the Ministries also cooperate closely on diplomatic outreach on health matters with representatives of the diplomatic staff assigned to the Ministry of Health to provide advice on international negotiations and foreign policy. 'Brazil's professional foreign specialists frequently sit side by side with senior Health Ministry

³⁵ Of note, Brazil's military dictatorship ended in 1985. (199)

officials to jointly craft the country's approach to key global health policy concerns.' (187)(p. 4)

Within Brazil's Ministry of Health, an international affairs office manages global health projects. The bulk of international cooperation is carried out by the 110 year old Fundação Oswaldo Cruz (FIOCRUZ) attached to the Brazilian Ministry of Health - 'the most prominent science and technology institution in Latin America.' (201)(p.1) Founded in 1900 to research and develop ways to fight bubonic plague in Brazil, the organization now includes a school of public health, a training centre for health technicians, numerous research facilities, a Center for International Relations in Health that coordinates Brazil's international cooperation global health activities and a training program focused on global health diplomacy. (187;201) Examples of FIOCRUZ facilitated activities include: 'donations of drugs and vaccines to face some particular need of neighbouring countries like Bolivia and Paraguay; capacity building to the Argentina National Institutes of Health; distance education in public health in Venezuela; and advising in the formation of the health components of the new Constitution in Ecuador.' (202)(p. 4) As one interviewee explained, "ABC counts with FIOCRUZ as the main advisor in the relation to health. And there is where the mission...the joint mission with different countries takes place." The other interviewee elaborated further:

I can say that the Ministry of Health and FIOCRUZ were very important in defining health in foreign policy. It's a connection; it's a priority in foreign affairs. It's not an isolated proposal of the Ministry of Foreign Affairs. It's a sharing proposal and this has been built during the last ten years, the last ten years when Brazil was very active in discussion of intellectual property and before this in the tobacco framework.

Paulo Buss, a medical doctor with a long standing interest and involvement in medicine and politics was President of FIOCRUZ from 2001-2008. He is regarded as one of the most influential players in Brazil and around the world in thinking about health in foreign policy. He served as the Brazilian Representative at WHO's Executive Board from 2005 to 2007 and President of the World Federation of Public Health Associations from 2008-2010. (199)

4.4.5 Actors

WHO and civil society

In addition to the key global health actors in Brazil already mentioned, (the President, FIOCRUZ, the Ministries of Health and Foreign Affairs) the interviewees also highlighted several others, in particular the WHO and civil society.

Brazil's perspectives and activities in health both domestically and internationally are based on the WHO's "health for all" programming goal that underlines the importance of primary health care first adopted in the 1978 Alma Ata Declaration.³⁶

Brazil followed the WHO program and with this has been trying to have the full coverage, using a program that's called the Family Health Program, including the whole team of health, that gives the full coverage to the whole population.

While WHO has influenced Brazil's approach to primary health care, Brazil has played a comparable influential role in WHO initiatives, such as the FCTC and the WHO Commission on Social Determinants of Health. Brazil supports and seeks to strengthen WHO's central role 'so that it can effectively defend the basic principle that has guided

³⁶ The Alma Ata Declaration is the declaration from the International Conference on Primary Health Care, Alma-Ata, September, 1978. It expresses the need for urgent national and international action to protect and promote the health of all, believing that it is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal. This goal requires the action of many other social and economic sectors in addition to the health sector. (203)

its inception, namely, promoting the fundamental human right to health,³⁷ as well as the state of physical, mental and social wellbeing.’ (191)(p.4)

The interviewees commented that civil society plays a prominent role in Brazil and provided examples of initiatives that were led by Brazilian civil society such as the World Social Forum³⁸ that started in Brazil in 2001. They noted that Brazilian civil society “is not especially active in the field of global health, but it’s very active in this broad sense...social...policies and social improvements.” In his paper about the FCTC, Alcázar highlights a key way in which civil society is engaged in health policy in Brazil. He notes that Brazil’s constitution established the participation of civil society in formulating health policy as a guiding principle. This participation is implemented through health councils at the federal, state and municipal level. Health councils are deliberative entities that formulate health strategies and are in control and execution of health policy, including its economic and financial aspects. They are made up of government officials (25%), health providers and health professionals (25%) and users (50%). (40) While it is not clear if such health councils deliberate over Brazil’s global health policy *per se*, they nonetheless appear to exert influence in the domestic health policy process that then influences the global. As Alcázar notes, the health councils played a key role in identifying tobacco control in Brazil as a main health priority, which then influenced Brazil’s leadership and positioning at the international level in the FCTC. (40)

³⁷ The Right to the Highest Attainable Standard of Physical and Mental Health Article 12 of the International Covenant on Economic, Social and Cultural Rights obligates states to ensure equitable access to a minimum set of health services while General Comment 14 (GC 14) identifies a broader range of actions required for the progressive realization of this right. (204;205)

³⁸ The World Social Forum (WSF) provides space and opportunities for social movements and NGOs around the world to discuss various themes, exchange opinions and share information and experiences. The WSF launched in to be a counter voice to that of the World Economic Forum (WEF) a meeting place of corporate leaders and Western politicians that espouses neoliberal globalization. (206)

4.4.6 Indications of impact

As this brief background case highlights, Brazil's positive impact on global health has been significant. Factors that have contributed to this impact include Brazil's commitment to health as a human right, as enshrined in its constitution. This commitment and position underpins all subsequent policy directions and processes in which Brazil engages.

Brazil's contributions to international development in addition to that indicated already (\$30 million for health projects) is particularly impressive, with one estimate placing it at close to \$1 billion per year, ahead of smaller OECD-DAC donors, like Finland and Portugal. (200) ODI reports that Brazil's technical cooperation, which is the transfer of knowledge, technologies and skills to promote development, is dominated by support for agriculture, health and education accounting for about half of its technical cooperation. (200) Brazil's policies in these areas are described as proven and successful providing good models for other developing countries to follow. (200)

As Bliss notes, however, Brazil's approach to date has been primarily ad hoc rather than truly strategic. ABC's activities in global health have not been governed by legislation nor by a broad strategy. Brazil's overseas engagement could also potentially be strengthened further through the establishment of a development agency rather than relying primarily on ABC and FIOCRUZ to undertake this work. (207)

4.4.7 Conclusion

The findings from the Brazil case lead to a few main conclusions.

First, as in the other background cases, leadership was a very important factor that led to the prominent place that health assumes in Brazilian foreign policy. In alignment with the Norwegian case, the Brazil case highlights the role that political ideology and leadership can play in positioning health in foreign policy and how this can permeate all aspects of government policy and practice. As Kingdon's model highlights, such leadership on its own is not sufficient in moving the policy agenda ahead, however. FIOCRUZ, and in particular, Dr. Buss, also played important roles as long standing, credible policy entrepreneurs advocating for health in all policies and international solidarity.

Second, health as a human right is enshrined in Brazil's constitution and as such provides a strong base for arguing for health in all policies. (73) In a way, the signing of Brazil's constitution in 1988 marked the beginning of what Fidler would refer to as a 'revolution' in global health in Brazil. Health became an overriding normative value and along with development, an ultimate goal of foreign policy. This interest has been sustained over time and does not appear to have fluctuated in an ad hoc manner according to the health crisis of the day. In the Swiss and Norwegian cases, health as a human right was not absent from the rationale for integrating health into foreign policy but it was not the most prominent theme as it is in the Brazilian case. Enshrining health as a human right in Brazil's constitution reflects the primacy of human rights over other public interests, a

position that legal and scholarly texts support, including Section 103 of the Charter of the United Nations and the Vienna Declaration and Program of Action (1993). (73)

Such primacy, however, is difficult for states, including Brazil, to exercise in practice, (74) as it does not fit well with the high politics of national security and economic interests. (73) While human rights is a cornerstone of Brazil's constitution and guides its cooperative work with other nations, its inability to comply fully with international human rights obligations, as Gagnon and Labonté highlighted in their recent paper about GHD and human rights, (74) is a potential sign of policy and/or practice incoherence. Moreover, a main concern with the human rights frame is that the right to health can be interpreted in legal decisions as an individual right only. Evidence of this has been found in Brazil where this right has become described as a 'strategy of the pharmaceutical industry, to take advantage of the large number of judicial decisions granting individuals a right to receive expensive medicines this industry produces.' (208) The cost to the public health system of financing such patent medicines may be at the expense of providing primary health care services known to benefit the poor, an application of the human rights legal framework that is more focused on collective than individual rights. (73) This individualistic interpretation of the right to health may not affect a country's GHD directly, although indirectly it could overlap with a country's economic interests in exporting patent medicines; or in Brazil's case, of working with its neighbouring countries to keep patent drug prices low and increasing accessibility to generic equivalents. While the interviewees indicated that global solidarity and human rights were the driving force behind Brazil's investments in global health, particularly with

South-South partners, Brazil's economic interests as an emerging global power were nonetheless mentioned as a potential competing force.

Third, how Brazil has gone about successfully engaging in global health diplomacy is regarded as a lesson for other nations. (40;42;43) At the domestic level, ABC and FIOCRUZ have facilitated collaboration across relevant government departments. For many years, such collaboration has been the institutionalized norm rather than the exception. Unlike the Swiss and Norwegian cases, involvement in health discussions and decision making is not an elite or exclusive process. Citizen engagement is an integral part of the process. Brazil's soft power approach at the international level has also garnered significant attention and contributed to its highly successful engagement with WHO to develop and implement global public goods, such as the FCTC. Such an approach seems highly relevant to the global health diplomacy process, which rests on the ability to collaborate, frame issues and set an agenda through attraction to shared values and to the duty to contributing to their achievement.

Finally, Brazil's contributions to development are significant given its status as an emerging economy. To fully optimize these contributions, as Bliss notes, Brazil's cooperation system could potentially be better coordinated and monitoring and evaluation enhanced across cooperation programmes. (200)

4.5 Conclusion: Analysis and Discussion of Background Cases

The background cases make the following contribution to advancing an understanding of how and why health is integrated into foreign policy.

First, the dominant rationale in the Swiss and Norwegian cases for integrating health into foreign policy was to strengthen global health security in the interest of the state. The top ‘main interest’ of the *Swiss Health Foreign Policy* was to protect the health interests of the Swiss population (36) and global health security was the dominant argument used to frame the *Oslo Ministerial Declaration*. These findings are consistent with those from the literature review and with Fidler’s remediation conceptualization, which assert that health does not hold a special place in foreign policy. Rather, it is another issue to address through traditional approaches to foreign policy focused on state self-interest, and/or acts as a strategic vehicle through which traditional foreign policy ‘high politics’ goals can be achieved. In contrast to Switzerland and Norway, Brazil’s *primary* motivation for paying attention to health as a foreign policy issue is based on the premise that health is a human right and on the belief and commitment to international solidarity. This makes Brazil a unique case, although despite health security assuming the highest profile in the Swiss and Norwegian cases, some reference to human rights exists in both cases.

Second, in all three cases, improving the ‘global health situation’ as stated in the Swiss policy through investments in international development, a focus on implementing the MDGs and by working with the WHO is arguably the second most prominent reason for focusing on global health in foreign policy. ‘Health has long been one of the desired outcomes of development,’ (73)(p. 5) and recent studies show that health is a

consequence of growth and also one of its engines. (209) Labonté and Gagnon argue that improving health through development as a way to advance other state interests (e.g. aid for economic return and aid for strategic purposes, such as security) is one of the major reasons why states have decided to advance health in foreign policy. (73) One of the reasons Switzerland was interested in improving global health is that ‘it has a major economic and political interest in improving the situation of the world’s health, especially in developing countries and countries in transition.’ (36)(p. 12) However, in addition to investing in development as a way to advance other state goals, the case studies also showed that there were normative and ethical reasons that the countries were investing in development to advance health. The *Oslo Ministerial Declaration* asserts that development cooperation models should ‘reflect the requirements of those in need and not one that is characterized by charity and donors’ national interests.’ (24)(p. 1377) Brazil’s approach to providing aid is based on health as a human right and cooperation in the name of global solidarity.

Third, both political leadership and leadership within the bureaucracy were critical factors that influenced the development of health as a priority within foreign policy, helped to keep it on the policy agenda in a sustained manner and facilitated policy implementation efforts. These findings are consistent with lessons from the trade-health context that Fidler summarized in his 2008 paper summarizing lessons based on the WHO’s work building linkages between health and trade ministers, which included: obtaining and maintaining political leadership and buy-in; recognizing and valuing the significance of individual leadership in the process; increasing mutual awareness and knowledge; and remaining resilient. (7) The leadership of key individuals or policy

entrepreneurs, Dr. Silberschmidt, Mr. Støre and Dr. Buss, was particularly important. These leaders encompass Kingdon's three qualities of policy entrepreneurs. Because of their expertise and authority they each had a 'claim to a hearing,' they were politically well connected and they were persistent. Each also demonstrated a long-term commitment and tenacious approach to catalyzing attention on health as a foreign policy issue. It is also noteworthy that each of these leaders has both health and foreign policy expertise gained through either formal training and/or through career experiences. As such, they cross health and international relations domains, which is an important capability for those who aim to contribute effectively to global health diplomacy processes.(21;22) Arguably, for all three countries, leadership in global health, and in particular, in global health diplomacy, was also seen as a way to promote and strengthen each country's national reputation on the world stage, which could be interpreted as another form of self-interest.

Fourth, in each case, the relationship between policymakers and the non-state actors was an important enabling factor that contributed to the integration of health into foreign policy in a number of ways. For example, in Switzerland, informants indicated that government health actors have long enjoyed a close relationship with the academic community particularly through the Graduate Institute in Geneva. This relationship has been further strengthened over recent years with the establishment of the global health diplomacy training program that the Swiss government supports. (210) In Norway, the FPGH initiative, while "elite-driven" has led to a closer connection between academia and foreign policymakers. (179) In Brazil, FIOCRUZ is the long-standing glue that binds public health researchers, civil society and government policymakers together. As

Kingdon's model shows, these policy communities play an important role in framing policy issues.

Fifth, the processes that each country undertook to develop the policy statements and/or approaches to the integration of health into foreign policy were highly context specific and driven to a large extent by the intent of the specific desired outcome. The Swiss policy was meant to be an internal policy to improve government coordination and coherence; therefore it was developed internally without participation from non-state actors. The Swiss case highlighted the importance of timing and finding a window of opportunity when the policy, program and political streams are in alignment to enact policy change. The challenges associated with developing a whole-of-government policy were also illuminated. The cross government policymaking process was itself an exercise in health diplomacy, requiring skillful negotiation and the reconciliation of differences. Swiss informants indicated that as a result working together is now "automatized." The *Oslo Ministerial Declaration* was an agreement of the foreign ministers of the countries involved with the primary intent of attracting and sustaining attention on health as a foreign policy issue. It was therefore developed at that level without the involvement of other actors, in particular those from health. While the *Declaration* has catalyzed attention on health in foreign policy and led to a new commission focused on global health governance, its informal and non-transparent processes and exclusive membership have led some to question its effectiveness and sustainability. Integrating health in all policies is a matter of course in Brazil. Long-standing inclusive, participatory processes facilitate this intent. Because of the importance that Brazil places on civil society, policymaking appears to be a ground up, socially constructed process however further

study would be needed to corroborate this conclusion. One of the key lessons from the Brazil case was the role that a soft power approach can play in achieving agreement on collective global health goals. Brazil's impact at the global level is attributed to its soft power approach; which is interesting given that it is a member of FPGH, which has been described as elite driven and closed. It is not known exactly why Brazil decided to support the FPGH but indications are that it was invited to do so as it is a 'strategically important country.' (169) As FPGH enters a new phase, Brazil is also taking even more of a leading role in the initiative. (174) Interestingly, Fidler noted in his assessment of FPGH that a recent report about Brazil's approach to health in foreign policy mentioned its membership in FPGH but did not make any further elaborations on this link or whether it has had an influence on Brazil's policy directions. (141) The informants from Brazil also did not mention the FPGH nor did the authors of the report that was submitted from Brazil to the 2009 Prince Mahidol Awards Conference. (202)

Finally, one key finding across the three cases was the importance placed on working with the WHO on internationally led initiatives to advance individual and collective global health objectives. While self-interest appears to be the prevailing motivation underpinning a focus on health in foreign policy, the state actors studied also acknowledged and accepted that the WHO plays an instrumental role in helping them cooperate to develop and implement global public goods for the benefit of all. The role of the WHO will be elaborated on further in Chapter 6.

Chapter 5: *Health is Global-A UK Government Strategy 2008-2013*

5.1 Introduction

Health is Global: A UK Government Strategy was released in 2008 largely in response to globalization and the realization that ‘the old distinction between ‘over here’ and ‘over there’ is becoming increasingly redundant’ and requires nations to co-operate to achieve ‘health for all.’ (1)(p.3) It was officially launched at Portcullis House, London by the Secretary of State for Health, Alan Johnson, Minister of State for Public Health, Dawn Primarolo, Minister of State at the Foreign and Commonwealth Office, George Mark Malloch Brown, and Gillian Merron, Parliamentary Under Secretary of State for International Development. The launch was co-hosted by The Lancet, London School of Hygiene and Tropical Medicine (LSHTM) and Chatham House. When released, *Health is Global* was described as a ‘cross government strategy’ to highlight the breadth of challenges that face ‘all of us’ in the area of global health. (211)

Health is Global is intended to span five years (2008-2013) however ‘its vision covers a 10-to 15-year period’ and ‘sets out the breadth of global health issues and our plan for tackling them.’ (1)(p. 7) In general, informants described the strategy as a very positive development referring to it as “motivational,” “a commitment to global health,” and “more than just another report.” The following case study, structured in the same manner as the background cases, uses the policy analysis circle to provide a detailed description of the strategy followed by discussion, analysis and conclusions in Chapters 6 and 7. To help understand the policy context within which *Health is Global* was developed it begins with a brief look at British foreign policy from 1997 to 2008.

5.2 Context

5.2.1 Overview of British foreign policy 1997-2008

The late 1990s marked the beginning of an increasing focus in the UK (and elsewhere) on the relationship between globalization and health with the UK's Nuffield Trust playing a key role in catalyzing attention on this phenomenon and the integration of health into foreign policy. The late 1990s also marked the beginning of Tony Blair's premiership of the UK, a position that he held from May 1997 to June 2007 after which Gordon Brown became Prime Minister until 2010.

As Lunn, Miller and Smith write, three main foreign policies of Tony Blair's 10 year span as UK's Prime Minister were an activist philosophy of international interventionism,³⁹ maintaining strong alliances with the US and a commitment to placing Britain at the heart of Europe. (213)(p.3) While the second and third themes had been central to British foreign policy since the Second World War, activist interventionism was regarded as a genuinely new perspective and approach. (213) Other developments in the area of foreign policy included reforms to the strategic and institutional frameworks for the formulation and implementation of that policy, including a focus on more 'joined-up-government.' (213) Under Brown, some 'recalibration' of the three themes occurred but Lunn, Miller and Smith conclude that there was more continuity than change from Blair to Brown. (213)(p.3) Of these three prongs, interventionism and the UK's special relationship with the United States (US) appear to be the most relevant contextual factors that influenced why *Health is Global* was developed and what was included in it. A focus

³⁹ Interventionism is defined as the use or threat of force or coercion to alter a political or cultural situation normally outside the intervener's moral or political jurisdiction. It commonly deals with a government's interventions in other governments' affairs. (212)

on more ‘joined up government’ also helps explain why *Health is Global* is a whole-of-government global health strategy.

The Blair Administration

The 1999 Kosovo crisis set in motion Blair’s interventionist foreign policy. During this crisis Blair delivered his famous Chicago speech in which he unveiled his ‘doctrine of international community.’ (213) This doctrine was based on the explicit recognition that nations were becoming increasingly interdependent and that national interest was to a significant extent governed by international collaboration. (213) Mutual dependence was linked to the idea that boundaries between the domestic and the foreign were becoming increasingly blurred; therefore, an overriding policy of non-intervention was no longer an option. Indeed, in cases of genocide or crimes against humanity, it was a moral imperative. (213)

While initially expressed through a paradigm of humanitarian intervention, after 9/11, Blair’s support for interventionism became increasingly linked with protecting national security, fighting terrorism and backing the US invasion of Iraq based on evidence about weapons of mass destruction in Iraq that it appears that Blair knew to have been fabricated. (214) This shift led critics to claim that respect for human rights and international law were subordinated to the UK’s focus on its relationship with the US and the ‘war on terror.’ This alignment ‘led Blair astray over the war in Iraq.’ (213)(p.12) To counter his somewhat tarnished reputation as a result of Britain’s decision to support the US in the war in Iraq, some argued that Blair decided to focus more on international development in his second term through initiatives such as the government’s sponsorship

of the Commission for Africa, which reported in March 2005, when the UK held the presidency of the G8. (213) As discussed in the next section, one of the UK interviewees supported the viewpoint that *Health is Global* was in part politically motivated as a way to improve Britain's tarnished reputation post Iraq. While these arguments indicate that the decision to focus more on international development was in part politically motivated, one of the interviewees provided a counter viewpoint. This interviewee claimed that Blair was instrumental in focusing attention on the importance of eliminating world poverty and "saw it as a moral imperative of the first order."

It also appears that the UK's special relationship with the US may have influenced why *Health is Global* was developed in the first place. The US Institute of Medicine 1997 report, *America's Vital Interest in Global Health* is listed as a key influence and rationale for a government-wide strategy in the proposal that led to the strategy. 'The US Institute of Medicine, in a 1997 report, made a strong case for why that country would benefit from investing in health abroad. The report identified three pillars: protecting people, enhancing the economy, and advancing international interests.' (93)(p. 857) These themes eventually became the backbone of *Health is Global*. One of the interviewees also indicated that the Nuffield Trust's relationship with US colleagues in the American Association of Academic Health Centers in the early 1990s was another key development that attracted more focused UK attention on the links between globalization and health and the relationship between health and foreign policy. As this interviewee explained, "Basically the Association wanted to know whether I would have a continuing interest in working with the Americans on matters of mutual interest and on the health agenda."

Essentially, these matters of mutual interest appeared to be focused on protecting US interests. “They said, well, what we have in mind is American interests in the former Soviet Union and in Africa.” Stemming from this initial discussion, the Nuffield Trust began collaborating with the “Americans” on efforts to better understand the impact of globalization on health, which led to attempts to attract UK attention on this issue, as well.

I was then invited to become a member of the Institute of Medicine, US Academy of Science that was looking at health science and technology as diplomatic imperatives. I thought maybe I should ask the same question to the UK Foreign Office,⁴⁰ to which the answer was, did I not understand that foreign policy was first-order international politics and that health-type people would only come through the back door? So, I asked, what do you have to do to get through the front door? And that’s why we then began to push the door of the Foreign Office, saying, the foreign policy agenda has moved on from simple concentration on state security, around rather conventional hard power ideas, to some of these issues where health crosses boundaries.

In the context of increasing international worry about bio-terrorism and global infectious disease, these early interactions eventually led to the US requesting to work with the UK on a global health surveillance system. The interviewee from the Nuffield Trust was part of a key exchange that took place in Washington between the UK’s ambassador to the US and the State Department. At this meeting the State Department offered to develop a global public health surveillance network.

And you can imagine, this was unbelievable. And I said, Ambassador, I can’t even get our Foreign Office to actually open the front door to have a conversation about health matters. I asked are you going to match the State Department’s offer? Eventually, we basically decided to press on with this and that’s where I then began to pull together, not yet the health people that traditionally worked with WHO but people that were working on more mainstream foreign policy and then began to pull people in from the security services, including the military.

⁴⁰ The British Foreign and Commonwealth Office (FCO) is responsible for promoting and protecting Britain’s interests abroad. It houses Britain’s diplomatic services. The Secretary of State for Foreign and Commonwealth Affairs is responsible for the FCO’s work. (215)

Liam Donaldson, the Chief Medical Officer eventually became very interested in global health and foreign policy along with the Permanent Secretary of the UK Department of Health, Nigel Crisp⁴¹ and academics from the London School of Hygiene and Tropical Medicine (LSHTM).

We saw matters related to trade, matters related to development, matters related to global government, as well as sort of the obvious first interest either deliberate release of chemical or infectious diseases crossing borders, such as SARS. I think the UK government's response now is a much broader appreciation of the foreign policy and international relations aspect. After a long period – it took ten years; I suppose the UK government has developed a much more mature and more comprehensive appreciation of what global health and foreign policy and international relations is all about.

While a more sophisticated understanding of global health appeared to emerge during the Blair years, McInnes' study of the links between public health and foreign and security policy during Blair's first two administrations (1997-2005) does not necessarily show that this translated into action. (138) His study found that public health was not a dominant force in driving policy in the UK and that the overriding reason for focusing on health in foreign policy was to protect national interest. Narrowly focused domestic security concerns were key motivating factors as seen in the emphasis given to bio-terrorism and infectious diseases. (138)

The Brown Administration

Gordon Brown's government retained the broad principle of interventionism but sought to recast it to be less about hard power intervention and more about conflict prevention

⁴¹On Blair's request in the wake of the Commission for Africa and the Gleneagles G8 Summit, Nigel Crisp wrote *Global Health Partnerships: The UK contribution to health in developing countries* in 2007. This report is a review of how the UK's experience and expertise in health could be used to support developing countries, in particular to reach the MDGs. As Blair wrote in the foreword, 'Improving global health is clearly in Britain's interest. The NHS and health partners have a role to play in development.' (216) (p. iii) *Health is Global* references this report and in the government's response to it, led by DFID and the Department of Health, includes the *Health is Global* strategy as one of the main mechanisms through which Crisp's recommendation will be addressed. (217)

and humanitarian agendas. It could not, however, completely repudiate the exercise of military power at a time when British troops were in both Afghanistan and Iraq but did emphasize that military action in the future would be a last resort. (213) In his speech to the Lord Mayor's banquet on November 12, 2007, Brown summarized his approach as 'hard-headed internationalism.'(218)(p. 15)

'My approach is head-headed internationalism: internationalist because global challenges need global solutions and nations must cooperate across borders-often with hard-headed intervention-to give expression to our shared interests and shared values; hard-headed because we will not shirk from the difficult long term decisions and because only through reform of our international rules and institutions will we achieve concrete, on-the-ground results. Building a global society means agreeing that the great interests we share in common are more powerful than the issues that sometimes divide us. It means articulating and acting upon the enduring values that define our common humanity and transcending ideologies of hatred that seek to divide us apart. And critically-and this is the main theme of my remarks this evening-we must bring to life these shared interests and shared values by practical proposals to create the architecture of a new global society.' (218)(pp.15-16)(219)

In his speech, Brown made it clear that the government's primary obligation is the safety of the British people and the protection of the British national interests. He also went on to say that no country can escape the consequences of interdependence; therefore a nation's self interest will be realized through cooperation to overcome shared challenges.⁴² (218)(p.15) Many of these fundamental policy themes and the reasons

⁴² In the context of growing interdependence, FCO launched a new strategic framework in 2008. Its title '*Better World, Better Britain*,' aimed to reflect that in an interdependent world, environmental, physical and economic security in the UK could not be realized without promoting it overseas. In other words, 'a better world will help make a better Britain.' (220) The framework aimed to guide FCO's work in three areas: 1) support the British economy; 2) support British nationals abroad; and 3) support managed migration for Britain. The four new policy goals of the FCO were to counter terrorism, weapons proliferation and their causes; prevent and resolve conflict; promote a low carbon, high growth, global economy; and develop effective international institutions, above all the UN and EU. (220) *Health is Global* is meant to complement the foreign policy set out in this new strategic framework. (1)(p. 15)

behind them (economic globalization) permeate *Health is Global*. What is particularly noteworthy in Brown's policy directions is the apparent struggle to achieve a coherent balance between hard-headedness and Britain as a good global citizen. In part this could be a result of the UK's relationship with the US that disproportionally influenced its priorities. For example, in 2007 while British foreign policy was emphasizing disarmament and new diplomacy, the Minister of Defense was endorsing US ballistic missile defense plans. (218)

Placing Britain at the heart of Europe continued to be a top priority under Brown. In particular he saw the stability of Britain's relationship with Europe as critical to mutual economic prosperity. He did not think that the stability of Britain's relationship with Europe should be questioned and reiterated that economic reforms were vital to trade, prosperity, jobs and security. (213)

In addition to traditional 'high politics' priority areas and partners (the US and Europe), the Brown government continued to promote international development. Over the course of the Blair to Brown years, the Department for International Development (DFID) enjoyed a reputation as a progressive, innovative and effective donor agency with a strong voice across government. (221) During that time, British aid spending tripled in real terms and it plans to spend 0.7% of gross national income on international development by 2013. (1;221)

Brown himself assumed a key leadership role in development efforts, including those focused on health. In July 2007, he launched the MDG Call to Action along with the UN Secretary General (1) and in September 2007 the International Health Partnership, a global compact for achieving the health related MDGs.⁴³ (224) He also demonstrated his strong support for the WHO Commission on Social Determinants of Health when he opened the two day conference on November 6 and 7, 2008 at which the commission's final report was presented and discussed further to its launch by Dr Margaret Chan, WHO Executive Director, in Geneva on August 28, 2008. Brown was a strong proponent of *Health is Global*. In the July 2009 Department of International Development (DFID)'s white paper he reiterated that even in tough economic times, 'securing global justice remains one of my top priorities,' (225)(p. 5) and recommitted to keeping the UK's promise to support the realization of the MDGs.

The seeds for *Health is Global* were largely sown during the Blair years but it was under Brown's leadership that the policy was launched. This brief look at British foreign policy during that time provides important context for why *Health is Global* was developed and what it ended up focusing on. In particular, it highlights the potentially conflicting goals and priorities that needed to be balanced in UK foreign policy and hints at the cross government struggles that underpin arriving at a common policy framework, such as *Health is Global*.

⁴³ Brown's commitment to the MDG dates back to when he was the British Chancellor of the Exchequer in the 2000s. At that time he spearheaded an initiative called the International Finance Facility (IFF) calling for the richest countries to increase their long-term donor commitments and then to use those commitment to leverage additional money from the international capital markets. The immediate focus of the IFF was to provide funds for the MDGs. (222) The initiative also led to the establishment of the International Finance Facility for Immunisation (IFFIm) in 2006 to rapidly accelerate the availability and predictability of funds for the Global Alliance for Vaccines and Immunisation announced in 2000 (GAVI Alliance). (223)

5.2.2 Findings relevant to context

‘Economic prosperity, security and stability for the UK and the rest of the world’

The three main goals of the strategy, which are arguably the overriding reasons why it was developed and what it is aiming to achieve, are summarized in Table 6. The ultimate goal of the strategy is actually not global health *per se* but rather ‘economic prosperity, security and stability for the UK and the rest of the world.’ As it states:

‘a healthy population is fundamental to prosperity, security and stability - a cornerstone of economic growth and social development. In contrast, poor health does more than damage the economic and political viability of any one country - it is a threat to the economic and political interests of all countries.’ (1)(p. 7)

Based on this reasoning it appears that global health is a means to an end and not an end in itself. Therefore, ‘improvements in the health of the UK and world’s population’ through ‘greater coherence and consistency between international policies that affect global health’ are sub-objectives that support the overriding goal of economic prosperity, security and stability - traditional preoccupations of foreign policymakers.

Table 6: *Health is Global: A UK Government Strategy* - The five areas of action and their link with economic prosperity, security and stability (1)

Economic prosperity, security and stability for the UK and the rest of the world			
Improvement in the health of the UK and world's population			
Greater coherence and consistency between international and domestic policies that affect global health			
Better global health security Global health security is crucial for economic and political stability – but health is vulnerable to a wide range of complex and daunting issues. Priorities are: 1. Combating global poverty and health inequalities 2. Tackling climate change and environmental factors 3. Tackling the effects of conflict on health and healthcare 4. Reducing the threat from infectious disease 5. Managing the health of migrants and tackling human trafficking	Stronger, fairer and safer systems to deliver health A healthy population needs a strong, fair and accountable system for delivering good health. These are absent in many countries and in some of the poorest countries that is a key reason that progress on achieving the MDGs is slow, and why so many people are beset by chronic disease. Priorities are: 1. Increased finance for health systems with universal healthcare coverage 2. Stronger health systems through the International Health Partnership 3. Addressing the global workforce crisis 4. Access to medicines, technologies and innovations and increased patient safety 5. Emphasizing sexual, reproductive and maternal health 6. Focusing on non-communicable diseases and injuries	More effective international health organizations The world needs effective international institutions to provide a stable global order. Further reform is needed if they are to be more effective in tackling global health. Priorities are: 1. A reformed United Nations system with an effective World Health Organization 2. Supporting the European Union to play an effective role in global health 3. A coherent approach to resourcing health programmes and projects in low-and middle-income countries, and to resourcing international agencies	Stronger, freer and fairer trade for better health Trade in health services, drugs and medical devices contributes significantly to the UK and global economies. The marketplace for these commodities means that the UK and other economies can benefit from the opportunities that come through freer and fairer global trade in health services and commodities. Priorities are: 1. Stronger, fairer and more ethical trade in the health sector 2. A robust system of intellectual property rights, innovative and flexible to promote access to medicines 3. Enhancing the UK as a market lead in well-being, health services and medical products
Strengthening the way we develop and use evidence to improve policy and practice			
Health policy, public health and service delivery should be based on reliable evidence drawn from high-quality research. At present, research on global health problems worldwide is under-funded, inadequately coordinated and does little to benefit the poorest 90% of the world's population. Priorities are: 1. Identifying and supporting research and innovation that tackle global health priorities 2. Using evidence and innovation to strengthen policy and practice 3. Maintain the UK as a global leader in research and innovation for health, well-being and development			

In addition to helping to achieve economic prosperity, security and stability, the document review and informants identified a number of other reasons the strategy was developed as summarized below.

Globalization

Globalization was a strong influencing force that led to the development of the strategy and its priorities. As stated on page 7 of the strategy, ‘safeguarding good health is not simply the province of individual countries. A globalised, interdependent world, characterized by the increasing movement of individual and populations - and where disease recognizes no borders - means that health has become a global issue.’ (1) The strategy is a mechanism through which the UK aims to exercise its ‘responsibility’ for harnessing ‘the opportunities of globalization to improve the health of people across the world, and in particular in the UK.’ (1)(p.7) Closely linked to the theme of globalization in the strategy is the idea that improving global health in the context of globalization ‘requires co-operative actions and solutions.’ (1)(p. 14) The idea of ‘working with others’ for global health permeates the document.

The role that globalization played in catalyzing the strategy was also a main theme in the interview data. Several interviewees referred to the recognition of the important linkage between globalization and health as the driving force behind the attention it garnered from the Foreign and Commonwealth Office (FCO) in the early millennium. “FCO was a key player in late 1990s/early 2000s in the context of globalization.” “Globalization” required a “rethinking of how government works,” one in which “you need a joined-up

approach.” This ‘joined-up’ approach had already been established “under the New Labour quite early on.” Another informant said that the strategy development process:

looked at the whole issue - economics, competition, attractiveness of foreign investments in the UK and within that it became clear that globalization had an important linkage with global health such as communicable disease but also there were opportunities clearly in healthcare as a growth area in terms of business opportunities.

Pursuing business opportunities is a component of the main rationale that underpins the strategy as described in the next section - to protect and promote Britain’s interests.

“First it’s UK”

I think it would be foolish not to admit that a large part of it is done for UK benefit and that it has been recognized that there are global threats. So first its UK but longer-term benefits in terms of relationships and protection from threats and so on. There is a need and that runs through the development concept that it’s about working with other countries to reduce the global risk. The UK would want to protect its own positions, its own population, by recognizing these global threats.

The most prevalent and strongest rationale for the development of *Health is Global* is what one key informant succinctly stated, “First it’s UK.” In other words, the strategy was developed primarily to benefit the UK. This rationale is evident through the focus on global health security (i.e. protecting the UK population from global health threats) that permeates the strategy. It is also apparent in a number of other ways that reflect the UK’s self-interest in developing the strategy, including for economic gain and to enhance its reputation as a leader globally.

Global Health Security: “we are united when it comes to being secure in the UK”

In the wake of the 2003 SARS pandemic, the need to strengthen global health security and ‘ensure the safety’ (1)(p. 3) of the UK population described as the ‘first duty of any government’ (1)(p.3) was clearly a strong, if not the strongest, rationale behind the

development of *Health is Global*. This focus is also a priority of the UK's first ever national security strategy also launched in 2008. (226) There is meant to be a 'strong link' (1)(p. 15) between *Health is Global* and the national security strategy that includes the risk to the UK of diseases such as pandemic influenza along with international terrorism, weapons of mass destruction, conflicts and failed states. (73;226)

The bulk of the section in *Health is Global* that explains why the UK needs a strategy to address global health is devoted to reiterating the events that occurred as a result of SARS outbreak, including the UK response (a government-wide SARS taskforce was established) and disruptions in international travel, which contributed to the socio-economic impact of SARS. It is clear that SARS was the precipitating event that led to the strategy and to the identification of 'better global health security' as one the main areas for action.

While 'global health security' *per se* is not clearly defined in the strategy, a key theme that underpins the strategy's discussion of this concept is 'common vulnerability.' Threats that can compromise health security include poverty, wars, conflicts, climate change, natural catastrophes and man-made disasters. 'All of these endanger the collective health of populations across geographical regions and international boundaries.' (1) The strategy focuses on health security primarily as a way to keep the UK's population safe, but to achieve this objective it must also improve the health of populations outside the UK because, stating *verbatim* the argument made in the earlier *Oslo Ministerial Declaration*, 'we are only as strong as the weakest link.' (1)(p.13) The

five priority areas that fall within global health security focus on strengthening weaker links by: combating poverty and health inequities; tackling climate change and environmental factors; tackling the effects of conflict on health and healthcare; reducing the threat from infectious disease; and managing the health of migrants and tackling human trafficking. (227)(p.5)

Findings from the interviews support global health security as the driving force behind the strategy. As one informant stated, “it does rather focus on diseases crossing borders which is probably one of the reasons it’s come to such a high profile.” Others noted that, “SARS was a wakeup call” and that “One of the things that we’ve done in the UK is essentially accepted global health as the securitization of the health agenda.” There was some support for this perspective: “Development of sources or pockets of insecurity has led to, from my perspective, an equivocation of global health to global health security.” Another commented that “when Malloch Brown⁴⁴ talked at the launch of the global health strategy, the crux of what he was talking about was actually about health security and about infectious diseases.”

One informant talked at length about how “through securitization health diplomats got into rooms that they weren’t previously in.” He described this as “piggybacking” on the securitization agenda to bring focus to global health issues more generally.

⁴⁴ George Mark Malloch Brown was Minister of State in the Foreign and Commonwealth Office when *Health is Global* was launched.

They (academic researchers) got invited to cabinet committees to sit at tables with four-star generals in a way that they weren't able to previously- academic researchers suddenly found that they could advocate for research funding because they were talking about things that might kill millions of people, like AIDS. Policymakers in global health who want to be taken seriously need to piggyback on the security agenda.

While the majority of informants acknowledged that global health security was the main motivating factor behind the strategy, several of the non-state informants were highly critical of this positioning. One stated:

I know why they're doing it- for government buy-in, but it's not enough to think of health as a foreign policy as global security. I'm very much a believer in social justice and the fact that all those children die every day from preventable illness, it's just not right. With this global security thing you get governments who are in it for themselves. The focus of global health security obscures that really we're talking about pandemics and all that kind of thing rather than social justice.

Another commented that:

The security of health agenda has gone unchecked and unchallenged because too many people have too much to gain from it. I'm not saying it's a bad thing but I'm not sure it's not the great thing that we're making it out to be and I'm a little bit concerned that with the policy communities, within the academic communities, there's nobody stopping and saying actually is this the best way for us to look at this?

“Disease and malnutrition will kill far more people than a really strong pandemic but those are the doomsday scenarios that will always get a bit more policy attention,” said another.

These responses highlight a theme related to global health security, namely its potentially uneasy and conflicting relationship to global health equity. As one interviewee stated, “There are a lot of unaltruistic drivers of the development of the securitization of health agenda and one of these is the diminution of the health equity agenda.”

Another reflected:

If it's really just about protecting your borders, eventually you end up just promoting a very different global health policy to the social medicine approach which states that health is a human right. We need to align ourselves more closely with those working to build human security rather than defensive security.

This particular informant also alluded to how the global health security argument can be used to insert other global health goals into diplomatic discussions. This approach, however, should be used only by skilled diplomats who are credible and capable of combining global health security with global health equity. “I trust people like [WHO Director-General] Margaret Chan to use security to get a discussion going and then in the same speech move on to a health equity agenda. I think there are some people capable of doing that.”

Other benefits for the UK

Although strengthening global health security, primarily as a way to keep the UK population safe, was the main rationale for its development, three other reasons were also cited.

First, as one informant commented, the UK’s traditional “colonial” approach to foreign policy means it likes to be seen as a leader on the global stage and will do things in order to protect that reputation. One interviewee stated that it was very “disappointing” that the UK did not sign onto the *Oslo Ministerial Declaration*.⁴⁵ The comment was also made, “it’s so typical UK – have still got this old colonial, oh, we’re so great and think that we can go it alone.” In the same vein, another informant said, “there was this thing that the UK still likes to see itself as a leader in things whether it is or not. That we must lead in

⁴⁵ While the UK did not sign onto the *Oslo Ministerial Declaration*, the strategy includes a reference to it as evidence of the increasing link between global health and foreign policy. (1)(p. 14)

global health. So the UK will do things in order to lead.” The proposal for the government-wide strategy also alludes to UK leadership as one of the driving forces behind it, ‘the UK has been at the forefront of multilateral initiatives, such as cancelling the debt for poor countries, access to medicines...the 2005 UK presidency of the Group of 8 wealthiest nations (G8) drew attention to global health, climate change, investment in health systems, and partnerships with government of developing countries.’ (93)(p. 859) *Health is Global* was seen as a logical extension of the UK’s leadership in global health.

Second, also in keeping with the motivation to protect and enhance the UK’s reputation abroad, another interviewee commented that the strategy was in part a response to the UK’s involvement in the war in Iraq:

I think there was also and I don’t know how much this motivated the government but I think because of the opprobrium and the criticism of the UK government’s positions on the Iraq war and so on, I don’t know to what extent that might have influenced them to try and see how they might get a better international profile by focusing on positive contributions the UK could make to strengthening health and development.

A 2006 commentary published in *The Lancet*, which was highly critical of the UK’s involvement in Iraq, argued that ‘a renewed foreign policy that might at least be one positive legacy of our misadventure in Iraq’ (228)(p. 1396) was desperately needed. This policy should focus on ‘human security’⁴⁶ rather than national security, around health and well being in addition to the protection of territorial boundaries and economic stability.’ (228)(p. 1396) It concluded that health ‘is now the most important foreign policy issue of our time and should be used as an instrument of foreign policy.’ (228)(p. 1397) How

⁴⁶ Only one reference to human security was included in the strategy, in the context of climate change. (227)(p.9)

much this article or the perspective it conveys may have influenced UK policymakers is not known. Its arguments, however, are explicitly referred to in the proposal that led to *Health is Global*, albeit without making any reference to the UK's role in Iraq as a contributing factor. (93)

Third, there is evidence that the strategy was developed in part to enhance UK business opportunities overseas in the context of globalization. 'Health as a commodity' was identified as one of the main reasons for developing the government-wide strategy in 2007. (93)(p.858) Indeed, harnessing 'the force of globalization' to improve health which the strategy asserts is fundamental to prosperity, security and stability, is largely about trade and investment opportunities for the UK, although in doing so it is also regarded as a way to improve global health and access to care and services for the 'poorest people in the world.' (93)(p. 858)

The strategy is meant to complement 'UK foreign policy set out in Better World, Better Britain, particularly the contribution that health can make to UK competitiveness and to a low-carbon, high-growth economy.' (1)(p. 15) Comments from an FCO informant support this priority:

with FCO's strategic objectives there is an objective to improve the UK economy and provide support to UK companies looking for business opportunities overseas. And so, you know, we have, if you like, a codified commitment to helping UK companies.

Another interviewee commented that, "you have UK companies looking to win business overseas" and another who said "there were opportunities clearly in healthcare as a growth area in terms of business opportunities." This priority is reflected in the strategy

in the section on trade that discusses ‘enhancing the UK as a market leader in well-being, health services and medical products (including pharmaceutical and medical devices)’ including the priority to promote the ‘best of British healthcare’ both because it can contribute to strengthening health systems in other countries and also because it can bring ‘significant benefits for the UK economy.’ (1)(p.29)(227)(pp.66-67) As one informant noted, a comment similar to that made in relation to the Swiss case, “the pharmaceutical industry is a big and important player in the UK’s prosperity.” Another stated that “enhancing trade was a huge issue at the stakeholder workshops.”

For the benefit of others

While it appears that the rationale for development of the strategy was largely grounded in UK self-interest, other drivers or rationales that focused more on contributing to improving health and prosperity outside the UK as a goal in its own right were also invoked as justifications. As stated in the foreword by the Prime Minister, ‘the strategy is one way for us in Britain to build a stronger, fairer world.’(1)(p. 3) Along with global health being a question of security, it is also a question of ‘morality’ and is defined in the foreword as a ‘force for good.’ (1)(p.3)

Development

As several informants described, *Health is Global* stems in part from the UK’s focus on development that became a more prominent part of the government’s agenda under Tony Blair. A separate Department of International Development (DFID) was created in the late 1990s and several policies that focused on the UK’s role in international development were released. (227) “There was a genuine interest in development in the

government in the late 1990s and a growing concern about inequalities,”⁴⁷ said one informant. Another stated that “unless you address the underlying determinants of health properly, you are not going to get a more stable, happy, equitable world.” The strategy comments that ‘improving health and reducing health inequalities requires tackling the underlying causes of ill health- the conditions in which people live and inequalities in the resources and opportunities to which they have access.’ (1)(p. 19) It commits the UK to working with ‘the WHO, the EU and others to take forward key recommendations from the WHO Commission on Social Determinants of Health and ensure that actions to address these issues remains high on the international agenda.’ (1)(p.19) Focusing on the social determinants of health is one way in which the strategy aims to contribute to addressing health inequities.

In their responses, a few informants frequently linked the concept of “health equity” with that of “development.” As one noted, “in the UK we talk about development rather than equity.” Another commented, “I don’t see equity being a central concept in the policy discourse. It’s in a larger concept of development, which is then unpacked in various ways but I think very much informed by the neo-liberal premise.”⁴⁸ One informant noted that the “equity lens is not fundamental. It’s just part of the discourse - part of the mix,” which another noted has been placed and kept on the agenda by non-state actors: “activists, essentially, of one sort or another.” These comments that seem to downplay the importance of the health equity argument are interesting because promoting health equity

⁴⁷ While the Blair government was concerned about inequalities in health, recognition of inequalities in health and the need to focus on improving health equity dates back much further and most recently in Britain to the 1980 Black Report, the 1998 Acheson Report and the 2008 WHO Commission on Social Determinants of Health led by Sir Michael Marmot. (38;229-231)

⁴⁸ By “neo-liberal premise” this informant was referring to an investment in development to further state economic interests in the context of globalization.

and reducing health inequalities is a fairly prominent concept throughout the strategy. One of the strategy's ten principles (principle 5) explicitly refers to the importance of promoting equity within and between countries. (1)(See Table 7) As well, health impact assessments are included in the strategy as a recommended approach to assessing the equity impact of domestic and foreign policy. (227) In keeping with interviewee comments, perhaps the inclusion of health equity as a priority in the strategy reflects the work and determination of a few strong non-state actors in the policymaking process. As one non-state interview noted, "I had to fight so hard to get human rights and health equity in it. They only play this card when it suits them." This informant expanded further on this viewpoint, "they don't really believe in equity either. Again it's good when they want to score brownie points or something but if it means they are going to have to give over sacrificing something they're not interested."

Table 7: Ten Principles that underpin *Health is Global* (1)(p. 8)

We will: 1) set out to do no harm and, as far as feasible, evaluate the impact of our domestic and foreign policies on global health to ensure that our intention is fulfilled; 2) base our global health policies and practice on sound evidence especially public health evidence, and work with others to develop evidence where it does not exist; 3) use health as an agent for good in foreign policy, recognizing that improving the health of the world's population can make a strong contribution towards promoting a low-carbon, high-growth global economy; 4) promote outcomes on global health that support the achievement of the MDGs and MDG Call for Action; 5) promote health equity within and between countries through our foreign and domestic policies;	6) ensure the effects of foreign and domestic policies on global health are much more explicit and that we are transparent about where the objectives of different policies may conflict; 7) work for strong and effective leadership on global health through strengthened and reformed international institutions; 8) learn from other countries' policies and experience in order to improve the health and well-being of the UK population and the way we deliver healthcare; 9) protect the health of the UK proactively, by tackling health challenges that begin outside our borders; and 10) work in partnership with other governments, multilateral agencies, civil society and business in pursuit of our objectives.
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While some interviewees expressed doubt as to the strategy's commitment to development and global health equity, *Health is Global* nonetheless commits to investing in development. It aims to complement and build on DFID strategies by including actions focused on combating poverty and health inequalities in support of the Millennium Development Goals (MDGs) and improving the social determinants of health in impoverished nations. As the strategy states, 'the health targets of the MDGs are among those least likely to be met, and *Health is Global* dovetails with health's place as a vital component of the Prime Minister's MDG Call to Action.' (1)(p. 15) Furthermore, DFID will 'spend £6 billion on health systems and services up to 2015, with a further £1 billion invested into the Global Fund to Fight AIDS, TB and Malaria.' (1) (p. 11) One informant praised the government's commitment to development saying, "I think the British government to be fair, has been very proactive ... partly because civil society were onto it straight away, in saying we will keep our overseas development commitments."

Part of the rationale behind supporting development for health is based on the premise that 'a healthy population is fundamental to prosperity, security and stability.' (1)(p.14) Quoting the WHO Commission on Macroeconomics and Health (2001), the strategy reiterates that 'ill health is a drain on society, while good health is a cornerstone of economic growth and social development in developing countries.' (1)(p. 14) Taking this one step further, the strategy also asserts that in the context of globalization, poor health 'does more than damage the economic and political variability of any one country - it is a threat to the economic and political interests of all countries.' (1)(p. 7) While the development rationale is primarily about what the UK can do to help developing nations

through trade and economic development, it also includes elements of self-interest. Several informants acknowledged that the need for the UK to continue to contribute to development in low and middle income countries as a way to improve the social determinants and health and health systems was a rationale for developing the strategy but also emphasized that more recently development had taken a back seat to security. As one stated, “security is now more centrally part of it (i.e. the reason for investing in global health),” not development.

Human Rights

Donaldson argued that one of the reasons the UK must engage with the global health agenda through the establishment of a coherent global health strategy is because ‘health is a human right.’ (232) He cites relevant UN declarations and covenants along with the reports from Paul Hunt, the UN Special Rapporteur on the right to health to support his position and concludes that:

‘These agreements mean that the UK Government has to ensure its population enjoys these rights but also that its domestic and foreign policies do not prevent others from the progressive benefit of them. This includes availability of healthcare, health promotion and protection, safe water, adequate sanitation and occupational and environmental conditions conducive to good health.’ (232)(p. 47)

Likely as a result of Donaldson’s proposal, but also stemming from stakeholder input, the right to health underpins the ten principles included in *Health is Global*. (1)

The initial thinkers behind this likely would not have been able to readily articulate which line they wanted to go down so we held a series of stakeholder workshops and what was clear in these workshops was how vast the agenda was and how diffuse people’s understanding was. There were some who saw this through the axis of human rights, some health and conflict and Afghanistan and Iraq. There were some that could only see this through the development lens and actually couldn’t understand why you needed anything in addition to the development policy in the health sector. So, we had some discussions with Paul Hunt and after talking with him we decided to go along with the others trying to

focus on what the practical implications are and the principles are that would provide that quasi human rights approach to this document. We decided not to quote from various human rights charters principally because we thought it's so easy to use up loads and loads of paper setting this out again and again and again. Let's try and show what principles and what action we're going to take forward as a result of that work of thinking.

As the policy states, 'we believe that every individual - whatever part of the world they come from or live in - is of equal value.....Human rights belong to every individual in every part of the world and the strategy's principles and actions are practical ways of upholding these rights.' (1)(p. 16) The strategy highlights that the UK was one of the original 1948 signatories of the Universal Declaration of Human Rights but does not make any additional references to any of its specific obligations under international human rights covenants. Having said this, however, *Health is Global* does commit to including health as a section in the government's annual human rights report.⁴⁹ (1) It also makes some explicit references to human rights with an emphasis on gender rights in the context of sexual and reproductive health and cautions that unfair or unethical trade can deprive workers of their 'rights to security of employment and compensation.' (1)(p.60)

Of the 14 UK informants interviewed, five did not make any reference to human rights, and only two mentioned international health rights frameworks in their response. The majority of those who referred to human rights did so to simply affirm that human rights had been a consideration in the development of *Health is Global*. These comments embody the normative but not the legal dimensions of international human rights, which is consistent with how state actors tend to regard human rights as a rationale for focusing

⁴⁹ Though not necessarily delineated in one section, both the 2009 and 2010 reports make multiple references to health and healthcare. The 2009 report includes a section entitled a 'human rights based approach to development' in which health and education are highlighted as two areas in which the UK takes 'a particular interest.' (233)(p.29) The 2010 report does not include a similar section. (234)

on health in foreign policy. (73;74) The strategy was informed by stakeholder workshops in which the organizers aimed to have diverse viewpoints “at the table,” including those focused on human rights. Only one interviewee explicitly referred to health as a “right” while others referred to concepts related to human rights such as health equity, social justice and improving global health as an obligation. One interviewee referred to health equity as a “moral imperative.” A prominent theme in the interview data was challenges associated with ensuring that a human rights perspective had an equal seat at the table in policy discussions along with trade, economic growth and security.

Climate change

Health is Global commits to leading efforts across the world in responding to the health effects of climate change. (1) Actions it commits to taking include continuing to support the International Climate Change Network that will help poor countries gain a better understanding of the social economic and environmental impacts of climate change and promoting the importance of the health sector taking the lead in reducing greenhouse gas emission and adapting to climate change. (1) One informant from the academic community praised the UK for focusing on climate change in the strategy and thought that the commitment could be strengthened even further.

I think the UK had quite a strong position on climate change, in terms of seeing the need for a strong mitigation policy and also because climate change is already with us and helping the poor populations to adapt to climate change, reducing vulnerabilities is truly extremely important and needs to be integrated into a global health policy. So I think it probably arises from the fact that even prior to the Blair government, there was considerable support for initiatives to address climate change. What we need to do now is to make this a centre piece – we have opportunities now to strengthen health in developing countries now that in the future they may be greatly impacted by climate change.

Influences from outside government

As already discussed, the Nuffield Trust played a key role in bringing the issue of the effects of globalization on health and the integration of health into foreign policy to UK policymakers' attention beginning in the later 1990s and early millennium. As one informant explained, "the idea came a long time ago from outside government," in particular from the Nuffield Trust and "from people with academic interest in global health diplomacy and the emerging concept of global health diplomacy." The Nuffield Trust's role as a key influencer is supported in Bargeman's recent Master's thesis in which she concludes that it was 'an early and pivotal force in driving forward the discussion of health as a critical foreign policy imperative' including 'funding leading researchers to generate critical academic research as evidence in supporting this discussion' and using its position to build extensive networks of senior level officials engaged in health as a foreign policy issue. (235)(p. 8) She describes the Nuffield Trust as a 'driver' of the policy discussion that 'ultimately established the foundation for the development of *Health is Global*.' (235) (p.9)

In addition to the non-state actors already mentioned other members of civil society also appeared to play an influencing role in establishing the need for, perhaps not the strategy *per se*, then a greater focus on global health by state policymakers. As one informant commented, "I think civil society has definitely had an influence through campaigns like Make Poverty History." The UK had played a leading role in launching the Make Poverty History campaign in 2005 which challenged Tony Blair, UK's Prime Minister at the time and President of the 2005 G8 Summit in Gleneagles to tackle issues of trade, aid and

debt. (236) As lead for the Summit that year, Tony Blair made Africa and climate change the priorities. Blair had set up the Commission for Africa in 2004 arguing that all states have a role in creating a strong and prosperous Africa. The Commission proposed a number of recommendations, including those pertaining to how to best support Africa to meet MDGs targets that were taken forward to the G8 when it met in Gleneagles in July 2005. (237) At the 2005 G8, G8 members from the European Union committed to a collective aid target of 0.56% of gross nation income by 2010 and 0.7% by 2015. (238)

International developments that focused on health and foreign policy, in particular the publication of the *Oslo Ministerial Declaration* in 2007 also played a role. (1) The UK strategy refers to other examples of actors and events that were raising the profile of global health around the time, including:

- the European Commission that adopted a health strategy in 2007 that for the first time set out an overarching strategic framework spanning core issues in health, including those relevant to global health; (1)
- the G8 that identified global health as a key area where more could be done; (1)
- the 1997 US Institute of Medicine Report that made a strong case for why the US should invest in health abroad; (96) and
- a 2006 Lancet article that described the advantages of using health as an instrument of foreign policy. (93)

As one interviewee stated, these developments exerted “international pressure” on the UK “to get in the game,” though as already noted, and as this informant emphasized, “the UK likes to go it alone.” Another interviewee reflected:

Nuffield was a contributor but not sufficient to make the strategy happen. It enabled it as far as UK institutions were concerned but there were a lot of other pressures. There was the international dimension. So you have countries putting

their stamp on their field saying this is what we understand by it. To me that raises the significance of a policy area, that when more than one state starts to do it then it becomes important for the UK to have its version of this discourse because it's achieving a degree of international prominence.

Influences from inside government

Call for a whole-of-government approach

The intent to put in place a whole-of-government approach to addressing global health was a major driver behind its development. As one informant put it, “another thing to bear in mind with New Labour is the greater focus on government coherence, joined-up policies. It’s also important to see this as a driver for looking at how one policy area can impact on another.” Chief Medical Officer, Sir Liam Donaldson argued in his report that led to the development of the strategy that DH, DFID, FCO and many other government departments and their agencies all have a role to play. A coordinated approach would be needed for the UK to maximize its impact on the international stage. (93) This viewpoint also made its way into the strategy itself:

‘Many UK government departments and agencies work on issues that directly or indirectly affect the health of the world’s population. To be most effective in our work on global health, and to make the most of opportunities to improve UK health, we need a consistent and joined-up approach across government. A more coherent approach and also raise awareness of any unintended adverse effects of UK government policy, and highlight policies that conflict with efforts to improve global health.’ (1)(p. 15)

Political Support

A very important factor that influenced and enabled the development of the strategy is the political support it had from the Prime Minister, Gordon Brown, and his Ministers of the day. Gordon Brown signed the foreword demonstrating “support from number 10.”

Another informant reflected that Gordon Brown likely supported the strategy out of personal conviction:

Obviously Gordon Brown has undertaken some high level initiatives around increased aid flows, he's committed the government to getting up to the UN target of 0.7% of GDP, he's created this new financial vehicle for vaccinations and immunizations so he himself would seem very supportive of global health but has that been done for foreign policy reasons or because it happens to be his personal conviction? I don't think he's doing this in a major way for foreign policy objectives but out of personal conviction.

Ministerial support for the strategy reflected in a common voice and position across government was also critical and appears to have been significant enabling factor leading to its development and eventual launch. Ministers that were the leads on collaborating to develop the strategy were present at its launch (DH, FCO and DFID) along with the Chief Medical Officer, Sir Liam Donaldson. The press release that accompanied the launch included quotes from each of them. (211;239) This demonstrated as one informant put it, “that the baseline was all signed up to this. That is why we have an HMG (Her Majesty’s Government) document.” Another reflected that:

one of the things that I've learned working in government is that conducive personalities are the biggest driver for change. One minister getting on with another minister across the pond will do more for catalyzing or evolving a policy area or an agreement between countries than years and years of careful negotiation and planning. It's the same with domestic policy within a particular government's approach.

Idea came from FCO

As several interviewees communicated, the Foreign and Commonwealth Office (FCO) was a key player in the late 1990s/early 2000s in the context of globalization in bringing attention across government to the rising significance of health in foreign policy. It also played a major role in ensuring that *Health is Global* was developed and launched. “FCO ran a series of workshops on a kind of interface of health and foreign policy that helped open a few doors to the strategy actually being published, to get the conversation going with FCO at an institutional level.” Several informants noted that “FCO support was key”

and that there was a “push within government from a powerful part of government - FCO
- to see this delivered.”

It would have been difficult to have seen this thing delivered if it simply came from the Department of Health. The strategy was led principally by the Foreign and Commonwealth Office. They discussed this in the context of globalization and how the UK should respond to it and there was agreement from that that one of the deliverables could be setting out what our global health policy-strategic approach could be and this dovetailed very nicely with what people were saying on the outside.

Department of Health (DH) leadership

Although Liam Donaldson was Chief Medical Officer at the time when the strategy was developed and launched and was a proponent of it, several informants commented that there would not be a strategy without the lead public servant, Dr. Nick Banatvala, in the Department of Health (DH) who kept it moving forward. “There was a very, very committed individual in international health who was a dynamo, very, very brilliant and even when the time is right if you don’t have an individual, a sort of champion, then sometimes you don’t get things done.” Dr. Banatvala was described as the “real hero.” His understanding of the NGO world which he came from and his previous work with DFID were seen as critical to his success. He was also a medical doctor. It appears that Dr. Banatvala was successful in moving the strategy along not only because he was from the bureaucracy where “it really happens” but also because he had experience in and understanding of the different worlds, players and issues that needed to be integrated into the strategy. Another very important support for the lead public servant was “having people outside giving him the leverage to help inside government and for networking.”

5.3 Content

Health is Global is composed of a summary strategy document and a comprehensive set of annexes that describe in detail the actions that will be taken to deliver on the strategy. Table 6 summarizes the five strategy action areas and how they link with its overall goals and Table 7 summaries the ten principles that underpin the strategy. As part of the process, criteria were developed to determine the areas covered in the strategy: 1) has a direct link to an important global health issue⁵⁰; 2) the UK has particular expertise and experience of working in the area and/or the ability to influence others; 3) implementation requires effective cross-government working; 4) what can be delivered can be identified with specific, timely, measurable results; and 5) the UK stands to benefit directly from engaging in the issue, for example, where there are clear links to the health of the UK population. (1) The principles are meant to guide decision making particularly when conflicts among priorities arise. As Donaldson and Banatvala acknowledged, potential conflicts exist between policy priorities.

‘For example, reconciling UK trade interests (including trade in commodities) with sound pro-poor development policy and maintenance of international human rights might be difficult.....A coherent UK global-health strategy is important in navigating an economically and ethically acceptable path through the priority areas.’ (93)(p. 857)

The final priorities and principles reflect the potentially conflicting reasons why the strategy was developed and allude to the likely difficult process that was required to reach a consensus on what eventually ended up in the strategy.

⁵⁰ The 2006 study, Global Burden of Disease and Risk Factors (Lopez AD, Mathers CD, Ezati M et al (eds). The World Bank and Oxford University Press, was used to help determine what the important health issues were. (1)(p.37)

5.4 Process

5.4.1 Policy development process

As described in the strategy, in 2007, England's Chief Medical officer, in his capacity as Chief Medical Advisor to the UK Government, issued *Health is Global: Proposals for a UK Government-wide Strategy*. The Prime Minister and Cabinet approved the discussion paper, which set out the rationale for a strategic framework for global health. (1)(p. 15)

An interministerial working group led by DH coordinated the development of the strategy and in July 2007, several government departments and devolved administrations joined forces with The Lancet, the London School of Hygiene and Tropical Medicine and the Royal College of Surgeons of Edinburgh to host workshops with a wide range of stakeholders to debate what the UK government strategy should say. (240) Those developing the strategy also received written responses captured through the *Health is Global* website and reviewed commentaries published in health and medical journals about health and foreign policy.⁵¹ The results of the stakeholder workshop discussion were also published on the website and used to help shape the strategy. The interministerial working group for *Health is Global* oversaw the organization of these workshops, which aimed to involve the UKs devolved administrations in the process and a wide range of stakeholders from private, public and civil sectors. (240)

Interviewees described the strategy development process as “an extensive exercise of consulting and getting feedback” that took about two years to complete. “It was clear how vast the agenda was,” said another. The process included a “cross-government

⁵¹ Two such commentaries are mentioned as references. These are *UK global health strategy: the next steps* by MA McKee published in BMJ in 2007 and *Health as an instrument of foreign policy* by R Horton published in The Lancet in 2007.

priority mapping” exercise that “helped crystallize who was coming from what perspective.” As one non-state interviewee commented, “a lot of us learned a lot about how government works and in a way just that process itself was an important outcome. We got to know each other’s business.”

In addition to the development of background papers and stakeholder consultations, the policy development process also appears to have considered relevant research evidence. This evidence, outlined primarily in Annexes 3 and 4, focused both on the major causes of death and ill health in the world using data from the 2006 Global Burden of Disease and Risk Factors study and the 2006 Disease Control Priorities in Developing Countries report (DCP2), which describe current knowledge concerning interventions to improve health and the related delivery systems in a variety of low-and middle-income countries. (227) The data and conclusions drawn from a summary of the Global Burden of Disease and Risk Factors study are meant to help UK policymakers focus *Health is Global* on ‘important global health issues,’ such as the rising burden of non-communicable diseases in developing countries and improving social determinants of health such as nutrition and sanitation. (227) The Annex that summarizes DCP2 concludes that health sectors in developing countries can make a real difference by focusing their energy, expertise and resources on ensuring that health systems efficiently deliver ‘the powerful interventions provided by modern science.’ (227)(p. 110) Areas the report highlights for focused intervention include under-five mortality, HIV and AIDs and non-communicable diseases and injuries. The report asserts that improvements in these areas are most effectively underpinned by strong health systems, research and development and effective

development assistance. (227) The findings from both reports appear to have informed a number of objectives and action areas in the strategy, including ensuring stronger, fairer and safer systems to deliver health and related actions such as focusing on non-communicable disease and injuries and identifying and supporting research and innovation that tackle global health priorities.

In addition to these two sources of evidence, the strategy refers to both peer and non-peer reviewed literature and findings of important and relevant commissions such as the WHO Commission on the Social Determinants of Health, the WHO Commission on Macroeconomics and Health and the Codex Alimentarius Commission. In particular, it refers to the WHO Commission on Social Determinants of Health (SDH) to support the premise that ‘dealing with the social determinants of health is also crucial,’ (227)(p. 7) and commits to continuing to work with the WHO and EU ‘to raise the profile of social determinants of health and to reduce health and social inequalities.’ (227)(p. 7) The UK had a significant stake in this Commission and provided leadership, expertise and financial resources to help it succeed. (38)

In reviewing *Health is Global* one might conclude that there was significant attention paid to research evidence in the development of the strategy and in the final product. Comments from interviewees, particularly those from the academic community and research organizations, did not necessarily support this conclusion. While these interviewees acknowledged that there were deliberate efforts to involve academics and other sorts of researchers in the process because it was recognized that “there needed to

be more evidence” considered as part of the process, evidence was only one of many factors considered in strategy deliberations alongside politics, ideology and values.

The drivers are not necessarily that you’ve got a body of evidence why global health is important. Globalization is changing the context of health and that’s a general body of evidence. There’s a political and discursive element to this as much as an evidence-based one. It will always be couched as evidence based because that is the main legitimating discourse for policy innovation in the UK.

One interviewee stated, “my personal take is that there’s kind of a political rationale that’s important in understanding why this has happened rather than being evidence based. To the extent that is it evidence based, its evidence of emerging infectious diseases.” Another commented:

How do you start thinking about evidence based policy for trade, for example, when it is such a political topic? I mean there’s an evidence base for pandemics because they’re the more scientific things but its other things even the climate change stuff that we’re just starting to do. So a lot of it is based on consensus, not evidence.

This particular interviewee also reflected on how evidence could be used going forward as the policy is being implemented:

My own ideal would be to have evidence collated now to develop policy further as well as supporting policy that exists...to be honest, it fell flat, you could have done so much more in that section about the research and how research would be used to improve policy for the future and give a state of the art – where we are now and where do we need to get to.

In contrast to perspectives provided from researchers, one of the lead public servants provided another point of view:

At one stage we had quite a difficult time with some of those researchers because they felt that the document as a sort of earlier iteration was not sufficiently evidence based and there lies a tension between policymakers and researchers. ‘You’re identifying these four priority areas. Where’s the evidence for that?’ There is time when you accept that you take the evidence as it is and you move forward on a particular piece of policy.

Reconciling differences

Developing *Health is Global* and agreeing on a final product required significant consensus building and reconciliation of differences and interests across the many players involved. Moreover, the government of the day had committed to seeing the strategy developed so a “certain degree of pragmatism” was required to ensure a final product was arrived at in a timely manner. Early on in the policy process it was acknowledged that there were potential conflicts between the priorities that were emerging and that there might be difficulty reconciling UK trade interests with sound development policy.

(93;241) Indeed, enhancing the ability to reconcile differences across government in the area of global health through a whole-of-government approach was one of the reasons the policy was developed in the first place. (232) The strategy itself acknowledges that there are potential conflicts in many aspects of domestic and foreign policy and provides ten principles that presumably should be considered when such conflicts do arise. (1) As a way to reduce policy conflicts, in the strategy the Department of Health commits to supporting other departments in preparing global health impact assessments, which describe the global health impact of their foreign and domestic policies. (1)

According to several of the interviewees, the process of developing the strategy did indeed advance understanding about global health and the reconciliation of potential differences in this domain because it required players from across government to sit down together and discuss and resolve such differences:

I guess one of the useful things that's come out of this is that we've been able to improve discussions between ...across government on what the different elements and issues are that intersect global health and then try to iron out what has been, at times, glaring contradictions in policy positions.

The process of ironing out contradictions and differences was clearly not an easy one however, with the majority of interviewees describing it as difficult and requiring significant compromise to arrive at a final document:

It's tough because our government doesn't think the same on anything and each department has its own priorities and mandates so trying to get something that all would sign-off on including the PM was a big challenge. So he (the lead from the Department of Health) took stuff out.

Another commented, "I think it shows a bit of a tussle that it had to settle in order to be written. It had to settle for a slightly narrower definition of health." Others described a "push and pull" process, "huffing and puffing over drafts" and being involved in interactions that "weren't altogether as productive as they might have been" resulting in a product that "wasn't truly a joint production." Another commented that the "broad tone is collegial and amicable but it's too far to say its consensual, there were very definite trade-offs."

Interviewees provided significant insight into the trade-offs as well as to the power struggles that took place among government players. As one interviewee noted, "whoever has the power is more powerful. DFID is like an NGO in government. The powerful are trade, industry, FCO." In keeping with the tradition 'high politics' areas of foreign policy, this comment likely explains what priorities rose to the top and received the greatest profile in the strategy (security and trade) as compared to those that received less (e.g. social determinants of health, health as a human right).

Two main areas that required negotiation and compromise were clear in an analysis of the interview data. First, as one of the comments in the previous paragraph highlights, there

was a lack of consensus as to what global health actually is. For example, there were those who regarded global health as primarily about diseases that cross borders (e.g. Health Protection Agency) and others who regarded it as being much broader and also encompassing the social determinants of health (e.g. Department of Health International Unit, DFID, NGO interviewees). As one interviewee explained:

The policy community that focuses on global health is very, very small. You're basically talking about one unit of a unit within the Department of Health. I think not more than half a dozen middle-ranking civil servants in DFID, and I'd be surprised if we've got half a dozen people in FCO who have a specific portfolio brief for global health. It's a very small group of people and to them global health means all the things that have been before, special health regulations, but also trade and IP, migration policy and health – outside that group of people, global health is equated to health security.

To resolve this issue, it appears that the players agreed to settle on what one interviewee called a “slightly narrower definition of health,” couched primarily within the rubric of global health security.

Second, as anticipated when the strategy was first under discussion, there were significant debates related to priorities that may conflict, such as ‘enhancing the UK as a market leader in well-being, health services and medical products’ on the one hand while ‘promoting access to medicines,’ (1) on the other. In other words there were conflicts between priorities that would primarily benefit the UK and certain interests within the UK (e.g. trade, security) versus those that were meant to primarily benefit others (e.g. development, human rights). Several themes in the interview data elucidate this struggle further.

The first example has to do with international trade in conventional arms, which is a significant issue given the UK is one of the world's largest arms exporters. (73) As an interviewee from FCO said:

There are certainly a lot of civil society organizations saying if you are serious about improving global health outcomes, you should be tackling the arms industry. Now that takes us into very, very sensitive territory for FCO because you know, automatically there are going to be conflicting interests at play.

A few other interviewees also commented on the arms issue with one indicating that “there were some pretty robust discussions between the Ministry of Defense, Department of Health and the Foreign Office around what our global health strategy would mean to things like arms agreements.” Another added:

I remember at one point we had a discussion of arms and how you know, how the arms industry was going to be integrated into all this and accepting that countries have a right to defend themselves but nevertheless, some arms exports end up in regimes which are unsavory, to say the least. I think that report rather dodged around that kind of issue.

This informant is likely referring to the section of the strategy in which the UK calls for a legally binding treaty for the international trade in conventional arms without impinging on ‘legitimate, responsible defense exports.’ (227)(p. 21) What this means exactly is not elaborated on in the strategy but it can be assumed that “dodging the issue” through lack of clarity and the use of diplomatic language was perhaps the only way that relevant government departments would collectively sign off on this content in the strategy.

Another concern that at least half of the interviewees mentioned relates to the issue of advancing UK as a market leader in health and supporting UK industries abroad while at the same time also aiming to reduce health inequalities through, for example, contributions to improving health systems and access to medicine and technology in low

and middle income countries. While the previous example brought in FCO, Defense and Health, comments about this issue focused primarily on conflicting priorities across DFID and the Department of Health. As one interviewee stated, “part of the DH role is to act as a sponsor for the UK health economy and you’ve got Trade and Industry which are responsible for trade promotion. DFID has been working on access to medicines so you can infer a potential kind of conflict there.” Another elaborated further:

When you look at trade and intellectual property issues, DFID would always say, well, look, what can we do for the developing world? And when that comes into conflict with actually what might be most beneficial for UK companies in terms of how they can get stronger intellectual property protection globally, DFID will not soften its stance which would be at odds with what other departments are doing, say the Department of Health which is the lead sponsor department for the pharmaceutical industry within government and would want to pursue a policy position that government would be sympathetic to industry.

As an interviewee from DFID emphasized:

The thing that drives us and drives most development agencies are the MDGs. That’s our focus, that’s our mission. That will drive things first and then we will try to align with other domestic partners. Our first and foremost objective is reducing poverty. That comes before anything else.

Another interviewee encapsulated DFID’s position in the following sentence, “DFID cannot support an agenda about the UK getting richer.”

One informant provided significant insight into the nature of the discussions that took place to hash out these sorts of conflicts and expressed some frustration with the DFID position. These comments also highlight that one of the positive aspects of going through the process of developing a strategy was the opportunity to hold discussions about contentious issues since it was imperative that a strategy be agreed upon and launched.

There were times when we got to air some intellectual laundry that we never, never got to in public or private between ourselves before. I remember one

particular exchange when we wanted issues related to medical devices, the pharmaceutical industry, the biotechnology industry, wanted all three of those approaches to get into the chapter and so we sat down, we had a meeting and agreed to the points we wanted to make and I went away and produced a draft. We shared it with our colleagues in DFID and it's not to say that there was ever any kind of intention of fighting but their comments displayed naiveté about the importance of economic issues and wealth generation for the UK and they'd state, which is true, our department can't support priorities which are about the UK getting richer. And we'd say, well, we understand that this isn't DFID speaking, this is the UK government. They weren't blocking the text going in but it was frustrating for us to see that there wasn't any commonsensical acceptance that this work that goes on to generate nine-and-a-half billion pounds worth of investment a year into the UK economy is quite useful as well and you know if the economy fails one of the first casualties is actually going to be the foreign aid and development budget. It's part of the kind of mentality that happens with all governments. You see Directors that don't understand the way that all policy areas link together. It was frustrating that certain departments and certain colleagues still didn't make the intellectual leap required to have a joined-up piece.

When asked how these sorts of issue were eventually resolved so the strategy could be written, this interviewee said, "That particular chapter ended up being compromised and shrunk in size, unfortunately." It also appears that there was an agreement between DFID and DH that the strategy would reiterate DFID's commitment to working with 'the poorest countries in the world' (227)(p.58) while DH would concentrate on middle income and emerging countries, such as Brazil, India and China. As the strategy states,

'we want to promote the best in British healthcare, to make an effective contribution to health systems in other countries. We will make sure that our approach fits with the country's strategy and that it neither increases health inequalities, nor becomes an obstacle to poverty eradication and the achievement of the MDGs. Our priorities will be China, Brazil and India.' (1)(p. 29)

Another interviewee provided some additional thoughts on how tensions were resolved during the policy development process:

I think there was a group of people who have a particular priority focus but who fundamentally have the same values and therefore discussion and re-discussion and redrafting and ensuring that the text reflected the commitments of the department whichever department you came from was not a completely painless process but it was done in a number of iterations to ensure that all stakeholders

were content. And I think that was a critical part of ensuring that the strategy itself was actually accepted and was able to be published as an HMG [Her Majesty's Government] document. I think the whole-of-government aspiration is there and it's been articulated in the strategy and that this is something we should be doing and it is a good thing.

Despite the contentious issues that arose during the process and trade-offs and compromises that were required to “all meet in the middle,” the majority of interviewees were satisfied with the final product. The process of developing it was seen as beneficial in achieving greater cross government understanding of issues and policy positions.

5.4.2 Policy implementation process

The strategy includes a detailed implementation plan with specific actions each with an assigned lead department(s). An interministerial Group for Global Health, now referred to as the Global Health Team, (242) made up of representatives from the departments involved in the development of the strategy (DH, Defense, DFID, FCO) is responsible for implementing the strategy and monitoring progress. (1) A cross-government steering group of senior official supports the interministerial group. (1)

‘Working with others’ is a key implementation theme in the strategy. In the strategy, the UK government commits to working with a variety of ‘non-governmental’ partners, such as global health partnerships and initiatives, industry business and the commercial sector, foundations, academia and research institutions, the National Health Service (NHS) and other UK health and healthcare organizations, the NGO sector, professional groups and the media. Actions it is taking to ensure partner involvement include holding regular partner events to review global health challenges and to assess whether the strategy is making an impact. (227) Since the strategy was launched, the Global Health Team has organized at least two partner meetings that brought together partners including those in

government, academia, non-governmental organizations and industry to continue to chart implementation progress and identify new opportunities for collaboration. (243;244)

In relation to working with others, one of the main priorities of the strategy is to help ‘reform international institutions so that they become representative and effective in the modern world.’ (1)(p.25) The strategy commits to working across government with the EU, WHO and other UN agencies on a number of initiatives including supporting consolidated and unified UN Country Programmes that have a clear emphasis on measurable progress towards the MDGs. (1) The UK’s institutional strategy with the WHO was also launched in 2008 and aims to guide its collaboration with the WHO and is purported to be coherent and consistent with *Health is Global*. (245)

The strategy did not commit new resources to support implementation but rather reiterated the relevant resources that it had already committed to global health particularly those for international development funneled through DFID. The strategy also emphasizes that existing resources from other government departments that finance programs that contribute to improving global health are important too. It asserts that ‘these resources need to be used strategically if they are to have maximum impact. This means supporting the priorities and approaches set out in the strategy and working with others to deliver them.’(1)(p. 33)

One area of new investment included in the strategy pertains to the global health security priority. While details of the level of funding and which department is contributing it are

not provided, the strategy commits to ‘new funding for the HPA (Health Protection Agency) to do more work internationally’ (1)(p. 21) and support for a new Chatham House Centre on Global Health and Foreign Policy. (227) The description of what this centre is meant to do is fairly generic in the strategy, but its focus is on global health security. The centre was established, and focuses on three main priority areas: disease threats and determinants that transcend borders; access to health-related products technologies and services, and international affairs, governance and health. (76) This investment of new funds demonstrates the importance of the strategy’s global health security priority. In addition, the strategy also commits to providing funding for the new European Council on Global Health now called ‘Global Health Europe’ that aims to strengthen the European voice in global health governance and be a powerful advocate for a sustainable European commitment to global health. (1;159;246) Global Health Europe Task Force members include Dr. Nick Banatvala, who led the development of *Health is Global* and Dr. David Heymann, Director of the Centre for Global Health Security at Chatham House. (247)

Several informants mentioned the role of Chatham House in helping to implement the strategy. Most considered this to be highly positive given Chatham House’s long standing reputation as a ‘world-leading source of independent analysis, informed debate and influential ideas’ about international and global issues. (76) One interviewee from an NGO was highly critical of this move, however, arguing that Chatham House has no experience in health and its focus on global health security as opposed to health equity was a “cop-out.” Only one interviewee mentioned the funding for the European Council

for Global Health which is an initiative stemming from the European Partnership on Global Health created in 2005. Two highly influential individuals from the Nuffield Trust were involved in establishing the Council, which may help explain why the UK is supporting it as part of *Health is Global*.

Depending on where they were situated, interviewees provided varying perspectives on implementation efforts one year or so after the strategy was launched (i.e. when the interviews took place). Those inside government described new formal and informal processes, structures and procedures that had been put in place to move the strategy forward and in general regarded the strategy to be “on track.” More formalized mechanisms mentioned included the interministerial working group responsible for implementing the strategy, a new cross government strategy working group with the WHO and the new cross government focus on ‘stabilisation’ through the Stabilisation Unit described by an interviewee as the “cross government hub owned by the Ministry of Defense, the Foreign and Commonwealth Office and DFID.” The Unit was set up to respond to the complex challenges of fragile and conflict-afflicted states, and works with countries to enhance their capacity for self-governance. According to one of the interviewees, it meets regularly with the Global Health Team to “enhance policy coherence.” Informal mechanisms mentioned were stronger relationships with colleagues across the government leading to more frequent interaction and increased “understanding of where they’re coming from.” Interviewees from outside government, however, mentioned that they were not aware of a process “to call people to account,” and saw “little evidence of progress.” They felt that “momentum had been lost” and there were

“lots of ideas, little action.” Whether from inside or outside government there appeared to be a general consensus that the strategy would need to be adequately resourced in order to succeed and that a change in government and a deepening global economic crisis could significantly threaten its intended implementation. As one interviewee put it, “so to succeed it will need ministers to continue to back it and support it and to resource it adequately to make sure that it happens and that’s always a big issue in government with everybody reducing size and resource people.”

5.5 Actors

The actors who were involved in the strategy development process have already been mentioned in the previous sections of this paper. To summarize, these included a relatively broad array of stakeholders who participated in the stakeholder workshops with representation from government, the private sector (e.g. medical device and pharmaceutical companies), the healthcare system, the health insurance industry, academia and research organizations (e.g. UK Collaborative on Development Sciences), the media, global health charities (e.g. MEDACT) and advocacy groups (e.g. Justice Africa), and health professional associations and a more intimate group of government and non-government actors who worked closely together to actually draft and finalize the strategy (this smaller group was the target group of individuals interviewed for this thesis project). This group was comprised of senior staff from each of the ministries that made up the interministerial working group (e.g. DH, FCO, DFID, Defense) as well as representatives from academia, NGOs and research organizations. (see Table 1)

Of the government actors, senior staff from the Department of Health (DH), the Foreign and Commonwealth Office (FCO) and the Department for International Development (DFID) were the key players; with close involvement from Defense, as well. FCO was regarded as likely the most powerful actor while DFID described by one interviewee as “like an NGO in government” held less power. Actors outside government were also regarded as highly influential. As well, the Prime Minister supported the strategy and signed his name to the Foreword. (1)

5.6 Indications of impact

The *Health is Global* strategy sets out a set of actions against which indicators will be developed and progress measured. (1) It commits to reviewing progress regularly ‘to improve the way we are working,’ (1)(p. 16) and overall impact at the end of the life of the strategy to determine what to do next. (1) As part of the evaluation process, it commits to commissioning annual independent reviews on progress on particular aspects of the strategy with a full review in 2013. It is not clear if such reviews have indeed been annual as only one such review conducted in June 2010 is publicly available. (248) It does appear, however, that the interministerial group is tracking progress on a regular basis as reported at partner meetings held at Chatham House since the strategy was released and in partner newsletters. (243;244) Furthermore, the UK government launched a *Health is Global* outcomes framework in 2011. Starting with the original strategy and the recommendations from the first independent review just mentioned, the government developed an outcomes framework to support the next phase of the strategy. This framework reaffirms the guiding principles and focuses efforts towards achieving a

consolidated set of twelve high-level global health outcomes by 2015 that will be underpinned across government by departments' own delivery plans.

Interviewees provided their perspectives both on what impact they thought the strategy had had so far as well as perspectives on success going forward. Overall, interviewees regardless of sector described the strategy as a positive and important milestone, particularly because it focused minds in a “more consistent way” across government, has been a “good driver” for individual and collective work because it is now “written down” and serves as a guide for identifying “how each department fits and where the gaps are.” It was also described as a concrete example of the UK's commitment to global health, “sticking our flag in the sand is a successful output” said one. Several mentioned what they regarded as concrete positive outcomes of the strategy so far, including the launch of the research program at Chatham House and new funding for the health protection agency. Another commented that the strategy is making a difference because it “builds awareness and support for the MDGs.” A few interviewees posed questions that should be asked as the strategy is implemented to help assess its success. These include questions such as, “Has the government kept to it? Is the government who signed onto it keeping to it? What has this strategy led to that would not have happened anyway?” Another thought that “Success will be what happens to the policy community around this. Will there be greater interaction between FCO, DFID and Health? Greater cooperation? Genuine engagement?”

5.7 Conclusion

As with the background cases, the policy analysis circle was used to categorize and describe themes from the document review and interviews conducted for the UK case. A discussion and analysis of these findings informed by those from the background cases, the literature and document review, and the conceptual framework follows in Chapter 6.

Chapter 6: Discussion and Analysis

6.1 Introduction

This chapter uses the findings and conclusions from the background cases, key findings drawn from the literature review and the conceptual framework to discuss and analyze the UK case findings. It focuses on addressing the main research question - how and why is health integrated into foreign policy - and discusses and draws conclusions about the two tentative hypotheses posed at the outset of this study. These hypotheses were: 1) the primary reason that state actors have chosen to integrate health into foreign policy is to protect national security and the material interests of the state. Therefore, the integration of health into foreign policy does not mean that health is an overriding normative value and the ultimate goal of foreign policy; rather it is an instrument of foreign policy that can be used to achieve other foreign policy goals. And, 2) since health is a highly technical and scientific domain and states cannot ignore the epidemiological reality of many health crises, it can be hypothesized that the health research community and scientific research evidence play a powerful influencing role in the policy development process.

6.2 The Importance of Timing and Stream Alignment

As in the background cases, timing and the alignment of the problem, policy and politics streams found in Kingdon's model were critical to the eventual development and government-wide agreement on *Health is Global*.

The growing awareness of global health and the globalization of health issues, and the potentially important relationship between health and foreign policy, had been brewing for several years in the UK policy community before the SARS crisis hit and was the “wake-up call” for the government to take concrete action to address global health issues. While SARS was the ‘focusing event,’ however, it appears that there had been significant political intent simmering prior to SARS (or around the same time) to improve the UK’s global reputation post Iraq. Investing in global health was one way to do this. The UK’s commitment to helping to achieve the MDGs was also a strong motivating factor for focusing on global health at that time. Within this mix, leaders within the bureaucracy were keenly focused on global health and set the stage for catalyzing stream alignment when the policy window opened with the SARS crisis. It appears that a bandwagon effect occurred at that point in time and created incentives for the various government actors with non-state actor participation to arrive at an agreement on whole-of-government global health policy - *Health is Global*.

6.3 The Importance of Actors and Leaders

In addition to timing and stream alignment, different types of actors played a significant role in influencing the creation of *Health is Global* and ensuring that it was developed, launched and is being implemented. Based on the case analysis and according to Kingdon’s model, these actors can be grouped into two categories - the policy community and policy entrepreneurs. Given its prominent and unique role as a global health institution, the World Health Organization (WHO) is discussed in a separate category.

6.3.1 The policy community

While *Health is Global* was launched in 2008, the policy community was actively influencing its eventual development at least for a decade before that. As described in Chapter 3, the Nuffield Trust, purported to be a well respected, independent source of research, analytics and commentary on health related matters in the UK with links to UK policy and decision makers, (91) in particular played a major role in attracting and sustaining focus and analytical scrutiny on the link between globalization and health and, with partners, in connecting the various players in the policy community (e.g. government, academia, think tanks). This leading and connecting role is critical to preventing the fragmentation of the community and the policy alternatives it espouses, which can significantly weaken such a community's clout as influencers in the process. (56) A more closely knit policy community can generate consistent ways of thinking, common language and issue framing, all of which are critical to softening up a policy space and stabilizing a policy system to influence change. That *Health is Global* was framed according to recommendations stemming from the Nuffield Trust led processes indicates that this policy community had an impact.

Government actors are part of policy communities and in the UK case, like in the background cases, the most prominent of these actors were the Foreign and Commonwealth Office (FCO), the Department of Health (DH) and Department for International Development (DFID). Whether these three actors considered themselves to be part of the same policy community during the policy development process is not known, although given the significant consensus building that was required to arrive at an

agreed upon strategy, likely they did not. As several informants described however, the policy development process itself brought departments with disparate views closer together creating somewhat of a closer knit policy community in government. The creation of the Global Health Team and the process to regularly bring government actors and other partners together may be strengthening this community further.

An interesting observation stemming from the interview data pertains to the somewhat tense interactions that academics who contributed to the process had with government policymakers. On the one hand, academics thought that there needed to be a greater focus on gathering and scrutinizing evidence to inform the policy, while on the other, the policymakers were focused on being pragmatic and moving forward with whatever evidence they had on hand. This tension is not surprising and is supported by ample literature about the challenges associated with the evidence-informed policy and decision making processes. (103;112;249-253)

It appears, then, that while there was representation and participation from academic community in the *Health is Global* process this does not necessarily go hand in hand with the conclusion that research evidence played a central role in influencing policy decisions. Drawing on conclusions derived from the application of Kingdon's model, policy is arguably primarily the result of politics, policy entrepreneurs and the convergence of the three streams and not the result of research evidence *per se*. The interview data corroborates this conclusion. To repeat one particularly relevant comment, "my personal take is that there's kind of a political rationale that's important in

understanding why this has happened rather than being evidence based. To the extent that it is evidence-based, it's evidence of emerging infectious diseases.” This comment resonates with Labonté’s who argues that technical evidence especially about risk and pandemic preparedness may have traction in global health policymaking as it aligns with the health security focus, but rarely is there a full consensus on evidence with respect to other global health areas such as aid and development, leading to a significant amount of political interpretation. (254)

Based on the findings from this study and this closer look at the role of the research community and evidence in the policymaking process, the tentative hypothesis that the health research community and scientific research evidence play a powerful influencing role in the policy development process cannot be unequivocally supported. The role of evidence and the research community in GHD clearly requires closer examination through future research.

6.3.2 Policy entrepreneurs

According to Kingdon’s model, policy change cannot take place without leadership from tenacious policy entrepreneurs. (56) In each of the background cases and in the UK case a policy entrepreneur played the key leadership role in advancing the policy directions.

While such entrepreneurs do not necessarily need to be politicians or public servants, based on the findings from this study leaders in global health diplomacy processes appear to possess at least two special attributes. First, they are either politicians or senior public servants, and second, they encompass both health and international relations expertise through formal training and/or education or a combination of the two. Three of the four

leaders in these case studies were medical doctors who could call upon their status as the elite profession within health, as needed; the one entrepreneur who was not a physician, Minister Støre, was a politician, a foreign minister and as one of the interviewees from Norway stated, the “most popular” politician in office. Leadership in global health diplomacy from the right kind of leader is clearly important. Despite their authority and influence, however, policy entrepreneurs cannot be successful unless they have backing of those from the highest level of political power. In the UK case, Prime Minister Gordon Brown was personally committed to *Health is Global*. Support from “number 10” was viewed as critical for the process to succeed. Similar political support and policy leadership from the very top was also a necessary contextual factor for the policy directions taken in the background cases.

According to Kingdon, policy entrepreneurs play the key role in ‘softening up’ the system and linking the problem, policy and politics streams. One way in which they do this is by developing their ideas and proposals in advance of when a policy window may open. This was indeed what happened in the process leading up to *Health is Global*. “The real hero” as one informant called him, Dr. Bantavala, contributed to the precursor proposal, a summary of which was published in *The Lancet*, for example. (93)

6.3.3 World Health Organization (WHO)

At about the same time that the UK released *Health is Global*, it also published a *UK Institutional Strategy* that will guide and frame its work with the WHO. Like the Norwegian strategy released a few years later, the UK’s WHO strategy is a joint strategy of the health, international development and foreign affairs departments. The strategy

coheres with *Health is Global* and sets how the UK and WHO will work together most effectively to support the goals and objectives of the UK government and of the WHO.

(245) This strategy and the multiple references that *Health is Global* makes to the priority that the UK places on working with and strengthening the WHO to advance global health objectives is consistent with findings from the background cases.

In each country case, the WHO figured prominently as an important institutional actor that can shape action in global health and in turn be influenced by states seeking to advance their own global health objectives. The UK WHO strategy acknowledges that as a ‘major force for good in global public health,’ (245) (p.6) the WHO is at the heart of responding to global health challenges, is responsible for providing leadership in global health matters and is also a key development partner for delivering on the MDGs. (245) The UK and Norway WHO strategies both acknowledge that the WHO as an institutional actor in the context of globalization plays a major role in helping them to cooperate to achieve common global health objectives. While self-interest, discussed in Section 6.4, prevails as the main reason that states like the UK are developing strategic approaches to investing in global health, acknowledging that the WHO is an important and relevant actor signals that negotiation and consensus building to improve population health both within and across states is also necessary and possible. This acknowledgment seems to imply that Brazil’s flexible and soft power approach rather than using hard power is required for global health diplomacy to work in the interests of the actors involved.

The current WHO context

A brief look at the current situation with the WHO helps to provide context to inform a better understanding of this actor in the global health diplomacy process and how the UK and the background countries see themselves engaging with the WHO.

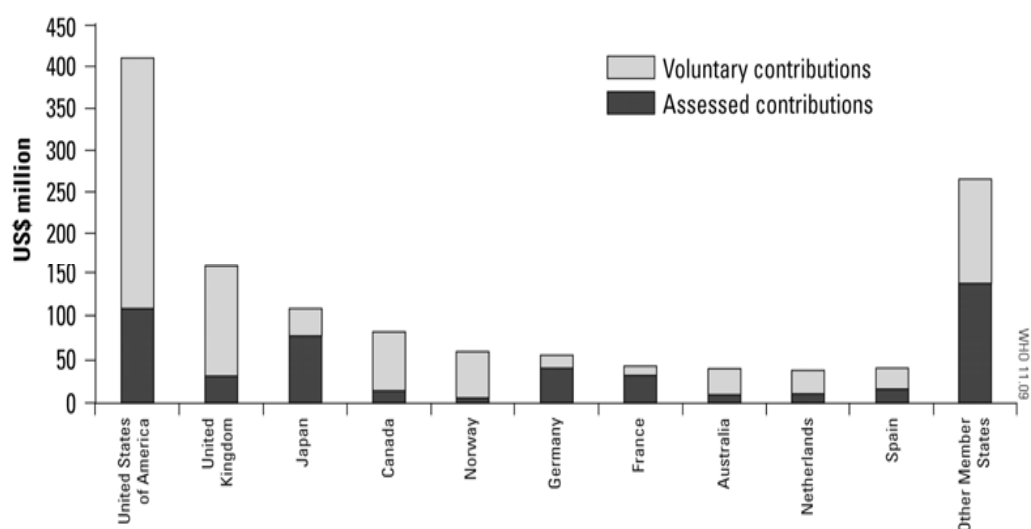
The WHO has been under significant scrutiny over the last few years stemming primarily from questions about its financing and what some see as a shift in the organization's priorities away from global normative development toward operational work at the country level. (255) Some have argued that reforms are long overdue and that cutting certain programs is necessary and would have little impact on the overall global health landscape. (256) In regards to financing, the main issue is that about 80% of the WHO's income relies on voluntary donor contributions including those from member states (see Figure 6).⁵² The total number of contributors is estimated to be more than 400 with the contributions of less than a dozen different donors accounting for more than 75% of all voluntary contributions to WHO. (258) Voluntary contributions are predominantly earmarked for specific purposes determined by the contributor leaving little budget flexibility for other priorities.⁵³ (261;262) Lee traces the growth in extrabudgetary funding for WHO initiatives to the creation of special programs for research in areas such

⁵² Contributions from member states reported in this similar graphical format for the previous three years included the 13 largest donors. Italy, Sweden and the Republic of Korea were not included in the top donor countries in 2010-2011. (257)

⁵³ WHO receives income in two different ways. Its regular budget is not earmarked and is financed through obligatory assessed contributions from member states. Once the World Health Assembly approves the programme budget, a calculation of each member state's contribution is made based on the UN scale of ability to pay (based on gross national product and population). Each state is invoiced on a yearly basis. A far greater portion of WHO's income comes from voluntary contributions most of which are earmarked. Voluntary contributions are made on the basis of agreements between the WHO and different public and private donors. (245;259;260) The WHO total budget in 2010-2011 was US\$4.540 billion. Operating revenue covers both programmatic (WHO led programmes) and non-programmatic activities (e.g. WHO partnerships outside the programme budget, reimbursable procurement and sales of publications). (261)

in human reproduction and tropical diseases in the 1970s. (260) While initially viewed as a positive way to support important initiatives, as the proportion of the budget dependent on voluntary contributions grew in the 1980s and 1990s, there were increasing calls for budget reforms to decrease WHO dependency on earmarked contributions and to address the growing influence of the largest donors. (126;260)

Figure 6: Ten Member States making the highest contributions to WHO 2010-2011 (US\$ million)(261)



The UK and Norway are among the top ten contributors and the vast majority of their contributed funds are voluntary. Total voluntary contributions from Brazil, Switzerland, Norway and the UK for the last three years are in Table 8. For Norway, Switzerland and the UK contributions rose significantly in 2009 and then dropped substantially in 2010 but not to levels as low as they were in 2008. Perhaps the deepening world financial crisis can help explain this drop although the exact reasons for it are not known. It appears,

however, that the UK, Norway and Switzerland decided not to fund the Water Supply and Sanitation Collaborative Council in 2010 and kept their funds in other project areas such as the Special Program for Research and Training in Tropical Diseases and Special Program of Research, Development and Training in Human Reproduction instead. Of note, Brazil made a voluntary contribution in 2010 when it had not done so in the two previous years and all of those funds were earmarked with a small portion going towards the Special Program for Research and Training in Tropical Diseases. In 2010 -2011, member states provided just over 50% of total voluntary contributions to the WHO down from ~63% in 2004-2005, (263) 21% came from UN and intergovernmental organizations (e.g. UNICEF, UNAIDS, GAVI), 18% from foundations (e.g. Bill and Melinda Gates Foundation, the Rockefeller Foundation), 1% from the private sector (about 50% from local organizations in Japan to finance the costs of a WHO office in Kobe and 50% from pharmaceutical companies that directed their funds toward neglected and tropical diseases) and 7% from NGOs and other institutions (e.g. Rotary International for work on polio eradication). (259;261)

Table 8: World Health Organization voluntary contributions and how the funds are allocated: Brazil, Norway, Switzerland, UK for year-end 2008, 2009, 2010 (in US dollars)

Country	2008 (264)	2009 (265)	2010 (266)
Brazil	0	0	Total 350,000 300,000 (VCS) 50,000 (TDR)
Norway	Total 38,789,824 3,827,025 (VCS) ⁵⁴ 34,962,799 (VCC) ⁵⁵	Total 103,923,252 33,505,627 (VCS) 7,130,735 (TDR) ⁵⁶ 3,267,896 (HRP) ⁵⁷ 1,192,059 WSSCC) ⁵⁸ 30,068,776 (VCC) 28,758,169 (OVCC) ⁵⁹	Total 55,867,661 22,941,970 (VCC) 27,274,543 (VCS) 1,855,601 (HRP) 3,795,547 (TDR)
Switzerland	Total 2,880,431 266,700 (VCS) 2,613,731 (VCC)	Total 19,536,942 7,134,121 (VCS) 3,406,126 (TDR) 4,020,101 (HRP) 4,769,475 (WSSCC) 4,480,789 (VCC) 774,327 (OVCC)	Total 5,890,893 4,820,937 (CVCA) 873,036 (VCS) 717,300 (HRP) 1,475,699 (TDR)
UK	Total 55,211,163 28,747,434 (VCS) 26,463,729 (VCC)	Total 205,510,011 127,065,015 (VCS) 9,516,118 (TDR) 7,202,903 (STBP) ⁶⁰ 6,366,163 (HRP) 1,430,615 (RBMP) ⁶¹ 2,496,753 (WSSCC) 36,042,146 (VCC) 15,389,299 (OVCC)	Total 115,182,487 19,262,802 (CVCA) 2,528,802 (OVCC) 3,289,474 (HRP) 4,780,408 (STBP) 6,427,180 (TDR)

⁵⁴ Specified voluntary contributions (VCS) are earmarked for specific purposes determined by the contributing donor.

⁵⁵ Core voluntary contributions (VCC) from members states are not earmarked and constitute about 2% of the WHO's budget. (177)(p.20)

⁵⁶ TDR (Special Program for Research and Training in Tropical Diseases) was established at 1975. It is based at the WHO and is a global programme of scientific collaboration that helps coordinate, support and influence global efforts to combat a portfolio of major diseases of the poor and disadvantaged. (267)

⁵⁷ HRP (Special Program of Research, Development and Training in Human Reproduction) is the main instrument within the United Nations system for research in human reproduction. It brings together policy-makers, scientists, health care providers, clinicians, consumers and community representatives to identify and address priorities for research to improve sexual and reproductive health. It was established 40 years ago. (268)

⁵⁸ Established in 1990, WSSCC (Water Supply and Sanitation Collaborative Council) is committed to contributing substantially to global efforts to improve sanitation and hygiene for vulnerable sections of society, with a special focus on communities in Africa and Asia. (269)

⁵⁹ From the resources reviewed, it is not clear if 'Other core voluntary commitments' (OVCC) are earmarked or not earmarked.

⁶⁰ The Stop TB Partnership (STBP) was established in 2001 and operates through a secretariat at the WHO in Geneva. Its mission is to serve every person who is vulnerable to TB and ensure that high-quality treatment is available to all who need it. About 1000 partners that include international and technical organizations, government programmes, research and funding agencies, foundations, NGOs, civil society and community groups and the private sector are part of the partnership. (270)

⁶¹ Roll Back Malaria (RBMP) was launched in 1998 and operates out of a WHO secretariat in Geneva. RBM is the global framework to implement coordinated action against malaria. The Partnership is comprised of more than 500 partners, including malaria endemic countries, their bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, and research and academic institutions. (271)

As WHO's 2010 Financial Report concluded, the organization has a complicated financial situation. (261) Approval of the budget does not automatically lead to full financing and earmarking may provide reassurance to donors but constrains the WHO's ability to allocate funding towards its priorities. (261) It has been argued that the WHO's role in global health diplomacy and governance is becoming increasingly weaker because of these financial difficulties with claims that the WHO is 'outmoded, underfunded and overly politicized.' (272)(p. 1) Moreover, because its performance has come into question, some members fear that there could be a high risk that it will not be in a position to attract increasing amounts of unearmarked financing going forward. (262) An informal WHO consultation pertaining to WHO financing that took place in 2010 concluded that:

'increasing donor support for more flexible funding will only result from greater clarity of purpose, tighter priorities, greater efficiency, excellence in delivery, and the capacity to communicate effectively to a wide audience about how and where results are being achieved.' (262)(p. 19)

As for possible sources of funding, the Delhi Statement coordinated by Medico International in May 2011, an international NGO active for many years in promoting health as a human right, cautioned against the WHO turning to the private and commercial sector for financing citing the risk of conflict of interests. (273) It argued for member states to increase their financial contributions instead and to enhance their impact on the organization. (273)

Questions about its financing also highlighted issues related to WHO governance and the organization's leadership role in an 'increasingly globalizing world.'(255)(p. 2) When WHO was first created there were few major international players with political and/or

financial power to influence global health agendas. This is no longer the case as numerous global health actors have appeared on the global landscape over the last decade or so, including the Bill and Melinda Gates Foundation, pharmaceutical companies, GAVI and Médecins Sans Frontières. Global health may have benefited greatly from the work of these actors, but this pluralism is also creating a leadership gap for an overarching convening and coordinating role that some argue the WHO should fill. (255)

Acknowledging the need for reform, in 2010 the WHO's executive considered its future and after a consultation with members states decided that significant reforms were needed. (274-276) The reforms will focus on 'refocusing core business to address the twenty-first century health challenges facing countries in the world, reforming the financing and management of WHO to address health challenges more effectively and transforming governance to strengthen public health.' (276)(pp. 1-2). Priority areas include: 'health systems and institutions; health and development; health security; evidence on health trends and determinants; and convening for better health.' (276)(p.2-3) Plans to further develop reform priorities and processes are underway. Program and priority setting will be through a 'member-state driven' process beginning in February 2012. Member states will be invited to submit comments on proposed governance reforms and managerial reforms. (277;278)

WHO reforms and the UK, Norway, Brazil and Switzerland

As two of the member states that contribute the highest levels of voluntary contributions to the WHO, both the UK and Norway have recently set out strategies for working with the WHO to strengthen the organization and to achieve mutual objectives for engagement

in areas such the MDGs and strengthening health systems in developing countries. In these strategies they commit to active participation in WHO reform and to continuing to provide the WHO with financial support. (177;245) Both countries support a broad, leadership and coordinating role for the WHO. The *Swiss Health Foreign Policy* also makes frequent references to the importance of the WHO in global health and commits to strengthening its normative role. (36) Brazil's commitment to the WHO is reflected in its active role in WHO processes and initiatives including the WHO Commission on Social Determinants of Health and the Framework Convention on Tobacco Control.

While a strong supporter of the WHO, Brazil has recently criticized the organization for being unduly influenced by donors with commercial interests. At the World Health Assembly (WHA) in May 2010, the Brazilian ambassador claimed that some member states were using public health to disguise trade and commercial interests through the work of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT). (279) Opponents of this taskforce say it has led the WHO to confuse substandard, falsified or otherwise unsafe drugs with 'counterfeit medicines.' (279) IMPACT supporters, primarily developed countries with large brand name producers, argued that the group's aim is to address public health issues and not patents and should remain involved in WHO. (279) At the 2010 WHA, Brazil, along with India asserted that the WHO's work against counterfeit and substandard medicines was 'being influenced by brand-name producers with an interest in undermining legitimate generic competition.' (279)(p.1) Intellectual Property Watch (IPW) reported that the Brazilian ambassador said there was a hidden agenda against generics from countries like Brazil. It further reported

that the ambassador had received a round of applause when she asked at the WHA if WHO was a police organization or should be concentrating on quality, safety and efficacy. (279) Brazil's concerns about the WHO's capacity to protect the interests of *all* member states as a global health governing body are noteworthy, particularly since Brazil has not to date been in position to contribute substantially to the organization over and above its annual assessed contributions. Its criticism appears to support claims that WHO is potentially being unduly influenced by the highest paying donors and supports the need for the WHO reforms that will soon be underway. Despite Brazil's weaker financial clout in terms of the voluntary contributions it has been able to contribute to WHO, it appears to have significant influence within the organization and with other member states.

As another way to further elucidate the four countries' perspectives on the role the WHO as an effective leader in global health diplomacy and governance, reports that each country submitted as part of the WHO's consultation process about the future of its financing were reviewed. High level conclusions from those reports are summarized in Table 9. Overall, the four countries strongly support WHO's role as a convener, leader and facilitator of global health diplomacy - an institutional actor with an important role to play that should be strengthened further. The process of WHO reform will be complex and will require significant negotiation in regards to some potentially contentious issues, including how to decrease WHO's reliance on earmarked funding. The four countries, however, appear to be highly committed to actively engaging in this process, which reinforces the conclusion that they view WHO as a relevant and essential actor in helping them achieve their national global health strategies.

Table 9: Summary of Comments from Brazil, Norway, Switzerland and the UK – the future of financing for the WHO, 2010

Brazil (280) • WHO's role is primarily to coordinate global governance of health and to facilitate an exchange among countries while remaining a neutral intermediary that establishes international norms • WHO should assist countries with their policies, strategies and strategic plans to improve health and its determinants • In times of crisis, support from WHO should be adapted to the needs of each country, while preserving neutrality and meeting its responsibility for humanitarian action • WHO needs to participate more actively in unifying global governance for health • Donors should speak with a single voice in order to mobilize resources • WHO should establish clearer objective, set stricter priorities and achieve greater efficiency and excellence in providing services and communicate better about how results are being achieved
Norway (281) • There is no dispute that WHO has a normative role on behalf of the global community • Health security and response to international health threats is a function that only the WHO can undertake • WHO should fill the need for coherent and coordinated global health governance • Strong performance and results measurement is required • WHO's high dependency on voluntary contributions puts it in an extremely vulnerable situation • WHO should explore increasing assessed contributions • Increased confidence in WHO's ability to deliver results is needed based on a strong results-based and performance-based frameworks and reporting
Switzerland (282) • 'Switzerland is firmly committed to strengthening WHO.' • WHO should focus on its normative function in the broadest sense as well as on its coordination and advisory functions rather than on operational implementation • WHO should reduce the types and magnitude of the activities that it undertakes • WHO needs a coherent funding approach • WHO should be supported to fulfill its constitutional mandate as the directing and coordinating authority of global health using a ground-up approach • Switzerland's policy toward the WHO gives priority to the prompt payment of assessed contributions and non earmarking of voluntary financing • Truly innovative sources of financing should be encouraged including private donations and legacies as long as clear mechanism are in place to avoid undue external influences
United Kingdom (UK) (283) • There is strong consensus around some of the WHO's core work (global norms and standards, surveillance, response to epidemics, the research agenda) but divergence about development, partnership, technical assistance and country level work • WHO's greatest comparative advantage is to continue to ensure that scientific evidence is the foundation of WHO • WHO has a clear role and responsibility to address the impact that other sectors have on health • WHO should continue to drive forward the recommendations from the Commission for Social Determinants of Health • WHO should continue to play its part in humanitarian coordination in partnership with NGOs and the wider UN family • In terms of financing, increased flexibility and predictability will best come from even clearer demonstration of outputs and outcomes

6.4 Self-interest Dominates

Findings in the UK case lead to the conclusion that *Health is Global* was developed primarily to benefit the UK. Such self-interest is reflected in the strategy's focus on global health security in the wake of SARS, the priority the strategy places on capitalizing on global health as a business opportunity and the revelation that the strategy was likely developed in part to improve the UK's global reputation that had been tarnished as a result of its involvement in Iraq. These observations point to the overriding conclusion that is consistent with Fidler's remediation conceptualization that the strategy is using global health to further other traditional foreign policy goals. They are also consistent with findings from the literature review. This conclusion supports the tentative hypothesis posed at the outset of this study that health does not hold a special place in foreign policy but rather is used to further other foreign policy objectives. Such traditional motivations also underpinned the *Swiss Health Foreign Policy* and Norway's leadership in FPGH, though in all three cases, improving the global health situation through international development and a normative appeal to health as human right were also stated as important objectives. In this set of country cases, Brazil is the outlier committing to health as human right through its legal entrenchment in the country's constitution as the primary reason for improving global health. As Brazil becomes more prosperous and powerful, however, self-interest may become more of a motivating factor.

While "First it's UK" was the driving motivation behind *Health is Global*, not all informants agreed with this rationale indicating that it was a threat to health equity and undermined development efforts which should be directed at those with the greatest need

rather than on nations considered to be security threats, for example. Using development aid to further the UK's security agenda is one of the policies that Britain's new Prime Minister, David Cameron, is supporting. In his first Lord Mayor speech in November 2010, Prime Minister Cameron, like Gordon Brown before him, focused on hard-headed internationalism albeit with an even stronger 'hard-headed' intent.

'Our foreign policy is one of hard-headed internationalism. More commercial in enabling Britain to earn its way in the world, more strategic in its focus on meeting the new and emerging threats to our national security.... Above all, our foreign policy is more hard-headed in this respect. It will focus like a laser on defending and advancing Britain's national interest.' (284)

This statement reinforces the conclusion that it is the primacy of self-interest that will drive foreign policy under the Cameron government, potentially even more so than it had under Brown. In October 2010, Cameron unveiled the new UK security strategy allocating a larger proportion of DFID's budget to addressing issues of conflict. (285) Strengthening governance and security in fragile and conflict-affected countries, in particular Afghanistan and Pakistan is among DFID's five priorities. (286) Critiques described this as 'development as counter-terrorism' arguing that aid should be disbursed on a needs basis and not 'according to Whitehall's security agenda.' (287)

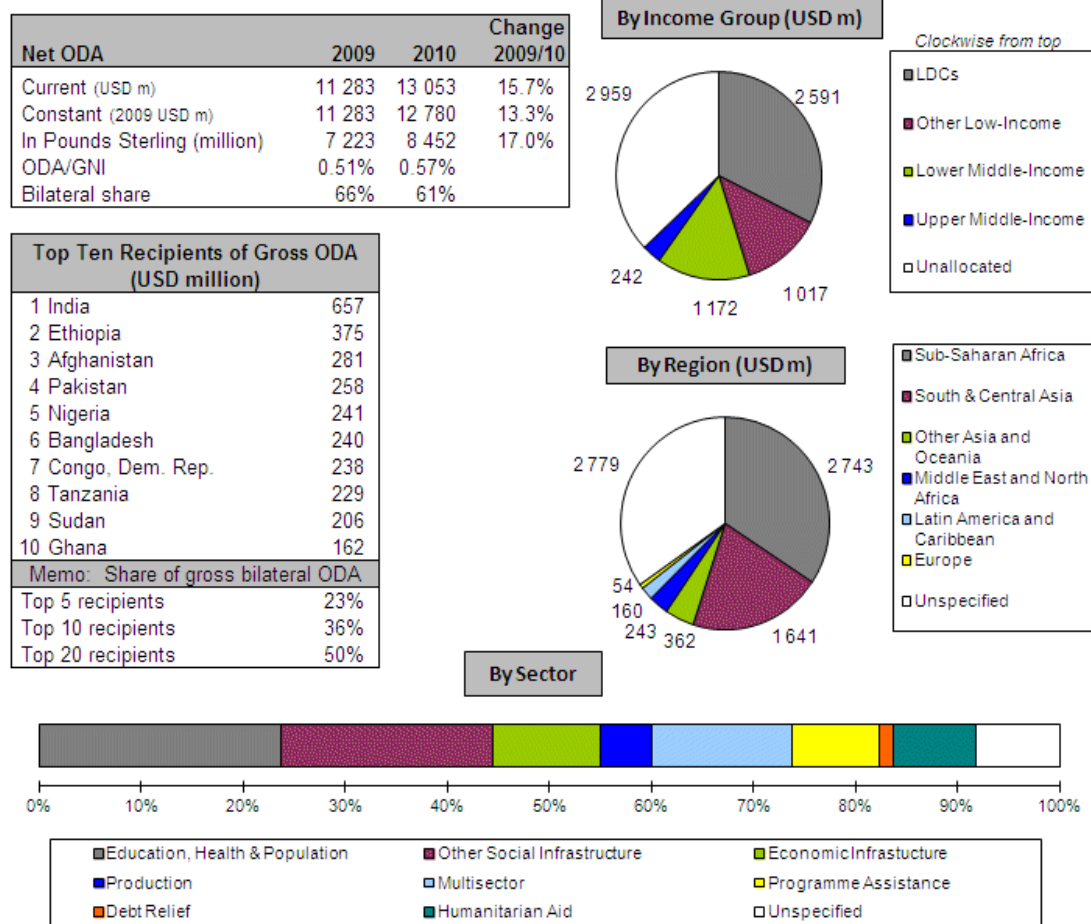
Investing in development based on self-interest also appears to be part of the messaging in DFID's 2011-2015 business plan which refers to development as 'tremendous value for money and good for our economy, our safety, our health and our future.' (286)(p.2) In keeping with the government's new structural reform agenda, the plan also strongly focuses on demonstrating value for money with an emphasis on results, transparency and accountability. Labonté and Gagnon write that the argument for performance or results

based aid as a way to retain taxpayer support could possibly jeopardize global health equity. (73) While this approach to aid can potentially allow a better assessment of aid effectiveness, carried to an extreme it could end up favouring projects with short-term deliverables at the expense of long-term infrastructure or countries with a greater existing capacity to show returns at the expense of more vulnerable states. (73) Having said this, and while DFID's business plan contains certain 'hard-headed' elements, it also includes those that reflect the UK's commitment to benefiting others by investing in aid. The plan reiterates the UK's commitment to spending 0.7% of gross national income on aid by 2013, which OECD reports it is well on the way to achieving, (164) and includes priorities such as leading international action to improve the lives of girls and women, combating climate change, responding to humanitarian disasters and improving the global development system. (286) Figure 7 provides a profile of the UK's investment in aid for 2009 and 2010. The profile shows that a significant amount of UK aid is going to fragile states and that overall almost 50% of the UK's total aid is spent on education and health. Moreover, Figure 8 shows that investments in these areas have been increasing since 2006/2007.

Figure 7: United Kingdom Aid Statistics 2009, 2010 (165)

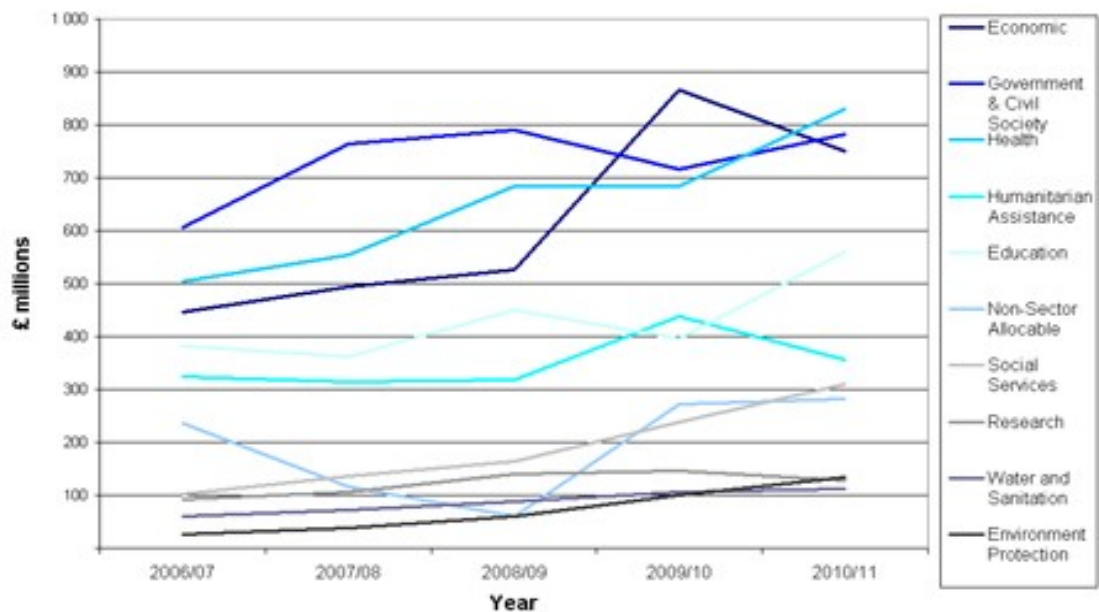
UNITED KINGDOM

Gross Bilateral ODA, 2009-10 average, unless otherwise shown



Source: OECD - DAC ; www.oecd.org/dac/stats

Figure 8: DFID bilateral programme by sector, 2006/07-2010/11 (288)



The UK's investment in development provides a mixed picture of the country's commitment to aid to benefit others juxtaposed with its increasing commitment to aid based on self-interest.

It has been argued that allocating aid based on self-interest may exacerbate global health inequity rather than reduce it. (73) Therefore, while self-interest manifested through the global health security framing may attract the attention of foreign policymakers, such positioning is potentially fraught with risk for global health and can lead to global health 'regression' rather than 'revolution.' Adding to this risk is the lack of a clear and universal definition for this phenomenon. As Aldis argues, policymakers in industrialized countries emphasize protection of their populations against external threats when talking

about global health security, while policymakers in developing countries and the UN system understand the term in a broader public health or human security context. (181) This definitional problem may help explain why the term is used somewhat confusingly as a catch all phrase in the *Oslo Ministerial Declaration*. As a policy position developed by Ministers from both developed and developing nations it raises the question as to whether there was a common understanding of this concept as presented in the *Declaration*. It is also difficult to assess the impact of such high profile framing on other global health policy processes, but as Kingdon's model highlights, issue framing is an important part of the policy process that can lead to a significant bandwagon effect. (56)

6.5 Policy Process is Global Health Diplomacy

In the conceptual framework for this study, global health diplomacy is defined as 'policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives.' (25)(p. 10)(88) The examination of the *Health is Global* policy process provides evidence to support this definition. It also leads to a few specific conclusions about the nature of the global health diplomacy at the state level when actors aim to develop whole-of-government strategies. As a starting point, the in-depth analysis of the UK process and the briefer look at the Swiss process allows a number of more specific defining characteristics of the process to be formulated:

- While non-state actors provide important inputs into the process, the final negotiation of the content of the strategy takes place among state actors, in particular those representing health, foreign affairs and development government departments which, assuming that there is political will behind the policy direction, are compelled to arrive at a strategy within a given timeframe that is acceptable to all relevant government actors. As the UK case revealed and the Kingdon model helps to explain, the process leading up to the state negotiation stage can be lengthy, potentially lasting many years. It is during this time that non-state actors can act in policy communities as policy advocates softening up and framing the policy space. Connections with policymakers and other policy entrepreneurs provide opportunities to influence policy direction further as does the development of evidence to support varying policy alternatives. As the UK case showed, non-state actors can play an important challenging function, particularly during the strategy framing process, by drawing attention to global health equity issues.
- State actors negotiate the finer details of the strategy but as the UK case showed an inclusive process that includes a diverse array of actors who will work with government to eventually implement the strategy appears to be an effective approach. As was discussed in the background cases, the desired outcome helps to determine what process to put in place. If the intent is to develop a comprehensive global health strategy that will require multi-sectoral actors to help implement, then based on research that looks at the effectiveness of the implementation of health interventions, such actors should be involved as partners in the process from the outset. (289;290)
- Leadership in the policy process by an authoritative, credible policy entrepreneur was a critical success factor in each country case study. These leaders had specific attributes, the most important of which is that they have knowledge, experience

and training in both health/medicine and international relations enabling them to understand, be credible and connect within both contexts.

- Based on data from the UK interviews, it can be concluded that the whole-of-government process is difficult, complex, fraught with differing policy perspectives and positions and time consuming. Skillful negotiation and consensus building is required to arrive at an acceptable strategy for all involved. In the Swiss case such negotiation was led by foreign affairs that acted as a broker between health and development. In the UK case, the lead policy entrepreneur from health was the “real hero” effectively negotiating to reach consensus. The UK case showed that significant compromise could be required to reach an agreement and ‘sign-off’ on a strategy. For example, interviewees indicated that they needed to collectively adopt a narrower definition of health as security to come to an agreement. “We are united when it comes to security in the UK,” said one. While the process is difficult, interviewee comments indicated that it was nonetheless an important way of building common understanding across government and broke down silos to working together. This was perceived to be a positive consequence of the policy development process.

6.6 What Difference Has it Made?

6.6.1 Introduction

Informants provided mixed perspectives on the outcomes of the strategy at the time when the interviews were conducted. In general, the conclusion can be made that they thought developing and launching of the strategy was in itself a significant accomplishment. An examination of a number of initiatives and activities underway since *Health is Global* was launched provides the basis upon which additional conclusions can be drawn about the impact of the strategy so far.

6.6.2 Annual independent review of the UK government's global health strategy

The first annual independent review of the strategy conducted in 2010 assessed the coherence and consistency of the UK government working in the BRICS countries (Brazil, Russia, India, China and South Africa) against the strategy reflecting the importance of these countries to the UK. Overall the review concluded that there was a fairly good level of awareness of the strategy among UK staff working with and in the BRICS countries and some good examples of successful joint working across government departments. However, there were several areas where UK government departments could better coordinate and plan their approaches. Much of the activity was seen to be ad hoc and opportunistic. Moreover, the spirit of the strategy was not well embedded in the main government departments that have the highest level of funding and responsibility for working overseas (DFID and FCO). The review showed that the strategy was too ambitious for a coherent implementation in the BRICS given available resources. There was an overall impression that better cross government coherence and leadership on global health was needed. (248) These conclusions support the sentiment expressed by an informant in the Swiss case, that the whole-of-government process of working together even after a strategy is developed is “long-term work.” Table 10 summarizes the main recommendations made in the first annual review.

Table 10: Summary of Conclusions and Recommendations of the first Annual Independent Review of the UK Government's Global Health Strategy, June 2010 (248)

Overall Conclusions	
• At the 18 month mark, there is a fairly good level of awareness of the strategy; most who are aware are very positive about the strategy as a way to improve coherence across government • Action in the BRICS countries appears to be ad hoc, opportunist and lacks a strategic framework • There is some evidence that UK work on health is not entirely consistent and coherent due to lack of strategic planning, leadership and lack of staff and resources • But, there are examples of how departments have been working well together, a degree of shared language and some high level commitment to global health thinking • Improvements can be made in planning, leadership and allocation of staff and resources	
Area for improvement	Recommendations
Priorities and strategies	• DH should lead a process with other departments to prioritize which BRICS and other middle income countries to focus work in a way that will have the highest impact for <i>Health is Global</i> • Develop plans or strategies for global health work in BRICS priority countries
Leadership	• DH should develop its role as functional lead and natural custodian of <i>Health is Global</i> in the UK work in BRICS. This will need a more active role for ministers and directors. • The FCO should support DH in convening and coordinating at ministerial level on a regular basis • The FCO or DFID should provide leadership in the priority countries
Communications and coordination	• The UK global health steering committee needs to meet more regularly and become more institutionalized within government • The lead in each priority country should set up a coordination mechanism that can link all UK work on global health and that can also act as an informal network between and within government and non-government organizations • DH should develop some simple messages from <i>Health is Global</i> for communication throughout government • DH should investigate parliamentary awareness of the strategy • Consider using the health impact analysis methodology in priority countries for health impact analysis of policy choices in those countries
Systems and resources	• DH London based staff should be better enabled to monitor and coordinate global health work in priority countries to ensure a consistent and coordinate approach • A cross government fund for implementing the global health strategy in priority countries should be considered • In the priority countries, a position in the FCO or DFID (DH funded and shared) should be made available for coordinating global health work. Staff working on the <i>Health is Global</i> internationally should have the right skills and experience.

6.6.3 Global Health Team partnerships and communication

Despite negative perspectives that some UK interviewees expressed about the implementation process and outcomes achieved at the time of the interviews, it appears that the strategy (or a slightly modified version of the original) is being implemented, monitored and resourced. At least two partner events focused on the strategy have taken place at Chatham House since it was launched and the Global Health Team in the Department of Health International Branch in collaboration with the other founding departments has established a regular newsletter (four issues released to date) that is distributed to all partners.

Partner events

Since *Health is Global* was launched two partner events have been held, one on March 25, 2010 and the second on March 31, 2011. A copy of the summary of the first partners' forum was obtained from the Global Health Team in summer 2011 but it was not possible to access a copy of the full summary of the second forum. This section describes the first forum derived from the full summary and the second forum based on a brief report about it published in the Global Health Team April 2011 newsletter.

Summary of the First Partners' Forum (243)

The purpose of the first partners' forum was to assess progress on delivery of the strategy, explore new challenges and identify new opportunities for collaboration. The event took place about 18 months after *Health is Global* was launched and on the eve of the 2010 UK election. The invitation list included individuals from government, non-governmental organizations, academia and industry. (291) A list of who actually attended is not included in the meeting summary but the agenda included participants from DH,

DFID, the Health Protection Agency, University College London, Embassy of Brazil, Ministry of Defense, Global Health Europe, UK Mission to the UN Geneva, London School of Hygiene and Tropical Medicine, UK Collaborative for Development Sciences and the Association of the British Pharmaceutical Industry.

The meeting began with an opening address from Nick Banatvala, Head of Global Affairs, DH and then four panel sessions were presented according to the main themes in *Health is Global*: 1) Ways of working with Brazil, Russia, India, China and South Africa (BRICS); 2) UK health systems contribution to global health; 3) Health security and foreign policy; and 4) Research and development for global health. In his address, Dr. Banatvala made the following key points:

- Improving global health requires collaboration and partnerships. It is ‘not something this government or another could do on its own.’(243)(p. 6)
- When the strategy was launched there was no global financial crisis. In the changing environment there is a need ‘to take a hard look at future priorities.’ (243)(p.7) (DFID’s 2009 health portfolio review was provided as an example of a ‘real attempt’ to describe the impact of DFID’s activities in the health sector and demonstrate ‘value for money.’⁶²) The financial crisis also highlights the importance of ensuring that governments and partners ‘do all they can’ to promote UK industry as an increasingly stronger and influential partner in the health sector. (243)(p.6)

⁶² DFID undertook a review of all of its spending at country and global levels in health related programmes in 2009. The report indicated that findings were being used to support DFID’s focus on achieving and demonstrating the results of UK development assistance for health. The purpose of the review was to assess the results of DFID’s spending in health and how it could better allocate resources to further improve ‘value for money’ in the future. (292) It reported that DFID provides about £1 billion a year to improve health in developing countries, about 15% of the UK’s total development assistance. ‘Making the most of the money’ is a priority of the UK government. (292)(p. 4) DFID channels its fund through bilateral programmes, the multilateral system, (the European Commission, UN system and global health initiatives) and to health research. In 2008/2009, £720million was spent bilaterally on health, £240million multilaterally and £50 million on research. (292)(p. 4)

- *Health is Global* committed to improving cross-government coherence and consistency. Examples include the publication of the first ever cross-government strategy for working with the WHO.
- Government departments are responding individually to the challenges set out in *Health is Global* as well. DFID published a nutrition strategy and committed to £1billion for water and sanitation in Africa.
- Partners are also contributing to implementing the strategy, including through the new Centre for Global Health Security at Chatham House and the research funded through the UK Collaborative for Development Sciences.

In the meeting summary, the following conclusions from the panel sessions were drawn:

Working with Brazil, Russia, India, China and South Africa

- These countries are important global players and will become increasingly so in the future.
- China was the main focus of discussion. ‘Ambitions are high and delivery in China is likely to surpass expectations.’ (243)(p.2)
- Health inequalities and non-communicable diseases are major health issues in emerging economies. Tobacco control is a particular challenge.
- The *Health is Global* principles are good guidelines for engaging in partnerships in these countries.

The UK Health Systems Contribution to Strengthening Health Systems in Other Countries

- A new *Framework for NHS (National Health Service) Involvement in International Development* was launched on the same day as the partners’ forum. This framework is one way that the UK is delivering on the recommendations outlined in Nigel Crisp’s 2007 report on global health partnerships and the contribution that the UK can make to health in developing countries. (216) It also coheres with *Health is Global*, which highlighted NHS as a key partner in improving health globally and the opportunities for the NHS to learn from what is going on in other countries. (293)

Health security and foreign policy

- The discussion highlighted the importance of the security and foreign policy lens in global health. Issues such as climate change, conflict and economic instability were mentioned. The aim is to reduce health risks.
- Developing and implementing relevant policies is complex and requires a range of diplomatic skills. Working with civil society is an important part of the process.
- *Health is Global* seems to have provided a useful framework. Management and good processes are required to support effective delivery.
- Issues mentioned included how to collaborate better with multilateral institutions.

Research and Development for Global Health

- There are significant opportunities for multidisciplinary research in global health that now spans the breadth of global health issues, from reconstruction in fragile states to climate change.
- Building capacity for research and partnership to ensure that research is relevant is challenging. Translation of evidence into practice and policy is particularly challenging.
- Investments in health information systems, information technology and open access to research can support capacity building.

Summary of the Second Partner's Forum, March 2011

Anne Milton, Parliamentary Under Secretary of State for Public Health and Stephen O'Brien, Parliamentary Under Secretary of State for International Development launched a revised version of *Health is Global - Health is Global: An outcomes framework for global health 2011-2012* (described in Section 6.6.4) at the second partners forum held on March 31, 2011. The forum included partners from over 60 organizations, including multilateral organizations, professional associations, academia, NGOs, private sector and think tanks along with representatives from six government departments. Meeting

presentations focused on the future of UK aid, health adaptation to climate change and UK global health research. (294)

Global Health International Branch newsletters

In general, information in these newsletters is categorized into two areas: updates on *Health is Global* and international engagement both multilateral and bilateral. The first newsletter released in October 2010 (242) mentions that *Health is Global* will be updated in light of the first review of the strategy conducted in 2010 and the priorities of the Coalition government that came into power in 2010. These priorities, while not described in the newsletter, are outlined in detail in the *Programme for Government* released soon after the government was formed in 2010. (295) The *Programme* describes the government's priorities in thirty-one areas, including foreign affairs, international development and national security. Table 11 summarizes the priorities for FCO. Many of these priorities cohere with those outlined in *Health is Global* leading to the conclusion that even though it was a strategy of the previous government, *Health is Global* in whole or in part will likely continue to be a whole-of-government framework for global health under the new government.

One of the new developments under the Coalition government is the implementation of structural reform plans. Each government department is required to publish a plan that sets out clear priorities and measurable deliverables and to regularly report on progress. For example, FCO publishes a report each month that is available on its website. (295) These plans are part of the Coalition government's effort to put 'power in the hands of the people' by 'replacing the old top-down systems of targets and central

micromanagement’ (295)(p.4) with plans that hold government departments to account in a publicly transparent way.

Table 11: FCO Coalition Priorities (295)(pp. 2-3)

<u>Coalition priorities:</u> <i>Structural Reform Priorities</i> 1.Protect and promote the UK’s national interest Shape a distinctive British foreign policy geared to the national interest, retain and build up Britain’s international influence in specific areas, and build stronger bilateral relations across the board with key selected countries to enhance our security and prosperity 2.Contribute to the success of Britain’s effort in Afghanistan Support military Forces abroad, protect British national security from threats, create the conditions to shift to non-military strategy in Afghanistan and withdrawal of UK combat troops by 2015, and support the stability of Pakistan 3.Reform the machinery of government in foreign policy Establish a National Security Council as the centre of decision-making on all international and national security issues, and help to implement the foreign policy elements of the National Security Strategy and the Strategic Defense and Security Review 4.Pursue an active and activist British policy in Europe Advance the British national interest through an effective EU policy in priority areas, engaging constructively while protecting our national sovereignty 5.Use ‘soft power’ to promote British values, advance development and prevent conflict Use ‘soft power’ as a tool of UK foreign policy; expand the UK Government’s contribution to conflict prevention; promote British values, including human rights; and contribute to the welfare of developing countries <i>Other major responsibilities</i> Reduce the risk to the UK overseas Ensure appropriate structures are in place to deal with terrorist incidents overseas, enhance the detection and disruption of terrorists and terrorist networks, and reduce the risk to the UK and UK interests by countering violent extremist ideology and undermining the terrorist narrative Support British nationals around the world Deliver a smaller and better Consular Service by managing resources more effectively and putting the needs of British nationals overseas at the heart of consular service provision Control migration to secure the UK's borders and to promote the UK's prosperity Work with the UK Border Agency and Whitehall partners to support the development and delivery of a migration policy that protects our security and attracts the brightest and best Support conflict resolution in fragile states Work with the Department for International Development and the Ministry of Defense to support conflict resolution and improve governance in fragile states Lead effective international action on climate change Achieve acceleration towards the low carbon economy in the EU and build momentum towards agreement in the post-Copenhagen climate negotiations

Three newsletters were released after the first, in February (244), April (294) and June 2011. (296) Each issue presented brief synopses of the UK's engagement with multilateral and bilateral partners, in particular the WHO and with the BRICS countries. Emerging partnerships with countries in the Gulf, in particular, Saudi Arabia, were also mentioned. Reported UK engagement with multilateral partners focused on issues such as tobacco control, health security, climate change and pandemic preparedness. Consistent with themes in *Health is Global* two general reasons for bilateral engagement were provided - to support UK prosperity and to share knowledge and expertise with these countries to help them enhance their healthcare systems. For example, the April issue reported that the Minister of Health of Saudi Arabia and the UK Minister of State for Health signed an MOU on health cooperation. Significant commercial opportunities for the UK in Saudi Arabia were reported as one reason for the MOU.

Conclusions

A number of observations and conclusions can be drawn from this brief examination of the UK's implementation processes that focus on partners and communication.

First, the UK appears to be following through on its commitment to continue to engage with partners post launch of *Health is Global*, reflecting the inclusive process used in its development. The UK's commitment to multi-stakeholder engagement and 'working with others' throughout the policy process is an important lesson in global health diplomacy. While time consuming and potentially resource intensive, such engagement is necessary given the multiple actors that are active in advancing global health. Governments cannot

establish nor achieve their global health strategies alone. As global health transcends boundaries so must the approach to understanding and addressing it.

Second, the establishment of resources and accountability for *Health is Global* implementation through the Global Health Team is a sign that the UK is committed to the successful implementation of the strategy. The partner events and regular newsletters may prove to be effective ways to keep the implementation momentum moving ahead in close collaboration with partners, although no attempt (to my knowledge) has been made to gather partners' perspectives on the usefulness of these processes.

Third, the partner events and newsletters provide insight into the proactive approach to policy adaptation that is arguably required when the initial context within which a policy was developed shifts significantly. At the first partner forum, the shifting context (i.e. changes in the world's economic climate and the anticipated change in the UK government) was a main preoccupation. Anticipated adjustments to *Health is Global* included ensuring that its impact could be measured to show 'value for money' based on outcome indicators. The newsletters alluded to the processes with partners that were underway following the first partners event to make potential adjustments to *Health is Global* to ensure its intent survived in the new context. This included developing a slightly modified and streamlined version of the strategy focused on outcomes, impact and measuring and reporting on results in the context of the new government's structural reform plans.

Fourth, the substantive content discussed at the partners events and in the newsletters is consistent with the priorities set out in *Health is Global*. Prominent themes include the focus on health security, the commitment to supporting the advancement of the MDGs, the UK's commercial interests related to investing global health and the importance of bilateral engagement with the BRICS countries. The reporting reflects the expeditious progress made in advancing these relationships, particularly with China. It can be argued that despite the UK's commitment to its international development targets, the theme of 'health as development' while part of the partner events and newsletter content, is not as prominent as the themes of 'health as security' and 'health as a business opportunity.'

6.6.4 *Health is Global: An Outcomes Framework for Global Health 2011-2015*

This Global Health Team led the development of *Health is Global: An outcomes framework for global health 2011-2015* launched in March 2011. The framework is a more streamlined, condensed and revised version of the original action plan for the strategy. An examination of the outcomes framework follows using the policy analysis circle as a heuristic device.

Context

There were two main reasons why the outcomes framework was developed. First, the government changed in May 2011 and 'radical reprioritization and refocusing of all government activities,' (297)(p.3) became a top priority, and, second, the results of the first annual review of *Health is Global* undertaken in 2010 made substantial recommendations about the implementation of the strategy (see Table 10). The first point that the outcomes framework makes is that the new government believes that UK's international engagement must be focused and strategic while assuring security and

prosperity at home and the UK's interests overseas. 'Emerging powers' such as Brazil, India and China are identified as the target of such focused engagement consistent with FCO priorities. The deepening global economic crisis is described as an important contextual factor that is shifting power and opportunity to these countries.

The outcomes framework reiterates the UK's commitment to *Health is Global* as a cross-government mechanism to help the UK protect the health of its population, harness the benefits of globalization and 'make the most of its contribution to health and development across the world.' (297)(p. 2) It acknowledges that global health interacts with all the core functions of foreign policy: national and global security, wealth creation, international development and promoting human dignity through the protection of human rights and the delivery of humanitarian assistance. (297) Particular global health challenges and opportunities it refers to cohere with those in *Health is Global* – pandemic preparedness and emerging infectious diseases, climate change and a worldwide healthcare industry. (297)

Content

To respond to the annual review recommendations and the government's directive to be more strategic and focused, the outcomes framework reaffirms the principles outlined in *Health is Global* (see Table 7) and focuses on three action areas: global health security, international development and trade for better health. It explicitly aims to support the government's foreign policy priorities and international aid commitments and includes references to both policies.

The outcomes framework explains that the five areas of work in *Health is Global* (see Table 6) were useful as broad groupings for a very broad range of commitments, but to focus more on achieving outcomes and not on ‘process-driven we-wills’ (297)(p. 7) the new framework prioritizes three main areas of action and twelve high-level outcomes to be achieved by 2015. This is a significant streamlining of the original strategy that included 31 outcome indicators and 41 process indicators. (297)(p. 13) Like in the original strategy, the aim is for research to be integrated across all action areas as a way to enhance evidence-informed policy. In each area engagement in global health is meant also to contribute to safeguarding the UK’s security and prosperity. (297) Table 12 provides a summary of the three action areas and twelve outcomes. Of note, the outcomes framework focuses on the action areas and does not propose any revision to the ultimate goal of the original *Health is Global* strategy, that is ‘economic prosperity, security and stability for the UK and the rest of the world.’ (1) The new framework aims to frame a more strategic approach to helping to achieve this goal. The action area that was dropped from the original strategy, ‘more effective international health organizations’ and the specific ways in which this was going to be achieved, appear to be integrated in this new framework within the ‘working in partnership’ theme that underpins the framework’s implementation process. Overall, the priorities in the framework are consistent with those in *Health is Global* and reflect the “First it’s UK” intent of the original strategy along with the goal to “benefit others” through a more strategic approach.

Table 12: *Health is Global: an outcomes framework for global health 2011-2015 – A summary of areas for action and outcomes (297)*

Global health security The UK and the rest of the world needs to be better prepared to predict, avoid and respond to these global health threats	International development - The UK is determined to reduce health inequalities - International commitments will be honoured to maximize the impact of the aid budget - The MDGs are the focus - A future challenge will be the increasing burden of non-communicable diseases	Trade for better health - Trade and development are closely interlinked - The goal is to enhance the UK as a market leader in health
Outcomes by 2015 1. MDGs - Food and water security - A greater proportion of the world's people will enjoy improved food and water security. 2. Climate change - Low and middle-income countries will be supported to assess and address their health vulnerability in relation to climate change. 3. Health and conflict - Reduced humanitarian and health impact of conflict. 4. Emergency preparedness - The UK and the rest of the world will be better able to predict, avoid and respond to emerging global health threats. 5. Research - There will be a deeper scientific understanding of the effects on health of changes in climate and water and food resources.	Outcomes by 2015 6. MDGs - Health systems and delivery - Resources will be used to support health systems strengthening. - The balance of healthcare workers in individual countries (losses and gains) should have a net positive effect on developing countries and economies in transition. 7. Non-communicable diseases - Stronger integrated strategies and actions, and effective support from international agencies, for tackling and preventing some non-communicable diseases as well as violence and injury in low and middle-income countries. 8. Learning from other countries - Improving the UK's population health outcomes to be amongst the best in the world. 9. Research - Better coordination of UK and European Union (EU) global health research. - Enhanced, low-cost access to research knowledge for researchers and policymakers in developing countries, making use of the emerging knowledge on strengthening evidence-policy linkages in developing countries.	Outcomes by 2015 10. MDGs - Access to medicines - Increased access to safe, high-quality and affordable treatments and medicines for the world's poorest through strengthening access to markets and safeguarding transparent provision. 11. Trade and investment - UK life sciences and healthcare sectors make the most of global trade opportunities, particularly in key emerging markets and support the growth of foreign direct investment in the life sciences and healthcare sectors in the UK. 12. Research - Investment and operational partnerships to address critical challenges in scaling up innovation and evidence-based interventions to achieve universal coverage, especially for the poor and in hard to reach areas.
Effective cross-government, multilateral and bilateral engagement		
Strengthened evidence base		

Process and actors

A cross government consultative process like that used for *Health is Global* was implemented along with informal processes to gather input from partners to develop the outcomes framework. ‘Working in partnership’ is described as the way that the framework will be implemented. The partners include those across government, NGOs and industry and with both bilateral (‘emerging powers’) and multilateral partners including UN institutions, in particular the WHO through the UK’s WHO institutional strategy.

Coherent and consistent cross - government collaboration is described as the way that the framework should be implemented given that many global health issues lay outside the tradition health sector. Each relevant government department will play a part in implementation by integrating actions and measurable deliverables into annual departmental delivery plans. Plans already underway in key departments will help define measurable outcomes for the new strategy. (298) Lead and supporting departments for each of the twelve outcome areas are identified in an annex to the framework. (297) In response to the annual review, the framework indicates that a strengthened cross-government steering group will be put in place to provide leadership, support coherency and track progress. The commitment made in *Health is Global* to hold an annual partners’ forum to review progress, set out new challenges and identify opportunities for collaboration is reiterated. The collaborative approach is described as a very important part of the process that should be continued despite pressures on government spending.

Indications of impact

The outcomes framework commits to monitoring progress through departments' annual delivery plans and to reviewing all the processes and mechanisms necessary to achieve the outcomes and incorporate these into 'year on year' delivery plans for each outcome. (297)(p. 13) At the time of writing no publicly available report on progress could be located, although since only one year had passed since the framework was launched this is likely not surprising.

Since it was launched the outcomes framework appears to have attracted some attention. Kickbusch referred to it as an example of a policy document that clearly calls on ministers of health to act with other countries to promote foreign policy that supports health. (100) Several months after it was released, The Lancet published a commentary about it that expressed both optimism that a more streamlined approach focused on outcomes had been developed but also pessimism that its objectives could be realized given the financial crisis and its potential to divert attention away from global health. The paper argued that there are limitations to what cross-government processes and mechanisms can achieve since 'global health does not receive the high-level attention of the Cabinet Office, except in response to pandemics.' (298)(p.e19) Non-state actors are becoming increasingly important in this context because government could become a 'diminishing part of global health activity.' (298)(p.e19) (Of note, the author was affiliated with Chatham House, a non-state actor.) The ability of governments on their own to effectively monitor the impact of such frameworks was also questioned. It concluded that ongoing collaboration with many of the UK's 'world-class global health

institutions' should remain an important part of the implementation, monitoring and evaluation process. (298)(p.e20)

Dr. Banatvala, described as the hero behind *Health is Global*, is no longer in his position with the Department of Health International Branch. In 2010, he assumed the role of Senior Adviser to the Assistant Director General, Non Communicable Diseases and Mental Health at the World Health Organization in Geneva. (299) It is not known if he has been replaced by a similar leader, but given the important role that a leading policy entrepreneur plays in the policy process, identifying an appropriate leader to ensure that the outcomes framework is successfully implemented will be critical.

6.6.5 Conclusion

From this examination of initiatives, processes and activities that have been underway since *Health is Global* was launched, the conclusion can be made that the strategy has made a difference. In terms of process, it appears to have been a mechanism through which stakeholders have been brought together and are collaborating to ensure that the strategy is implemented successfully. It also appears to have framed and guided work in a strategic way, particularly with the repositioning of the original strategy into the more streamlined and strategic outcomes framework. The UK's commitment to measuring and understanding progress made and adjusting directions in an iterative way based on evidence is commendable and a benchmark for others to follow. The transparency of the process through communication mechanisms also facilitates learning from it. The first annual independent review highlighted areas for improvement in actual delivery of the strategy. It is not known if subsequent annual reviews will report on progress made since

this first one and expand assessment and reporting beyond the BRICS countries. In terms of policy coherency, *Health is Global* and the outcomes framework both include references to other government documents that they aim to cohere with. Within the policy documents themselves, reconciling priorities that can potentially conflict is evidently a challenging part of the policymaking process. More evidence and evaluation will be needed as the strategy is implemented to evaluate and understand the impact that these potential conflicts may have on achieving the goals set out in the strategy in the interest of improving global health.

6.7 Conclusion

This discussion and analysis provides significant insight into why and how health is integrated in foreign policy, which has helped to better define and crystallize the global health diplomacy process at the state level. Self-interest is the dominant reason that the UK developed *Health is Global*, a rationale that could become even stronger and deeper in a climate of economic constraint. The role that policy entrepreneur leaders and other actors play in the process is extremely important. The WHO is regarded as a highly important and relevant institutional actor in global health diplomacy but organizational reforms are needed if it is to continue to play this role effectively. The UK and the background case countries appear to be committed to seeing these reforms transpire for the benefit of all. This discussion also highlighted particular characteristics of the global health diplomacy process at the state level that may be helpful for other states, such as Canada, to consider when developing similar whole-of-government global health strategy. Even if the current context in such countries is not ideal for such a strategy to take root because of the world's current economic situation, based on a more in-depth

understanding of the process, it is important for policy communities and entrepreneurs to remain persistent in their efforts to influence and lead policy change. The softening up process can take many years but is an important preparatory phase in creating readiness for policy change when the 'problem, policy and politics' streams align and a policy window opens.

Chapter 7: Conclusions

7.1 Contributions this Thesis Makes

This thesis was principally an exploratory study aimed at advancing understanding of how and why health is integrated into foreign policy to help further elucidate the global health diplomacy phenomenon. Through an in-depth examination of the UK's *Health is Global* and a look at other country leaders in global health diplomacy - Switzerland, Norway and Brazil - it has achieved this objective and made the following contributions:

- Helped to fill identified knowledge gaps through rigorous, primary research focused on understanding the global health diplomacy process from the perspectives of those who have been involved in it
- Provided further empirical support and critical analysis to advance understanding of the key arguments for health in foreign policy, including global health security
- Used a triangulated theoretical approach that incorporated the Multiple Streams Model of the policy process and Fidler's three health in foreign policy conceptualizations to advance theoretical understanding of global health diplomacy
- Expanded on Walt and Gilson's policy triangle approach to policy analysis by adding a new dimension to this heuristic device - impact (i.e. so what?) - and by using this expanded policy analysis circle to categorize and describe a comprehensive set of data from document reviews and interviews, an approach that can guide similar future studies
- As derived from an analysis of the processes that were undertaken to develop *Health is Global* proposed a more precise definition of the global health diplomacy process at the state level that is potentially a useful starting point for other countries that may embark on similar global health policymaking processes
- Contributed to advancing theory about global health diplomacy by elucidating some of the key factors that can lead to a successful global health diplomacy

process including the importance of leadership in the process from a specific type of ‘hybrid’ policy entrepreneur that can cross the worlds of health and foreign policy

- Contributed to the evidence base related to the role of evidence and academia in the state level policymaking processes
- Contributed some initial perspectives on what constitutes success of state level global health policymaking processes and outcomes

7.2 Future Directions for Research

As an exploratory study, this thesis has surfaced a number of areas for further in-depth research. In general, the research design it used could be duplicated to examine other state level global health strategies that have been launched since this work was initially undertaken, such as the new *Global Health Strategy of the U.S. Department of Health and Human Services*. (6) Such research could also help test and refine the proposed state level definition of global health diplomacy in other contexts. Research that compares global health diplomacy processes within the state with those between states and institutions at the international level (e.g. WHO) would also help further refine and understand the key ingredients of the various processes.

More specifically, a number of research topics could be pursued in each of the areas that make up the policy analysis circle – context, content, process, actors and impact.

Questions that drill down into the role, power, authority and influence of the different actors in the process, including policy entrepreneurs, policy communities, epistemic communities and various state and non-state actors, are highly relevant and important. Since global health diplomacy aims to involve a diverse array of state and non-state

actors, the nature of networks that link state and non-state actors, such as ‘flex-nets’ that operate at the interstices of official and private power and are particularly adept at supplanting official processes and information, (300) could be another important area of inquiry. In the UK context it could be argued that key institutions or nodes in these kinds of networks include the Nuffield Trust and Chatham House. Further empirical research into the key arguments that underpin health in foreign policy, how this discourse is potentially shifting in the current world economic environment, and in particular, how and why health diplomats make trade-offs in their advancement of these arguments is another area for further inquiry. Conducting additional case studies of similar processes to build the evidence base about state level global health diplomacy best practices would strengthen the knowledge base in this area. Other research topics could include a more in-depth look at the role of researchers and research evidence in the global health diplomacy process at the state level and knowledge translation practices that help facilitate the use of evidence in global health policymaking.

The findings also reveal the need for an expanded theoretical framework depending on which area is chosen for further research. For example, institutional theory could help further elucidate the significance of the role of the WHO in these strategies and theories from organizational science, leadership and management could be used to elaborate a more in-depth understanding of the role of leadership in the process. Another key knowledge gap is whether these strategies as mechanisms for advancing a plethora of interests in addition to global health or at the expense of health, make any real difference

to global health. What contributions do they make and how can this be assessed, is an important research question.

7.3 Future Directions for Policy and Policymaking

This study provided significant insight to the global health policymaking process at the state level that could inform similar processes that other countries might be considering embarking on. Understanding how whole-of-government global health policy is made using Kingdon's model as a guide is important for those who strive to influence and lead within this process. Leadership from an appropriate policy entrepreneur is fundamental to this process, as is timing and the influence of policy communities.

The Swiss policy highlighted that an official agreement between departments guiding how they will work together to achieve a government's global health objective can significantly enhance policy coherency and coordination. The Norway case highlighted the importance of strategic leadership in raising the profile of health in foreign policy and the Brazil case provided a number of lessons including the importance of using a 'soft power' approach to help achieve diplomatic success. Finally, the UK's approach to developing *Health is Global* is arguably an important benchmark for other countries that aim to pursue a multi-stakeholder policymaking process in keeping with an inclusive approach to global health diplomacy. It also highlighted, along with the other country cases, that it would be advisable for health diplomats to be aware of how global health arguments can be framed in policymaking and what impact such framing can have on the priorities that are set and investment decisions made, including whether these they are

based on global health need or aim to achieve other strategic purposes. Diplomatic negotiation of priorities is complex and time consuming requiring compromise and consensus building. However, the process itself can lead to significant outcomes such as better collaboration and understanding across government about global health.

7.3.1 Lessons for Canada

One of the objectives of this thesis project was to help identify lessons for Canada as it considers how and when it might develop a whole-of-government strategy. The need for such a strategy has been under discussion in Canada for several years. The recently released report from the Canadian Academy of Health Sciences aims to further strengthen the evidence base to catalyze Canadian leadership in this area. (28)

Two studies looking at global health diplomacy in Canada were also recently conducted, one has been published (79) and the other is in press. (78) In his study Hoffman used a qualitative case study approach including interviews and document review to examine and understand ‘Canada’s global health architecture.’ (79) He looked at Canada’s comparative advantage when it comes to engaging in global health diplomacy and recommended strategies for strengthening Canada’s global health diplomacy. He concluded that global health diplomacy may be a strategic opportunity for Canada but Canada’s cross-government architecture for engaging in this process requires significant strengthened through prioritizing health in foreign policy, promoting collaboration across government departments and engaging key partners and stakeholders. (79) The second study funded by the Canadian Institutes of Health Research (CIHR) used a research design and methods similar to those used in this thesis to examine the role of global

health in Canada's recent past, present and near-future foreign policy engagements. Findings were categorized into three areas: why Canada should care about global health diplomacy; how and what defines Canada's health and foreign policy stance; and the future of Canadian global health diplomacy. Converging with one of the main conclusions from this thesis, this study found that security and economic incentives were the main motivations behind Canada's interest in global health in the current political and economic context. The study also found that there is a keen desire for Canada to assert its presence in global health but barriers similar to those that Hoffman uncovered, such as a lack of understanding and collaboration across relevant government departments and lack of political will, were impeding progress. One informant, perhaps idealistically, concluded that health is a win - win situation and global health could be situated as a flagship of a renewed Canada foreign policy. (78)

On balance, these studies indicate a certain degree of support in Canada to develop more of a strategic approach to global health.⁶³ They also highlight significant barriers including an apparent lack of leadership from a policy entrepreneur within government and lack of political will. Despite this situation, based on the findings from this thesis, efforts to advance the discussion should continue as the policy space can potentially take a significant amount of time and effort to soften up. Leadership from within government will be critical to breaking down barriers and to the process to develop a whole-of-government strategy when the time is right.

⁶³ An interesting and important addition to these studies would be those that explore the potential role of Canada's provinces and territories in global health diplomacy and their perspectives on the need for a Canadian global health strategy.

Another important point for Canadian policymakers to consider when embarking on global health policymaking is the role that power dynamics between government departments play in the process. As a few interviewees in the UK case highlighted, certain government departments (e.g. Trade, Industry, FCO) enjoy significant power in the federal apparatus as compared to others (e.g. DFID, Health). In the Canadian context, Mahon describes these power dynamics as ‘the unequal structure of representation.’⁶⁴ (304)(p. 165) In Canadian public policymaking, the Department of Finance is the lead player in developing and containing the federal governments’ economic policies with Foreign Affairs, Industry, the Prime Minister’s Office (PMO) and the Privy Council Office (PCO) making up the other members of the inner circle of power. (304) Health and development are ‘marginal’ groups in this power arrangement. Finance’s dominance over the other departments is specifically achieved through its domination of the budgetary process and as a training ground for public servants who may later head other important departments. (304) Being aware of the power dynamics in the Canadian context and considering how to influence these powerful players given current policy priorities in Canada will be critically important considerations for health diplomats as they attempt to advance the development of a Canadian global health strategy. Leadership from within these most powerful departments and from the Prime Minister’s Office will be central to eventually achieving a coherent whole-of-government approach. Health diplomats should be fully aware that these players, given their positions in the government apparatus, would likely strive to drive and frame the policy content.

⁶⁴ While Mahon’s seminal work is quoted here, in the Canadian, and also in the UK context, there is a rich literature on the concentration of power in the executive and, more specifically, in the office of the Prime Minister. (301-303)

Addressing potential policy conflicts with weaker government department priorities will require skillful negotiation from effective policy entrepreneurs.

7.4 Revolution? Remediation? Regression?

Along with Kingdon's Multiple Streams Model of the policy process, Fidler's health and foreign policy conceptualizations have provided a useful framework for examining and understanding how and why health is integrated into foreign policy. Of these three conceptualizations, 'remediation', in which health does not hold a special place in foreign policy but rather is used for instrumental purposes to pursue other foreign policy objectives grounded primarily in state self-interest, helps to describe the rise of health as a foreign policy issue in the Norwegian, Swiss and UK cases. Diplomacy is an instrument in pursuit of power, survival and self-interest. On the other hand, 'revolution' helps to describe the prominent position of global health in foreign policy in Brazil. In Brazil, improving global health has become an overriding norm and, as such, is a goal of foreign policy. Brazil's ground-up, inclusive approach, in which state and non-state actors construct a normative model of reality from which they seek to derive global health strategies, appears to be based on cooperation and not competition. What foreign policy attends to, how and why is a product of multi-stakeholder engagements leading to more or less consensual agreements on policy directions. Global health diplomacy is the mechanism through which a normative model of reality can emerge resulting in collective strategies and approaches to advancing global health at both the state level and the global level. To a certain extent, the UK process also aimed to arrive at a collectively derived global health strategy, and as argued in this thesis, that goal was largely achieved. Unlike,

Brazil, however, the *principle* reality that emerged was not that health is a human right but rather that investing in global health is a strategic way to improve national and international security and the economic interests of the state.

In all four country cases, the WHO, although needing significant reform, emerged as an important and central actor. The four countries studied were highly supportive of the WHO and argued that its leadership and convening role should to be strengthened further to help them and other actors make sense of the increasingly complex global health context characterized by a multiplicity of actors and agendas. This finding highlights that multilateralism is consistent with Fidler's remediation theory; in other words, with a system of international relations in which self-interest dominates. As the Brazil case showed, however, it is also consistent with 'revolution.' Additional research focused on the WHO and other international institutions in GHD is clearly needed to better understand their role in this process and how states perceive of and interact with such institutions to achieve their goals.

'Regression' also helps to describe why some health diplomats are critical of the health security framing and why it is a potential threat to global health equity. While the security argument has served to attract attention on global health, it may also be tarnishing health's normative underpinnings or what made health special in the first place leaving health at the margins of traditional foreign policy and vulnerable to shifting foreign policy attention.

7.5 Concluding Remarks

This thesis set out to contribute to the relatively sparse but expanding empirical knowledge base about global health diplomacy and the integration of health into foreign policy. In particular, it has contributed to advancing knowledge about global health diplomacy at the state level and provides a launching point for further in-depth research in a number of areas. It also provided a number of important insights into global health policy and policymaking for other countries to potentially learn from. Since this study was first undertaken, the world economic situation has shifted spurring some to conclude that the global health revolution that began a little over a decade ago is now over. (27) Perhaps foreign policymaker attention has shifted to pressing economic concerns but a revolution of sorts appears to still be underway in the global health policy community. State level global health strategies continue to be proposed or developed, including in Canada, and the global health diplomacy policy community is becoming larger, more integrated and sophisticated. These processes are important as they are the foundation of readiness for future policy change.

At the time when this thesis was being prepared for submission and examination several relevant developments took place that serve as a postscript to this work. First, Norway released a white paper establishing clear priorities for a coherent Norwegian policy on global health towards 2020 (i.e. a whole-of-government global health strategy). (166) Second, Switzerland revised and released a new Swiss Health Foreign Policy building on the 2006 agreement. (305) Interestingly, this time it was developed in consultation with the Swiss cantons, civil society, the private sector and academia. And, third, the first

report stemming from the new research partnership mentioned in this thesis led by the University of Oslo and Harvard University was released examining cross-sectoral challenges to advance health as part of foreign policy. (306) These developments further highlight the relevance and importance of research focused on understanding how and why health is integrated into foreign policy and the growing interest in this area. They also signal that the global health revolution is alive and well and possibly entering a phase in which attention on global health is becoming sustained rather than crisis driven and ad hoc.

Appendix A: Draft Interview Guide

Project: Understanding how and why global health is integrated into national foreign policy

Time of interview:

Date:

Place

Interviewer:

Interviewee:

Position of interviewee:

Briefly describe the project.

Briefly describe the consent process and obtain consent.

1. Please tell me about your present job, and any work that you've done in global health and/or in foreign policy.
Probe: How would you describe the most important foreign policy goals for your country? In your opinion how would you rank these goals and why?
2. Some of your work has been associated with what has now come to be called global health diplomacy. What does global health and global health diplomacy mean to you and what are your experiences in this area?
3. Can you also comment on what global health and global health diplomacy means to officials in your government, to politicians in your government?
4. The integration of global health goals into foreign policy has been referred to as one way that national governments are engaging in global health diplomacy. Can you comment on and describe any initiatives in your country focused on integrating global health into foreign policies? [interviewer can also refer to and ask questions about specific policies (e.g. the UK's Health is Global strategy) where relevant]
Probes:
 - What other governments were involved in this initiative (those engaged in the foreign policy work)?
 - How would you describe their approach to global health and foreign policy?
 - What government departments have been involved in these initiatives?
 - How have the relations been between different branches of government involved in global health diplomacy (fully collaborative, some strain or difficulty, little intersectoral collaboration at this time)?
 - What department took leadership in creating the initiative?

- What new organizational structure(s) or procedural rule(s) have been created to advance global health in foreign policy? (when, why)
- 5. Why did your government decide to focus more on global health in foreign policy? Please elaborate on the motivations behind this policy direction and the policy and decision making context.

Probes:

 - What has enabled your government to pursue global health in its foreign policy (e.g. political will - alignment and organization of political interests)?
 - What barriers to pursue global health in your country's foreign policy have you encountered?
 - Did scientific evidence play a role in these decisions and if so, what kind of such evidence informed the policy discussions?
- 6. What individuals, groups, networks, were involved in and influenced the process that led to your government's decision to focus more on global health? (e.g. health researchers; non-governmental organizations; private sector actors?)

Probes:

 - Elaborate on how these individuals, groups or networks have been involved and on their specific contributions (e.g. providing scientific knowledge?).
- 7. Diplomacy is often regarded as involving compromises or trade-offs between different foreign policy goals. What compromises around the global health issue arose during (add reference to initiative from question 4)?

Probes:

 - Were there any competing policy goals? (Interviewer may cite such examples from policy documents)
 - How was such competition or compromise handled?
 - How would you describe the result (e.g., trade-off, health partially prominent, full policy coherence with health more central)?
- 8. How have your government's diplomatic strategies or practices changed with respect to the adoption of a policy framework that embodies global health diplomacy?

Probes: How do you think they will/might change and why?

Is there anything further that you'd like to add?

(Close the interview – thank the interviewee, propose a follow-up interview, if necessary, and ask for suggestions of other key informants who should be interviewed)

Appendix B: Recruitment Letter

Recruitment text for University of Ottawa Ethics Application

Recruitment for UK case study participants

Study Title: Understanding how and why health is integrated into foreign policy

Principal Investigator: Ronald Labonté

Co-investigator: Michelle Gagnon

Subject: request for your participation in a doctoral research study about global health diplomacy and the integration of health into foreign policy

Dear (INSERT NAME):

My name is Michelle Gagnon. I am a doctoral student in the University of Ottawa's interdisciplinary PhD Program in Population Health located at the University of Ottawa in Ottawa, Ontario, Canada. Because of your role in the development of the new UK Health is Global Strategy, I am writing today to request your participation as a key informant in my doctoral thesis project entitled, *Understanding how and why health is integrated into foreign policy*. My thesis supervisor is Ronald Labonté, Canada Research Chair, Globalization/ Health Equity and Professor, Faculty of Medicine at the University of Ottawa. This thesis project will aim to build understanding about how and why countries such as the UK have decided to develop coherent foreign policies that integrate global health from which lessons may be derived for other nations that might be interested in pursuing similar policy directions, such as Canada. Specifically, it will explore the motivations behind this policy direction, how health is positioned in the policy discourse and the process that led to the policy from the perspectives of those who were directly involved in the policymaking process such as yourself.

Participation in this study is completely voluntary and information collected will be kept strictly confidential and used only for the purposes of this particular study. Participants are free to withdraw from the study at any time and anonymity will be guaranteed. Names and other identifying information will not be used in any components of the study. A consent form will be provided to each participant and must be signed before the interview can take place.

Key informants who agree to participate will be asked to partake in one face to face or telephone tape recorded interview lasting approximately one hour. The interview will be arranged at a mutually agreeable time and location and the interview guide as well as the consent form will be provided several days prior to the interview. Participants may also be asked by e-mail to verify their responses to interview questions following the interview as required.

If you are interested in participating in this study and/or would like additional information or would like to discuss this further, please contact me at (INSERT CONTACT INFO)

Thank you for your attention to this invitation to participate as a key informant in my doctoral thesis research study.

Sincerely,
Michelle Gagnon

Appendix C: Consent Form



Université d'Ottawa
Institut de recherche
sur la santé des
populations

University of
Ottawa
Institute of Population
Health

Consent Form – Semi-structured interview

Title of the study: **Understanding how and why health is integrated into foreign policy**

Name of researcher: Michelle Gagnon, PhD candidate, Institute of Population Health, University of Ottawa

Name of supervisor: Ronald Labonté, Canada Research Chair, Globalization/Health Equity, Institute of Population Health and Professor, Faculty of Medicine, University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Michelle Gagnon, (student researcher) and Ronald Labonté, (supervisor).

Purpose of the Study: The purpose of the study is to explore and better understand how and why some nations have decided to develop foreign policies that integrate global health as a goal and objective of those policies.

Participation: My participation will consist essentially of participating in a tape recorded interview of approximately 60 minutes, either in person or by telephone, with Michelle Gagnon. I may also be asked to provide feedback by e-mail if required to clarify my answers to the interview questions.

Risks: There is no risk to me as a participant in this study.

Benefits: My participation in this study will help build understanding about how and why policy and decision makers at the state level have decided to pursue coherent foreign policy directions that integrate global health as a key priority from which lessons can be derived and shared with other nations that may be interested in pursuing similar policy directions. Because the link between global health and foreign policy is also very closely related to what has recently come to be called “global health diplomacy”, my participation will also help build understanding and contribute to the knowledge base about global health diplomacy.

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Ottawa ON K1N 6N5
Canada

www.uOttawa.ca

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for purposes of this study and that my confidentiality will be protected through the use of a neutral identifier such as a number or pseudonym in all data that is collected and in the publications that may result from this study. The use of a numbering system or pseudonym will also protect my anonymity. Other personal identifying information will also be removed (e.g. my job title or affiliation). I understand that even with these provisions, it may be possible that some readers might infer my identity.

Conservation of data: The data collected through interviews and from documents will be kept in a secure manner in a locked cabinet in Ronald Labonté's office at the University of Ottawa and will be destroyed 5 to 10 years following completion of the study.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be used in the study and stored and destroyed in the same manner as all other data gathered as part of this study.

Acceptance: I, _____ agree to participate in the above research study conducted by Michelle Gagnon of the Population Health PhD Program at the University of Ottawa, Ontario, Canada. This research is under the supervision of Ronald Labonté.

Before we start, do you have any questions about the study, or about this interview?

I, (Print Participant's Name) _____,
voluntarily agree to participate in this study.

(Participant's Signature)

(Date)

(Researcher's Signature)

(Date)

I agree to allow the interview to be tape recorded. YES
NO

I wish to review my transcripts following the interview. YES
NO

Participant's Name and Signature:

Witness (*needed in the case where a participant is illiterate, blind, etc.*):
(Signature) Date: (Date)

****PLEASE RETURN ONE COPY AND RETAIN ONE FOR YOUR FILES***

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