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21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health

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Introduction

In 2009, a new concept of global health diplomacy (GHD) was adopted by United Nations General Assembly (UNGA) Resolution 63/331 and reaffirmed by UNGA Resolutions 64/108,2 65/95,3 and 66/115.4 All of these resolutions recognize the strong interface between foreign policy and global health. According to the Secretary-General’s Note, “Global health interacts with the core functions of foreign policy: achieving security, creating economic wealth, supporting development in low-income countries, and protecting human dignity” (Ref. 5, para. 5). This statement draws attention to “making the relationship between global health and foreign policy an increasingly important issue for the United Nations, the World Health Organization, many intergovernmental organizations and processes, and national governments” (Ref. 5, para. 58).

However, although these proclamations hark back to the origins of health diplomacy over the past 160 years, it is only in the past decade that the technical areas of global health have been explicitly linked to

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the sphere of diplomacy. This linkage primarily results from shifts in the global political environment, the emergence of new epidemics, and the greater need for international cooperation in health. In today’s globalized world, nations need, now more than ever, to cooperatively address mutual threats. As former UN Director-General Kofi Annan stated in 2004, “No state, no matter how powerful, can by its own efforts alone make itself invulnerable to today’s threats.” In 2011, UN Secretary-General Ban Ki-moon highlighted in his remarks to the General Assembly after being appointed for a second term that “[W]e live in an era of integration and interconnection, a new era [in which] no country can solve all challenges on its own.”

The Origins of Health Diplomacy

The Multilateral Health Conference

Transboundary challenges in the 19th century put to use the diplomatic tool known as the “multilateral conference.” Its construct was both simple and revolutionary: a group of countries would meet ad hoc to reach agreements “on a common policy with regard to a common problem,” and then would later meet again to see whether these policies had been implemented and to determine whether adjustments to the agreements were needed. These meetings developed into a cycle of international conferences, the first of which was established in 1815 as the Central Commission for the Navigation of the Rhine. The objective of this commission was to bind states to a common purpose — in this case, to adopt rules on how to navigate the river Rhine in order to promote economic development and free trade.

With similar aspirations, the first meeting of the International Sanitary Conference (ISC) in 1851 brought 12 states together to “render important services to trade and shipping.” Today, the ISC’s successor organization is the World Health Organization (WHO), which brings together 193 countries to debate and formulate policies and agreements on common health threats, including those of a transboundary nature. These include diverse issues such as addressing health workforce migration, intellectual property and health, tobacco control, virus-sharing in
response to infectious disease epidemics, and destruction of the smallpox virus. Increasingly, each of these issues involves critical political and economic dimensions related to national security interests, geopolitical power shifts, and international trade. For example, the latest version of the International Health Regulations (IHR), adopted in 2005, states in Article 2 that the purpose and scope of the IHR are “to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and [that] avoid unnecessary interference with international traffic and trade” (Ref. 10, Article 2). These links have put health back on the foreign policy agenda.

None of this would surprise an observer from the mid-19th century. As the French Foreign Minister stated during the opening ceremony of the first ISC in 1858, that period in history was “so fruitful of new and great things.” It enabled modern international commerce, but it also witnessed the rapid spread of infectious diseases. The beginning of the ISC, then, was a “cosmopolitan moment,” which called for international cooperative action to address infectious diseases while preserving trade. The term cosmopolitan moment implies the recognition that it requires joint political action by sovereign states to avert a global risk: it becomes “an unprecedented resource for consensus and legitimation, nationally and internationally.” Cosmopolitan moments create new political spaces and enable or oblige new actors to join in global diplomatic instruments such as the IHR.

Increased movement of goods and people led to new types of organizations and agreements. Already in 1843 the Egyptian Quarantine Board was established in Alexandria, based on the Conseil Supérieur de Santé de Constantinople, which had been created in 1839 to regulate the sanitary control of foreign shipping in Ottoman ports. It was composed of the Ottoman health council and delegates of the maritime powers. In 1851, an unprecedented six million visitors attended the First Great International Exhibition, in London. It presented to the world a new age of optimism supported by great trust in science and technology: infectious diseases, and the poverty and destitution caused by them, were to be things of the past. However, the national policies and instruments available to control the spread of infectious diseases (such as quarantine) had failed to contain
several epidemics. For example, cholera pandemics struck Europe in 1821 and 1851; they led to significant loss of life, in particular among the poorest communities in London, Paris, and St. Petersburg. Merchants also suffered great financial burdens and bore the brunt of quarantine measures imposed without compensation for loss of trade revenue. In the face of tough global competition among states, there was political concern that quarantine measures were, in fact, applied by some in order to achieve unfair trade advantage. It was after the second pandemic, in 1851, then, that the new organization, the ISC, helped level the playing field for trade amid the very real health concerns at that time.

One hundred and fifty years later, in 2003, a cosmopolitan moment was again provoked by the epidemic of severe acute respiratory syndrome (SARS) and its global economic impact. This event convinced nations to act so that economies could be protected from the effects of disease spread in the 21st century’s borderless world. Because of “the growth in international travel and trade, and the emergence or re-emergence of international disease threats and other public health risks, the 48th WHA [World Health Assembly] called for a substantial revision of the Regulations adopted in 1969.” History had repeated itself.

Although the history of international health agreements includes some negotiations that were concluded in record time, many other such negotiations dragged on for long periods, because of the lack of political will or of easy consensus on multinational actions. Much has been written about the delayed outcomes of the ISCs. Achieving consensus proved difficult in these meetings because of major disagreements on the causes and modes of cholera transmission and subsequently on the measures that were needed to contain the epidemics. Ten conferences took place over about 50 years, and they often were marked by heated debates among different scientific schools of thought on the causation of cholera. In fact, because of the vicious nature of these controversies, diplomats in charge of negotiations at one point excluded scientists from some of the deliberations. The first convention document was signed in 1892, after 41 years of debate. This delay is remarkable, given that Filippo Pacini (in 1854) and Robert Koch (in 1883) had discovered *Vibrio cholera*, the causative agent of cholera. With these discoveries, the medical establishment finally accepted the fact that micro-organisms — and not simply filth — had
caused the illness. Science-based cholera control efforts were undertaken during the building of the Suez Canal (1892) and later supported by sanitary conventions during the Haj pilgrimage to Mecca (1894) and in the international response to plague (1897).18

**Learning by Doing**

Such negotiations at the interface of diplomacy and science had not previously been conducted. Political leaders, diplomats, and scientific experts had to familiarize themselves with new demands for health diplomacy and negotiations at the multilateral rather than at the bilateral level, where most diplomacy had been conducted until then. Initially, countries joining the ISC put concerns for trade at the center of their discussions, and thus these conferences focused on possible treaties to protect trade in the face of health threats. Over time, the meetings also became an international forum at which to present advances in science and to discuss a wide range of public health and medical issues. This process ultimately led countries to recognize the need for structured international health cooperation and laid the groundwork for the subsequent institutionalization of such cooperation. These processes also shifted some responsibility away from diplomats and onto health experts, because the focus of negotiations moved from political agreements and treaties to more technical issues based on the rapidly expanding medical and public health knowledge. Many health and political leaders felt that effective outcomes could only be ensured through a more stable governance mechanism, and thus the idea of a permanent international health agency was raised at the 1874 ISC in Vienna. However, it took another 30 years to establish the first such international agency (in 1907), as the Office International d’Hygiène Publique (OIHP). In the Americas, the Pan American Sanitary Bureau had been established in 1902 as the first regional international health structure.

One might contrast this slow, multinational bureaucratic process with the creation, also in the mid-19th century, of the International Committee of the Red Cross (ICRC; a voluntary organization) in just five years. This rapid startup was facilitated by Henry Dunant, a charismatic individual
who witnessed the death and abandonment of more than 40,000 wounded soldiers following the 1859 Battle of Solferino in the Austro-Sardinian War. The international response he was able to mobilize — a shocked general public pushed states into voluntary humanitarian cooperation — is not dissimilar to the global response to the HIV/AIDS epidemic at the end of the 20th century.

**Diplomatic Revolutions**

Diplomacy is the art and practice of negotiation and relationship building within different contexts and on many different subjects. States assert foreign policy priorities through diplomacy, and thus diplomacy is essentially a political activity. When we refer to diplomacy, we mean both specific methods for reaching compromise or consensus and a system of organization for representation, communication, and the negotiating process. Former US Secretary of State Henry Kissinger described this interface as “the adjustment of differences through negotiation… in a legitimate international order.” Diplomacy as a method has been practiced between states for centuries through the assignment of envoys and the establishment of resident missions. Over time, as the environment within which diplomacy functions has changed, both the methods and the system of diplomacy had to adapt to a new international order of nations, to changing international governance structures, and to a wide range of new organizational roles in foreign policy.

**The Modern System of Diplomacy**

The modern system of diplomacy emerged in 15th century Europe within the Italian city-states and was further developed through the establishment of national foreign ministries and the function of the resident ambassador. “By the early 18th century, most of the machinery of modern diplomacy was in place.” It is intricately linked to the emergence of the sovereign nation-state. The treaty called the Peace of Westphalia in 1648 introduced a new political order in central Europe, based upon the concept of state sovereignty over lands, people, and agents abroad. This proved to be the basis of all
later diplomatic efforts — the legitimate order that Kissinger refers to — and gave impetus to the pursuit of national interests within a basically bilateral system of representation and negotiation. The first foreign ministry was created in France in 1626 by Cardinal Richelieu. The priority given to diplomacy in France was only achieved by most other countries in the course of the 19th century.

The 19th century then saw the emergence of multilateral diplomacy. After the Napoleonic Wars the diplomatic innovation of the peacetime conference was turned into a “cabinet of the great powers” or, as it was sometimes called, the “concert of Europe.” These meetings not only allowed simultaneous negotiations among states, a necessary approach to areas of common concern in the age of colonial expansion and rapid economic growth, it also led to a sharing of international authority and provided the mechanism for continuous management of the problems at hand. What followed was an “explosion in multilateral diplomacy” which was characterized by the creation of regular committees and conferences and by an increase in the number of intergovernmental organizations with their own secretariats.20,23

After the First World War, with the establishment of the League of Nations (the League) in the early 20th century, yet another completely novel form was added to the diplomatic system: the universal membership organization, open to all states and committed to “open diplomacy.” This “new diplomacy” brought with it that negotiations were conducted not only simultaneously but in international assemblies modeled on a parliamentary process. This structure both allowed the participation of smaller countries and was designed to reach political solutions with transparency and accountability — the ideal was a universal association of nations. These organizations were run by a secretariat, i.e. a new corps of international civil servants who were, in principle, beholden to the international organization and not to their nation of origin. Very few countries had resident missions to interact with these organizations, and governments would send high-level representatives to attend the assemblies. The old-type conference diplomacy continued in parallel. After World War II these international structures were further elaborated through the establishment of the United Nations System,23 with the aim of providing it (through the Security Council) with more power.
Increasingly, they required a country’s presence (a permanent delegation) at the seat of the organization and new forms of representation and accreditation. Countries established high-level diplomatic positions such as Ambassador to the United Nations or Representative to the World Trade Organization. The delegations to multilateral organizations might further involve not only diplomats but also specific issue experts from ministries of health, environment, labor, or defense — raising the issue of the relationship between generalist and specialist diplomats. In view of the many dimensions of diplomacy, the Vienna Convention on Diplomatic Law was agreed in 1961 to guide countries and provide rules to be adhered to.

21st Century Diplomacy

Twenty-first century diplomacy is adapting to a globalized world community. Global challenges such as the environment and health and the growing awareness of global interdependence have transformed the very essence of diplomacy. At present, describing foreign policy as “the strategy or approach chosen by the national government to achieve its goals in relation with external entities” seems insufficient. A career UK diplomat, Robert Cooper, stated that the goal of foreign policy is increasingly “taken to be peace and prosperity rather than power and prestige.” Similarly, the UN Secretary-General defined the core functions of foreign policy as “achieving security, creating economic wealth, supporting development in low income countries, and protecting human dignity.” Others maintain that the role of the diplomat now includes a double responsibility: to represent both the interests of his or her country and the interests of the global community. This new role requires that global public goods for health be ensured and that trade and economic development regimes need to be complemented by binding agreements that ensure health and environmental safety.

Some analysts assert that the “management of the global system on a continuous basis” is increasingly the task of the modern diplomat. The day-to-day work of representatives to international organizations seems to underscore this assertion; specifically, technical experts (e.g. experts on the environment or health) are now routinely included in negotiating
teams and, increasingly, there are technically qualified diplomats working alongside foreign policy generalists. Member state support for international organizations is often dependent on how well these organizations manage the complexity of negotiating global health, trade, agricultural, or intellectual property regimes.

The 21st Century System and Method of Diplomacy

In the 21st century, the system of diplomacy makes use of bilateral and multilateral diplomatic processes that have been developed over the past two centuries. The unstructured pluralism reflected in this system has two dimensions: on the one hand, it offers the flexibility necessary for conducting complex negotiations on complex subjects, including testing the reception of negotiating positions in different fora; on the other hand, it allows an “à la carte” multilateralism, in which new forms of dialogue and “coalitions of the willing” are created to avoid obligations based on agreements reached in international organizations. The great power conferences have been reborn as the Group of Seven, Group of Eight, and Group of Twenty (G-7, G-8, and G-20). Summit meetings, which first became popular in the post-WWII period, have increased in number rapidly at regional and global levels and as regional rather than global negotiations. In fact, multilateral, ad hoc conferences have become the primary mechanism by which environmental and climate change agendas are advanced, while the development of health treaties has been repositioned under the WHO.

Membership in some international membership organizations may be conditional. For example, gaining membership to the World Trade Organization (WTO) is in itself a process of negotiation; any state or customs territory having full autonomy in trade policies may join (“accede to”) the WTO, but WTO members must agree on the terms of accession.

Other new fora are now part of the diffusion of the diplomatic system; for example, regular high-level gatherings such as the World Economic Forum in Davos, Switzerland; board meetings of public–private partnerships (such as the Global Fund for AIDS, Tuberculosis, and Malaria and the GAVI Alliance); and an increasing number of regional groups have become critical parts of the response to global health challenges. Finally,
as will be argued below, health diplomacy has itself become an accepted form of diplomacy, a form that is integral to the practice of foreign policy; it is now part of the diplomatic arsenal of countries as diverse as the United States, China, Norway, and Brazil. In fact, health was described as a “pillar of foreign policy” by the US Institute of Medicine in 2008.34

The method of diplomacy — the practice of the art — is also changing. Sucharipa35 has outlined an entirely new set of skills for the 21st century diplomat. He stated that the diplomat will need, first and foremost, to be an expert who works with a new diplomatic mind frame. This perspective embraces openness instead of secrecy, defines diplomacy as a “service industry,” redefines professional roles as network-based rather than hierarchical and, in the information age, requires well-developed analytical skills. The practice of diplomacy has also changed through the ease of travel and the introduction of new technologies, such as electronic communication and new forms of knowledge management. Geoffrey Wiseman,36 in his study “Polylateralism and New Modes of Global Dialogue,” proposed that “traditional state-centered bilateral and multilateral diplomatic concepts and practices need to be complemented with explicit awareness of a further layer of diplomatic interaction and relationships. Accordingly, the diplomat of the future will need to operate at the bilateral level, the multilateral level, and, increasingly, the polylateral level (relations between states and other entities).” In addition, the health diplomat in the 21st century will increasingly be female.35

In summary, some of the defining features of the new 21st century diplomacy in a globalized world are that it:

• Needs to function within a multipolar world and within a multi-level and multi-dimensional global governance structure, which increasingly includes a regional level.
• Is no longer conducted only by traditional, professional diplomats.
• Is challenged to manage not only the relations between states (bilateral and multilateral) but also the relations between states and other actors (polylateral); it manages these relationships at various diplomatic venues and by using a wide range of instruments.
• Is increasingly engaged in public diplomacy vis-à-vis an informed public and many new actors at home and abroad.
• Is involved in and contributes to a host of international issues which require global coordination under conditions of interdependence, such as security, health, the environment, global finance, and climate change.
• Needs to consider a much closer interface between domestic and international policies and cooperation with national ministries.33–41

These factors constitute the backdrop to global health diplomacy (GHD), as will be discussed below.

Health Diplomacy: Broadening the Scope of Foreign Policy and Diplomacy

When we speak of GHD, we aim to capture particularly those multilevel and multi-actor negotiation processes that shape and manage the global policy environment for health in health and non-health fora. Ideally, GHD is conducted in the spirit of a common endeavor to ensure health as a human right and a global public good, and it is based on the double responsibility of the diplomat to serve both national and global interests. It brings together a range of disciplines, including public health, international affairs, management, development, law, and economics. Its broadest focus is on health issues and health determinants that cross national boundaries, that are global in nature, and that require global agreements to address them.54

If well-conducted, GHD results in: (1) better health security and population health outcomes for each (and all) of the countries involved and an improved global health situation; (2) improved relations between states and a commitment of a wide range of actors to work together to improve health; and (3) outcomes that are deemed fair and that support the goals of reducing poverty and increasing equity.

As described above, health diplomacy can look back on a history of nearly 160 years. It is notable that international health negotiations have had an institutionalized mechanism for more than 100 years. Using the definitions of diplomacy introduced earlier, health diplomacy at the multilateral level can be considered as a method for reaching compromise and consensus in matters pertaining to health, usually in the face of other interests related to international politics, economic interests, and ethical values. Health diplomacy is — like all other forms of diplomacy — essentially a
political process (see the chapter by Feldbaum in this volume); it involves negotiation but also much relationship building and is part of the management of global affairs. As health becomes more politically relevant in domestic and foreign policy, health diplomacy plays an increasingly important global role. This change clearly is an expression of changes in the dynamic relationship between the health and diplomacy fields. Alcazar maintains that a “Copernican shift” in global health is underway. He says: “Globalization takes the issue of health from the relative obscurity in which it found itself, especially in developing countries, and brings it to the front page where it is featured not as health as we know it, but as global health in combination with foreign policy, which we are still struggling to define.”

The multilevel nature of health diplomacy is well illustrated in a presentation to an international audience by the Chinese Minister of Health, Professor Zhu Chen, who in 2009 introduced the following list of health diplomacy activities and relationships in which China engages:

- Multilateral: the WHO; the World Bank; the Association of Southeast Asian Nations; the Shanghai Cooperation Organization; the Global Fund for AIDS [acquired immune deficiency syndrome], Tuberculosis, and Malaria; and the UN Programme on HIV [human immunodeficiency virus]/AIDS (UNAIDS).
- Bilateral: 300 cooperation agreements with 89 countries.
- South–South: China–Africa Cooperation (Chinese medical teams).
- South–North: 11 regular ministerial dialogues with the United States, France, and other countries.
- Public–Private: the Clinton Foundation, the Bill and Melinda Gates Foundation, the China Medical Board, and Project Hope.

The Dynamics of Health and Foreign Policy

The changing dynamics between health and foreign policy can be illustrated if we assume a continuum with two endpoints — one (A) in which foreign policy neglects or even hinders health and another (D) in which foreign policy serves health (as represented in the Oslo Declaration on global health). Along the continuum, we can observe several different
interactions between health and foreign policy, two of which are of particular importance: (B) health as an instrument of foreign policy and (C) health as an integral part of foreign policy (Fig. 1).

All four points along the continuum in Fig. 1 serve foreign policy goals that are not necessarily distinct; they all serve the national interest, but they do so to various degrees. As one approaches point D, the dual responsibility — serving national interests as well as the global community — is particularly evident as a political commitment to health objectives. Indeed, the Oslo Declaration speaks of health objectives “as a point of departure” for foreign policy. A short review of the four types of interactions between health and foreign policy may help illustrate this perspective.

**Foreign policy neglects or even hinders health outcomes**

At point A in Fig. 1, public health may be severely endangered when diplomacy fails, and hard-power interventions might ensue. These interventions could include military actions and increasingly economic actions — for example, economic sanctions or agreements on trade or intellectual property that neglect the effect of the agreements on public health. They also could include a lack of agreement in such areas as climate change, as evidenced at the 2009 UN Climate Change Conference in Copenhagen. Currently, policies and agreements that are negotiated internationally or that are part of regional and bilateral agreements are seldom reviewed for their public health impact. Indeed, powerful countries often seek bilateral agreements specifically to avoid or circumvent multinational agreements that might constrain their actions in trade, economic development, and security matters.
Health as an instrument of foreign policy

Point B in Fig. 1 indicates that health may be an instrument of foreign policy that serves the national interest by improving relations among states in several ways. The long-standing Cuban medical diplomacy program is a typical example, as are the many health projects that form part of the agreements between China and African states. In 2003, at the height of the Iraq war, the US president launched the President’s Emergency Plan for AIDS Relief (PEPFAR), the largest international health initiative in history for a single disease (initially US$15 billion for 5 years, now US$51 billion for 6 years). The signals that these foreign policy initiatives send are intended not only for recipient countries but also for the global community overall; they are part of public diplomacy. In many cases, national governments support global health initiatives to improve their image at home and abroad; in particular, many of the smaller European nation-states (such as those of Scandinavia) use the health arena to demonstrate their commitment to the multilateral systems that provide them with a voice and allow them a leading role on the global stage.

In the Western countries, this use of health within foreign policy goals is often looked at critically by development agencies, public health organizations, and health activists, who argue that programs should be established “for health’s sake” — not for other motives — and that they should be based on criteria of need and equity, not political expediency. As a consequence, international development agencies — or, as is sometimes the case, ministries of development — are often at odds with ministries of foreign affairs over priorities and approaches, because the agencies do not want to be instrumentalized for goals other than health development. Many of the newly founded South–South initiatives in health, in contrast, support the new geopolitical positioning of the emerging economies toward Africa, which has been called “the continent of the future,” and countries such as China are considering the establishment of a development agency to structure and strengthen their level of influence in Africa. This approach has been termed “soft power,” which aims to bind developing countries to centers of power in a multipolar environment through means other than coercion. Lee et al. recently illustrated the use of this approach in the case of Brazil and the Framework Convention on Tobacco Control (FCTC).
Finally, in the Iraq and Afghanistan wars, health assistance has been used in parallel with military intervention in an effort to “win the hearts and minds” of the people in those countries. In part, this approach builds on the experiences gained by the Pan American Health Organization in Central America in the 1980s, when temporary cease-fires were negotiated to allow for vaccination programs. This type of initiatives came to be termed “Health as a Bridge for Peace” or described as “vaccine diplomacy,” and they also were used in the aftermath of the Balkan conflicts. The term “humanitarian diplomacy” is also gaining ground — and health is an important dimension of this approach.

**Health as an integral part of foreign policy**

An important part of the shift in the relationship between health and foreign policy indicates that some dimensions of health have now become an integral part of foreign policy (point C in Fig. 1) in many countries. There is of course a fluid line from using health as an instrument of foreign policy to integrating it into foreign policy strategies — this is sometimes termed “smart power.” Health as a part of 21st century foreign policy is reflected in approaches to “heath security,” which is similar to the involvement of foreign ministries in environmental diplomacy. Cooper underlined this by pointing out: “In the past, it was enough for a nation to look after itself — today, that is no longer sufficient.” The realizations that disease knows no borders and that pandemics and bioterrorist attacks can endanger national security have become a concern of foreign policy and security specialists, and have pulled health experts into these realms. In the United States in the 1990s, health issues, particularly human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), were of concern to the National Security Council and were a regular feature of national intelligence reports. Many other countries, as well as the European Union (EU), consider health issues to be part of their national security strategies. It was such a perspective that led to the rapid agreement by numerous countries on the revision of the IHR, despite the fact that the IHR transcends individual national sovereignty in some of its provisions.
Foreign policy serves the goals of health

Finally, we may see the increasing trend of foreign policy serving the goals of health (point D in Fig. 1). GHD and civil society advocacy have been extraordinarily successful in inserting health into the many negotiations underway in the general foreign policy environment. Health has become integral to the meetings of the G-7, G-8, G-20, and Group of 77; it is the subject of regular summit meetings as well as a myriad of multilateral ad hoc conferences; new UN-based health organizations have been created; new organizational forms, such as global funds, alliances, and initiatives, are being established; and regional bodies and fora deliberate on health matters. Two major health negotiations were conducted within the WHO, and within a very short time two major international agreements were approved: the FCTC (2003) and the revised IHR (2005). These negotiations were chaired and headed by senior diplomats (such as the IHR revision). Health is squarely on the UN agenda, for example as a central component of the Millennium Development Goals (MDGs) and most recently the high-level UN meeting on noncommunicable disease prevention and control. Particularly in the UN context, most negotiations of relevance to health are conducted by diplomats.

A group of seven ministers of foreign affairs have expressed this development in the Oslo Declaration, as follows: “In today’s era of globalization and interdependence, there is an urgent need to broaden the scope of foreign policy…. We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time…. We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make [the] impact on health a point of departure and a defining lens that each of 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.”

The Changing System of Health Diplomacy

Health diplomacy has its own system of organization (i.e., a range of dedicated health agencies) … first and foremost, the WHO and the approaches
and mechanisms of representation and negotiation that have emerged as health has become a more important dimension of diplomacy. The role of health as both an instrument and an integral part of foreign policy and the challenge of the “double responsibility” of the modern diplomat have led to the need for adjustment in both the system of diplomacy, which now includes health issues and health experts in new ways, and the health arena, which now needs to accommodate and make use of diplomatic expertise in new ways.

These adjustments are reflected in new types of relationships between ministries of health and ministries of foreign affairs at the national level, which sometimes take the form of official policy documents, as in Switzerland and the United Kingdom. They are also mirrored in the composition of many diplomatic representations in which an increasing number of health attachés and health experts serve and in the inclusion of health in the training of diplomats. The departments of international and global health in the ministries of health are growing in importance (but not necessarily in resources) and, in some cases, ministries of foreign affairs have also established units on global health that interact with or supersede the technical ministries. Regional bodies are moving in the same direction and, in May 2010, the Foreign Affairs Council of the EU adopted Council Conclusions on the Union’s role in global health. Special ambassadors have been appointed by countries or by the UN Secretary-General to negotiate on specific disease challenges. US Ambassador to the UN Eric Goosby serves as the United States Global AIDS Coordinator, leading all US government international HIV/AIDS efforts, and the UN Secretary-General has appointed a UN System Influenza Coordinator.

In the first years of this new century, as the number of health actors has greatly expanded, this system of “health negotiation in a legitimate international order” is being politically challenged with regard to representation, recognition, legitimacy, and transparency. As in other periods of historical change, health diplomacy must be shaped to fit the new environment. We have indicated above how the International Sanitary Conferences moved from a political process of health negotiations to an increasingly technical undertaking; to some extent the diplomacy system has come full circle — back to an increased interface of health and politics. The following rough outline of the phases of institutionalization of health
diplomacy focuses on the move toward a universal health organization. However, we must not forget that, even in the early stages of health diplomacy, the field of health diplomacy included many actors, not just states. Two of these actors deserve special mention: the ICRC (founded in 1863), which pioneered a new ethics of impartiality and neutrality in relation to health in humanitarian settings, and the Rockefeller Foundation (founded in 1913), which has been in the vanguard of foundation activity for health beyond borders. From its beginnings the foundation was so active throughout the world and in working with the health office of the League of Nations that, in 1928, it created its own international health division at its headquarters in New York. Its financial investments at the time compare with those of the Bill and Melinda Gates Foundation today.

Phases of Institutionalization of Health Diplomacy

The first phase of institutionalization of health diplomacy (1907–1919) led to the establishment of the Office International d’Hygiène Publique OIHP in Paris in 1907, by an agreement signed by 12 states (Belgium, Brazil, Egypt, France, Italy, the Netherlands, Portugal, Russia, Spain, Switzerland, the United Kingdom, and the United States). The regional Pan American Sanitary Bureau, which is often described as the first international health organization, had already been working since 1902, and a number of other international/regional health organizations were already in existence or were beginning to be established at that time. By 1914, the OIHP had grown to include nearly 60 countries and colonies, and its main concern — following the International Sanitary Convention — continued to be international quarantine; in one of its most important early acts, it prepared the ISC in 1926, which added smallpox and typhus to cholera, plague, and yellow fever. It also adopted measures of notification, requiring governments to inform the OIHP immediately of any outbreak of plague, cholera, or yellow fever or of the appearance of smallpox or typhus in epidemic form. Disease surveillance has remained a key issue of health security and is a key component of the revised IHR 2005.

In the second phase of institutionalization of health diplomacy (1919–1948), health became part of the remit of the first multilateral and multipurpose organization. The League of Nations was created in 1919 by
44 states; its establishment marked the beginning of a new phase of diplomacy for settling international disputes, ensuring peace, and solving problems common to all by taking an “institutionalized” approach to international affairs. As one of the problems common to all, health was included in the Covenant of the League; Article XXIII(f) provides that members would “endeavor to take steps in matters of international concern for the prevention and control of diseases.” This provision led to the creation of a health office within the League of Nations. For health, the hope was that the broad multilateral platform of the League would provide the means for dealing with the scale and urgency of health problems after WWI. For example, the great influenza pandemic of 1918–1919 was estimated to have killed 15–20 million people and, in 1919, almost 1.6 million people died in the former Russian Empire as a result of a typhus epidemic. Death and disease in the colonies were not yet a priority of the Member States of the League, even though the first institutes of tropical medicine had been established to conduct research, develop therapeutics, and preserve the economic viability of colonial enterprises through health interventions.

Action was hampered from the start by the fact that the United States did not join the League of Nations but continued to work through the OIHP on quarantine issues. The League developed a permanent epidemiology office to collect and disseminate data on the status of international epidemics (through the *Weekly Epidemiological Record*) and created technical commissions on malaria, cancer, typhus, leprosy, and biological standardization. Between the two world wars, the world had two international health offices — both of them weak and not well-resourced and, for political reasons, not well-coordinated — as well as some important regional bodies such as the Pan American Sanitary Bureau. During WWII, the work of the two health organizations was rendered impossible. The devastation during and the health challenges following WWII led the UN Economic and Social Council, at its first meeting in 1946, to call an international conference to consider the establishment of a single health organization under the UN. The intention was that such an organization would prove to be more effective if it was not subsumed under the political UN as an office, but if instead it worked as an independent, specialized technical agency with its own governing body, the World Health Assembly (WHA).
The third phase of institutionalization of health diplomacy (1948–1996) was decisive in its evolution. The International Health Conference convened under the auspices of the UN in New York on June 19, 1946. It adopted a most forward-looking constitution for the WHO, which would carry on the functions previously performed by the League and the OIHP. The WHO constitution would balance technical expertise and political decision-making by differentiating the functions assigned to the WHO’s Executive Board (a meeting of experts) and its Assembly (a meeting of states). A cosmopolitan moment, i.e. a major disease outbreak — a cholera epidemic in Egypt — again helped push the agenda forward, and the number of countries ratifying the WHO’s constitution grew quickly. The first WHO assembly convened in Geneva in June 1948; for the first time in history, there was a single international organization with the broad mandate to “act as the directing and coordinating authority on international health work.” A new, permanent venue for health diplomacy had been established in Geneva, bringing together all nation-states as members with equal representation (one country, one vote), which gave the organization a high level of legitimacy. The range of countries and their equal representation, as well as its broad mandate, differentiated the WHO from all other previous health organizations and underlies its convening power. For nearly 50 years, it remained at the center of all international health work.

The representation of countries in this new body gradually moved from diplomats to representatives from ministries of social affairs and then to ministries of health, which were increasingly important within the governments of Member States. The trans-boundary vision that had driven the International Health Conferences emerged in the successful drive to eradicate smallpox by 1976, but it became increasingly difficult to overcome national interests to reach other joint global goals. WHO Member States instituted important political commitments, such as the Health For All Strategy, adopted in 1977, but health remained very much a purely national rather than global concern, as health systems were established, colonies won their independence, and the industrialized countries celebrated the “victory” over infectious diseases. Many debates were hampered by the ideological positions of the two blocs of Cold War adversaries, which juxtaposed socialized medicine with the system of private health care. Furthermore, the opportunity provided in the WHO constitution to
develop health treaties was not utilized; the organization came close only when, as a remarkable exception, the WHA adopted, in 1981, The International Code of Marketing of Breast-Milk Substitutes.\textsuperscript{62} The International Sanitary Regulations (inherited from the OIHP) remained the sole binding instrument for international health agreements. They were adopted, revised, consolidated, and renamed The International Health Regulations in 1969. Further amendments followed in 1973. In 1995, the WHO and its Member States agreed on the need to revise the IHR because of their inherent limitations, but no agreement could be reached to move forward until the 2003 SARS epidemic, as described above.

Whereas the ISCs had been created because of a heightened awareness of the pressures of globalization in the 19th century and the recognition of interdependence, 100 years later it seemed to many that the existing organization, the WHO, could no longer meet the political and technical challenges of a new era.\textsuperscript{63} The diplomatic community was focused on the new global challenge of the environment, with major negotiations being conducted within the 1997 Kyoto Protocol. In the period of transition from international to global health,\textsuperscript{64} health came into focus at other venues, such as the World Trade Organization and the World Bank. A quantum leap made health move up the ladder to become a prime concern of social justice and international development — the cosmopolitan moment drove the emergence of the global movement to fight a new and deadly disease, HIV/AIDS.

The period of the diversification of health diplomacy began. The new health diplomats were the AIDS activists and the representatives of the development agencies. For them, the institutionalized forum of the WHO did not deliver what was necessary — neither the capacity to implement programs nor the political clout to effect changes in attitudes or in funding. At this point, the 20th century system of health diplomacy was in crisis, and the technical and the political world of health were out of touch with each other. Major powers were no longer committed to universal membership organizations or to multilateralism, and the world’s expert body for health, the WHO, had not been able to respond adequately to the AIDS crisis. It was deeply symbolic of this crisis that the WHO’s program on HIV/AIDS was shut down, and a new agency, UNAIDS, was established in 1996.
What has followed is the fourth phase of institutionalization (1996 to the present), which can be described as the establishment of an “unstructured pluralism” of agencies and actors in what had become a global health arena. This phase could also be considered one of transition, within which GHD has not yet found a functional architecture. Thus, an institutional form needs to be identified for the polylateral health diplomacy of the 21st century. In the late 1980s and the 1990s, there was a move away from the state-centric approach of the international organizations to mechanisms that could act more rapidly, could generate more resources, were more accountable, and allowed the inclusion of other actors. The private sector was promoted as being more effective and efficient in action, and this led to the creation of new types of organizations and mechanisms, such as public–private partnerships, involving large philanthropic organizations. The ability to achieve results — to “deliver” and to provide “more health per dollar spent” — became a key concept. As Bull and McNeill wrote, “Market multilateralism brought the norms of multilateralism and the interest of market actors together.” Such approaches were new for the health sector, but had been practiced conceptually in the field of environmental diplomacy from the very beginning of global negotiations on these issues.

At the same time, civil society and the social justice agenda became central in the global health arena. For a short period, analysts saw the system of diplomacy changing drastically toward a “post-Westphalia” world, in which states were increasingly losing power and multilateral organizations that had been built on state sovereignty were outdated. New organizations were created to take their place or to take on governance functions required in the new environment. In this phase, reference would frequently be made to the global environmental issue, which had made it to the top of the international agenda and was taken very seriously by heads of state. The global environmental agenda involved a host of international agreements, treaties, protocols, and advocates, and it had significant economic implications for trade, development, and long-term human security. Yet it did not have an intergovernmental organization such as the WHO to act as an organ of policy-making and debate. Questions were raised as to whether the institutional form of the state-based, universal, multilateral health organization was still workable, and an extensive debate on global health governance was conducted in order to search for alternatives in the global health architecture.
Major Factors in Environmental Diplomacy

The environment is often referred to as an exercise in global governance, having emerged in the latter part of the 20th century. It moved ahead, while GHD seemed to stagnate. Young emphasized that the challenges at hand were addressed with innovative approaches to regime formation; these approaches did not require the establishment of new centralized, international, state-based organizations. Instead, mechanisms were developed that included both civil society and the private sector in agenda-setting, negotiation, and operationalization of policies. This development meant that the environmental agenda was not hampered by state-centric rules. The 1992 Earth Summit and the 1997 Kyoto Protocol became symbols for the new global practice of diplomacy and indicators of what it can achieve.

A description of the rationale for environmental diplomacy from 1998 captures the essence of this new field of diplomatic activity: “Environmental policy has become one of the pillars of international cooperation in the post-Cold War era. Environmental regimes are intertwined with other areas of cooperation such as the international trade system and global financial institutions. The relationship between international environmental regimes and other multilateral treaties and institutions is characterized by conflict as well as by cooperation. In the past, economic interests have often prevailed over environmental considerations.” Environmental diplomacy set out to change the economic perspectives in favor of the environment and, for the health sector, this change was also necessary.

US Ambassador Richard Benedick, in his classic analysis of environmental diplomacy, described the multilateral negotiations that addressed global environmental issues. These negotiations began with the 1985 Vienna Convention on Protecting the Ozone Layer and reached their pinnacle at the 1992 UN Conference on Environment and Development (UNCED) in Rio de Janeiro, also known as the “Earth Summit.” UNCED was the largest gathering of heads of state ever held; nearly 180 nations participated, including 118 at head-of-state level. In addition, there were dozens of UN organizations and other intergovernmental organizations, plus thousands of observers who represented hundreds of nongovernmental organizations (NGOs), as well as extensive media representation.
The Kyoto Protocol, an international agreement linked to the UN Framework Convention on Climate Change, was adopted in on December 11, 1997, and it entered into force on February 16, 2005. It is generally seen as an important first step toward a truly global environmental regime, and it provides the essential architecture for any future international agreement on climate change. Its major feature is that it sets binding targets for 37 industrialized countries and the European community for reducing greenhouse gas emissions; whereas the Convention encouraged industrialized countries to stabilize these emissions, the Protocol commits them to do so. The Kyoto Protocol places a heavier burden on developed nations under the principle of “common but differentiated responsibilities.”

UNCED 1992 was a watershed: not only did it set the precedent for other global conferences and negotiations that were to follow, but it also shifted the responsibility for negotiations on environmental issues to the ministries of foreign affairs. Furthermore, it began to engage many other sectors of government, notably finance, economics, science, energy, agriculture, and development. This pattern was to repeat itself as global health gained in political importance. It became clear that these increasingly complicated negotiations required not only expertise in complex subject matters but also insights into the impact of health on the economy, agriculture, and human security. This complexity requires knowledge of international law and its instruments, an understanding of global power dynamics, and a well-honed set of negotiation skills. Benedick highlighted the five major factors that distinguish the new environmental diplomacy: (1) the nature of the subject matter; (2) the role of science and scientists; (3) the complexity of the negotiations; (4) the unique equity issues involved; and (5) the innovative features and approaches. These factors can clearly be applied to GHD.

Factors that Characterize Global Health Diplomacy

Five factors characterize GHD and are of a very similar nature to those described for environmental diplomacy:

(1) *The nature of the subject matter.* That is to say, health is a transboundary concern for all nations, and it requires joint action.
(2) *The role of science and scientists.* That is to say, the response to the spread of disease is heavily dependent on an understanding of the causes of the disease, and the productive interface between diplomats and health experts is critical to successful health negotiations.

(3) *The complexity of the negotiations.* That is to say, the interface between diplomacy and science, the multilevel, multifactor, and multiactor negotiations and the repercussions for trade and commerce, power relations, and values all make for complicated negotiations.

(4) *The unique equity issues involved.* That is to say, equity has been a driving force of the global health agenda since its inception, but it has gained force with the adoption of the MDGs, and a range of global health strategies deal with equity issues in specific ways, such as differential pricing.

(5) *The innovative features and approaches which characterize global health.* That is to say, throughout its history, in each institutional phase, health diplomacy has been highly innovative in developing methods, instruments, and organizational forms.

Many of the experiences gained in the field of environmental diplomacy have informed and inspired approaches to global health in its fourth institutional phase: involvement of the private sector, regime building through framework conventions, differentiated responsibilities, and strong involvement of civil society. The greatest difference between environment and global health negotiations lies in the difference in institutionalization and in the extent of the involvement of the private sector. The Kyoto Protocol, for example, allows for market-based mechanisms, such as emissions trading, and encourages the stimulation of green investment. With respect to global health, there has been a more critical approach to the private sector, and only recently have market-based approaches to global health investments gained broader acceptance. These include private–public partnerships, economic incentives for essential medicines, and negotiated agreements on drug pricing and technology transfer.

The Copenhagen Climate Summit in 2009, which served as a followup to Kyoto, raised questions about the kind of multilateral negotiation system that can bring results. Copenhagen clearly was a diplomatic
failure; it could be argued that an experienced secretariat and an accepted set of rules of procedure might have provided a better framework than the *ad hoc* multilateral conference approach that was taken. Surely, the summit would not have authorized a separate “Big Power conference” within the 170-member assembly; this exclusivity was a slap in the face of the “open diplomacy” on which the creators of the multilateral system in 1919 had pinned their hopes. It ignored the power shifts in global health and environmental leadership that have become so important to 21st century diplomacy.

Defining Features of 21st Century Health Diplomacy

As outlined above, the beginning of the 21st century has seen great changes in diplomacy, and global health is one of the areas in which this transition is most visible. The rules, norms, and expectations of the global health system are in a period of rapid transition. They can best be summarized as three parallel power shifts.

Three Parallel Power Shifts

The first of these power shifts is that between nations. It marks the transition to a multipolar world, in which an increasing number of power centers exist. There is an ever-growing presence in the global health policy arena of low- and middle-income countries, such as Kenya, Mexico, Brazil, China, India, Thailand, and South Africa. The second power shift marks a transition beyond nations. Although states remain strong and important players, various non-state actors from the private sector and civil society have entered the global health field and have radically changed the global architecture. The third of the power shifts takes place within nations, and it has to do with the continua between domestic and foreign policies and between hard- and soft-power issues. Health is now part of economic and foreign policies, and foreign policy agreements on health can have a significant impact on national health systems. These power shifts correspond directly to the three defining features of 21st century diplomacy.
The power shift between nations

Health diplomacy functions within a multipolar world and within a multi-level and multidimensional global governance structure, which increasingly includes the regional level. The more power centers there are, the more important the consultation, negotiation, and coalition-building become. As more and more countries learn to take advantage of the decision-making and political power of international platforms, multilateral organizations acquire new strength. Together with the emergence of new economic powers, bridge-building roles become increasingly important at multilateral venues. The new multilateralism promises success to those who are most able to show commitment, gather broader support, and form coalitions. In this context, health can be viewed as an instrument for deepening the relationships between different nations and as a stable basis for building alliances.

This multipolar world order influences the dynamics of health diplomacy. In an interconnected world, in which diseases can spread faster than ever before but also in which a growing understanding of the responsibilities of a global community exists, countries become increasingly aware of the need to cooperate on global health. They do so, however, in changing constellations within which they aim to find their place and their spheres of influence in what is often referred to as a “geopolitical marketplace.” A new geography of power emerges, and common challenges can develop new groupings of nation-states or divide earlier groupings.

The new global health arena is marked by the growing influence of emerging economies such as Brazil, Russia, India, China, and South Africa (known as “the BRICS”); they have reached a tipping point of power in relation to global agendas. With growing discursive and resource-based power, they use their diplomatic influence to include health in their strategic arsenal. China, for example, has more than 300 bilateral cooperation agreements with more than 89 countries and has provided medical teams in Africa since the 1960s. Brazil is “successfully leveraging its model fight against HIV/AIDS into expanded South–South assistance and leadership,” in service of its own foreign policy objectives for reform of the UN Security Council and a louder voice in the international monetary system.
At the same time, low- and middle-income countries are increasingly discovering and using the opportunities provided by regional and broader international platforms. The thinking in terms of well-defined North–South divides is more frequently challenged, as discussed during the UN High-Level Conference on South–South Cooperation in Nairobi in December 2009. The 4th Summit of the India–Brazil–South Africa (IBSA) Dialogue Forum in April 2010 illustrated the enhanced role of developing countries and the increasing dialogue among them. The IBSA facility fund, with US$3 million targeted annually for South–South development, is exemplary for leading the changing roles in South–South cooperation. The Africa–South America (created in 2006) and Africa–India (from 2008) summits also are illustrative of this development. Since 2011 the BRICS countries have also organized their own health summits.

The past two decades have also seen an increasing role for regionalism. Regional actors such as the EU, the African Union, the Common Market of the Southern Cone, the Shanghai Cooperation Organization, the Association of Southeast Asian Nations, the Asia–Pacific Economic Cooperation program, the Asia–Africa Summit/Focus on China–Africa Cooperation, the Union of the South American Nations, and the Central Asia Regional Economic Cooperation program are all expanding their program of work and at the same time putting health issues on their agendas. Cooperative activities include intergovernmental meetings and common declarations and strategies on health; the goals of the activities include addressing the social determinants of health, supporting access to medicines, enhancing human resources for health, and creating new surveillance, response, and pharmaceutical capabilities. The EU Member States have, for example, created the European Centre for Disease Prevention and Control. The African Union scaled up its activities on health issues, as reflected in the annual reports on the MDGs, the development of human resources for health, and the Global Health Workforce Alliance. The Asia–Pacific Economic Cooperation program established a Health Task Force in 2003, which became a Health Working Group in 2007, with the mandate to implement health-related activities agreed upon by the organization. However, the consequences of this expanded dialogue and increased cooperation go much further than health. They create habits of communication and, where possible, cooperation among countries, and thus they provide a basis for improved relationships overall.
The power shift beyond nations

Health diplomacy is no longer conducted only by professional diplomats; and it is challenged to manage not only the relations between states but also the relations between states and other actors. It is unique, in that it has a universal, multilateral organization with treaty-making power at its disposal.

In the rapidly changing international context of the 21st century, diplomacy engages a very large number of players. In the words of Haas,\textsuperscript{76} “a world dominated by dozens of actors, processing and exercising various kinds of power” has begun to take shape. Today, the practice of diplomacy no longer resides solely with traditional diplomats but also involves a wide range of other actors.\textsuperscript{33} A growing and increasingly diverse group beyond the nation-states has emerged and profoundly changed the global health landscape. On the global health stage, an ever-greater variety of civil society and NGOs, private firms, and private philanthropists work along with (and sometimes challenge) traditional actors such as national ministries and the WHO.\textsuperscript{72} The increased importance of global health has captured a growing interest among philanthropic foundations, advocacy networks, think thanks, and academic institutions. The new public–private partnerships, donors, funding organizations, and other actors have all contributed to the diversification of global health activities. For example, more than 200 public–private partnerships now work on global health issues.\textsuperscript{77} In less than a decade, 60,000 NGOs have focused their work only on HIV/AIDS.\textsuperscript{78} In 2010, there were 185 accredited NGOs in official relationships with the WHO.\textsuperscript{79,}\textsuperscript{a}

Besides the fact that there has been a marked increase in the number of non-state actors that are prominent in the area of global health, the role of these actors has grown and can be linked to all stages of the policy process. They have won a firm place in providing high-quality expertise, conducting research, providing policy analysis, and engaging

\textsuperscript{a}According to the WHO document entitled “Principles Governing Relations with Nongovernmental Organizations,” NGOs in official relationships with the WHO “shall be in conformity with the spirit, purposes, and principles of the Constitution of WHO, shall center on development work in health or health-related fields, and shall be free from concerns which are primarily of a commercial or profit-making nature.” For more information, see http://www.who.int/civilsociety/relations/principles/en/index.html.
in advocacy. They have been instrumental in providing educational opportunities and designing training programs, and they are particularly useful for efforts to bridge the capacity gap in low- and middle-income countries. Mobilizing resources and establishing field capacity has proven to be among their strengths in the fight against HIV/AIDS, malaria, polio, and many other global health challenges. NGOs also have provided expertise in program monitoring and evaluation, activities that increasingly are required in the era of private–public partnerships and new business-like models for health investment. Such capacities may influence different stages of the global decision-making process. The negotiations for the WHO Global Code of Practice on the International Recruitment of Health Personnel and the FCTC provide a clear example of the increasingly important role of NGOs in 21st century health diplomacy. From “outsiders,” NGOs are turning into “insiders,” which have strong influence on the traditional state-centric multinational organizations and even on national governments. The outcomes of this development have not yet been sufficiently analyzed.

The diversification of players on the global level is accompanied by changing relationships among them. Innovative forms of governance are emerging to accommodate the increasingly complex interplay among the public sphere, the private sphere, and civil society. As Held et al. wrote, “Nation-states have become enmeshed in and functionally part of a larger pattern of global transformations and global flows.” Much has been written on the hybrids of global entities and financing mechanisms that have emerged in the past decade. The key characteristic of these hybrids is probably that of the “interface,” which refers to the recurrent interaction and influence through discursive, organizational, legal, and resource transfers that take place in many transnational fora. Attracting resources and public attention, non-state actors have brought huge commitments to global health in terms of money, human resources, and expertise beyond what was expected a few decades ago. The global health enterprise has provided opportunities for innovation, creativity, entrepreneurship, rapid action, flexible alliances, and new types of partnerships. The challenges now are to address the structural implications of the (over)crowded field of global health and to ensure coherence in policy, actions, and financial sustainability.
With the evolution of the new context for GHD and the exponential increase in global health actors, the role of the WHO has often been challenged. In spite of the huge financial power that single non-state actors such as the Bill and Melinda Gates Foundation may bring, however, the WHO still provides the legitimacy for global collective action. It has universal membership that is open to all nation-states; its annual assembly is an unparalleled forum for discussion among the 193 Member States; and that forum provides a venue at which large and small countries can debate on an equal basis. The wide range of governance instruments at its disposal, including its treaty-making power, reinforces the leadership role that the WHO must play in global health. It is the agency tasked with ensuring global health stewardship, country support, and global health governance, albeit at the cost of a high degree of bureaucratization and politicization. Yet, the WHO needs to seriously consider how to better engage non-state players in a more transparent and rules-based approach to the negotiations that are conducted at the WHO.

The power shift within nations

For GHD, the intersection between the national and global levels becomes increasingly important. It encompasses a much closer interface between domestic and foreign policy and demands cooperation among a wide range of national sectoral ministries.

As Slaughter wrote, “Understanding ‘domestic’ issues in a regional or global context must become part of doing a good job. Increasingly, the optimal solution to these issues will depend on what is happening abroad, and the solutions to foreign issues, in a corresponding measure, [will depend on] what is happening at home.” National systems are core components of the global system. This shift also applies to health: global health begins and ends “at home.”

In response to the need to address the interface between national and global health issues, countries are exploring new mechanisms for policy coherence. Consistency is sought in two directions: first, across government sectors and the work of different ministries and, second,
between national interests and global responsibilities. Switzerland\textsuperscript{83} and the United Kingdom\textsuperscript{84} provide clear examples of such approaches. Other countries are preparing similar strategies and exploring other mechanisms to build the basis for coherence in the national approaches to global health. A more consistent approach to health policy on the national level and the improved coordination among the ministries are key to addressing global health challenges. Such an approach guarantees that national interests and international responsibility are balanced. It also helps ensure that any agreements reached on the international level will have the required political support within the country, so that they may be successfully implemented.

\section*{Conclusion}

As stated at the beginning of this chapter, the UNGA Resolutions on Global Health and Foreign Policy\textsuperscript{1–4} have ushered in a new phase of Global Health Diplomacy. Ministers of foreign affairs have affirmed the political realm of global health and, in the process, reinforced the significance of multilateral organizations as a platform for negotiations on global health. Of most interest is the question of how to balance the health agenda between the UNGA as the global political body and the WHO as the global technical organization. Politics and technical capacity have come together under the rubric of GHD as never before.

To some extent, however, health diplomacy has come full circle. In 160 years, it has moved from a political arena to a technical agenda and then back to a political arena of negotiation; it has also returned to the UN and to “open diplomacy,” not as an operational institution, but as a political priority at the highest level of the UN. The UN Security Council and the UNGA deliberate on health, as illustrated by UNGA Resolutions 63/33,\textsuperscript{1} 64/108,\textsuperscript{2} 65/95,\textsuperscript{3} and 66/115,\textsuperscript{4} of 2008, 2009, 2010, and 2011. As a result, the UN Secretary-General appointed a UN System Influenza Coordinator, and the UNGA devoted special sessions to HIV/AIDS and, in 2011, conducted a special session on noncommunicable diseases. Health is also at the heart of the MDGs, the leading framework for UN efforts to advance human development. Health is the specific subject of three of these goals and forms “a critical precondition for progress on most of them.”\textsuperscript{85}
In addition, the UN Secretary-General has identified the challenge of making people’s lives healthier to be a touchstone for the effectiveness of UN reforms (Ref. 5, para. 49). Health has also become a major issue for many other multinational bodies, such as the World Bank Group, the WTO, the World Intellectual Property Organization, the UN Children’s Fund (UNICEF), the UN Environment Programme, and the UN Commission on Human Rights.

The deeper relevance of the UN Resolutions on Global Health and Foreign Policy is that they emphasize both the core relationship between health and foreign policy in the 21st century and the dynamic role of diplomacy in supporting health. This perspective suggests the direction that the new phase of institutionalization of global health must take: health must become an integral part of foreign policy. In addition, foreign policy needs to be driven by the new mindset that accepts the diplomatic corps’ double responsibility: that for one’s own country and that for the global community. These responsibilities are the challenge for health diplomacy at the beginning of the 21st century.

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