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briefing paper

Assessing the Foreign Policy and Global Health Initiative: The Meaning of the Oslo Process

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Summary points

- The Foreign Policy and Global Health Initiative (FPGHI) is one of the most well-known efforts aimed at increasing health's importance in foreign policy. The FPGHI and its Oslo Ministerial Declaration gained prominence by reflecting health's rise as a foreign policy issue that was under way before the FPGHI's launch in 2006.
- The FPGHI emphasized 'global health security' to frame the link, proposed health as a 'defining lens' for foreign policy and developed an ambitious agenda. It has stimulated interest on global health and foreign policy in the United Nations General Assembly.
- Assessing the FPGHI's importance is difficult because it has not provided regular information about its activities or critically analysed its performance. External assessments are also lacking. On the available information, the FPGHI's impact appears limited, and other initiatives, processes, mechanisms and actions have had more impact in elevating health in foreign policy.
- The FPGHI 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 in many countries and geopolitical shifts in the distribution of power. Clarifying and deepening the meaning of the Oslo process would require more information and insight on how it has managed the dilemmas presented by pursuing health objectives in foreign policy.

Introduction

The Foreign Policy and Global Health Initiative (FPGHI), launched by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand in 2006, and the subsequent Oslo Ministerial Declaration of 2007, have developed an iconic status in the study of health as a foreign policy issue. The FPGHI and Declaration recognized the growing importance of health issues in foreign policy and established a process to make them a strategic foreign policy concern. With the fifth anniversaries of the FPGHI and Declaration approaching, this effort deserves scrutiny as part of the larger, ongoing attempt to understand the place of global health issues in foreign policy.

The FPGHI and the Oslo Declaration reflected a growing foreign policy awareness of global health challenges in the first decade of the 21st century and declared that global health 'is a pressing foreign policy issue of our time'.[1] The rise of health as a foreign policy concern of many nations began in the 1990s and had developed sufficient momentum by the FPGHI's launch in 2006 to be widely recognized as something new and controversial. The Oslo process gained prominence largely by harnessing and trying to continue this momentum through strategic foreign policy action. The FPGHI acted, for example, as a catalyst for adoption of resolutions on foreign policy and global health by the United Nations General Assembly.[2]

However, the FPGHI's impact does not appear to match its iconic stature. Assessing the FPGHI is difficult because it has not disseminated much information about its activities and external analyses of this process are lacking. Based on what is available for review, and compared with other initiatives and processes, the FPGHI and Declaration have not left a great mark on the relationship between foreign policy and health.

This apparent lack of impact on the relationship between foreign policy and health arises partly from the process itself. The FPGHI and Oslo Declaration overestimated the impact 'health' has on foreign policy. More importantly, the FPGHI's problems flow from the deterioration, after 2006–07, of the conditions that had made health more important in foreign policy during the previous 10–15 years. The Oslo process emerged just as health policy-makers began to confront daunting foreign policy problems reflecting crises in food, energy, climate change and finance. Now and for the foreseeable future, the FPGHI – as a diplomatic process – holds little promise for making health strategically critical to countries' foreign policy interests. It captured a moment in time that has passed, perhaps for good. Without better access to what the foreign ministers have actually done and learned under the FPGHI, future efforts to sustain health as a foreign policy concern should not expect much from the FPGHI and are best served by exploring other avenues of potential progress.

Before Oslo: the rise of health as a foreign policy issue[3]

When the FPGHI was launched in 2006, the rising profile of health as a foreign policy issue had generated significant attention, but little consensus on its meaning and importance. Between 1995 and 2005, policy-makers began to address health challenges more frequently and prominently than before. Prior to the FPGHI, efforts were well under way to understand and handle the foreign policy implications of emerging and re-emerging infectious diseases, the HIV/AIDS pandemic, biological terrorism, the probability of an influenza pandemic, health-related aspects of development, tensions between trade and health objectives, the health consequences of conflict and humanitarian crises, pandemics of tobacco- and obesity-related diseases, the impact of non-state actors on global health agendas, and human rights aspects of health. The foreign ministers participating in the FPGHI recognized this reality by

1 Celso Amorim et al., 'Oslo Ministerial Declaration global health: a pressing foreign policy issue of our time', *Lancet* (2007), 369: 1373–78, p. 1373 [hereinafter 'Oslo Ministerial Declaration']. This *Lancet* article contains three documents – referred to collectively in this paper as the 'Oslo documents' – a statement, background note and the Oslo Ministerial Declaration.

2 The briefing paper examines these resolutions and their importance below.

3 This section draws on David P. Fidler, 'Rise and fall of global health as a foreign policy issue', *Global Health Governance* (2011), 4(2): http://www.ghgj.org/Fidler4.2.htm.

observing that the 'early 21st century … has seen an unprecedented convergence of global health and foreign policy'.[4]

Their initiative, however, did not analyse this controversial convergence beyond describing general 'drivers of change'– technology, HIV/AIDS, civil society involvement, new governance processes and increased social inequalities – that led to more foreign policy action. While foreign policy-makers' consideration of health had grown, this development produced divergent perspectives on what the attention meant and where it would lead.[5] These perspectives revealed disagreement about the meaning of a conundrum – health's rise in foreign policy meant that it was seen as more politically important than in the past, yet it was still politically neglected in the present. Consensus did not exist on whether the newly acknowledged political importance should or could transform neglect into effective policy actions.

The pre-FPGHI rise of health in foreign policy requires scrutiny as part of assessing how the FPGHI framed the issue and what the Oslo Declaration provided as a strategy. Foreign policy has long addressed health issues, and two historical patterns are particularly prominent:

- Foreign policy responses to specific health threats, such as the cross-border spread of communicable diseases, that generate international problems; and
- Foreign policy uses of health-related cooperation to pursue non-health objectives, such as utilizing health assistance to increase a state's influence or secure better relations with other states.

The need for foreign policy-makers to address specific health threats was established in the mid-19th century when European countries attempted to deal with the spread of cholera, plague, and yellow fever by negotiating international sanitary treaties. Communicable disease threats have dominated foreign policy attention, although countries have also addressed cross-border transmission of pollutants, trade in dangerous products (e.g. food contaminated with toxic chemicals), and the need for harmonized standards for occupational safety and health. The increase in foreign-policy attention on health flows from the proliferation of issues that causes problems for inter-state relations, in particular involving the threat of communicable diseases.

> 'States have also long included health in strategies in the international competition for power and influence'

States have also long included health in strategies in the international competition for power and influence. During the Cold War, rival states – including the United States, the Soviet Union and China – engaged in health diplomacy, cooperation and assistance to boost their geopolitical positions and ideological ambitions. For example, the Soviet Union's push in the 1970s to host a conference on primary health care (eventually held in Alma-Ata in 1978) was motivated by the desire to 'demonstrate to the underdeveloped world that their form of socialism could accomplish what other political systems could not'.[6] This motivation can also be seen over the past 10–15 years in assertions that health constitutes part of 'soft' or 'smart' power that states can exercise in pursuit of their national interests.

These historical patterns show that much of the 'unprecedented' rise of health in foreign policy

4 'Oslo Ministerial Declaration', p. 1373.

5 See, for example, David P. Fidler, 'Germs, norms, and power: global health's political revolution', *Journal of Law, Social Justice & Global Development* (2004), http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/fidler/, which argues that global health's new political profile is enigmatic; and David P. Fidler, 'Health as foreign policy: between principle and power', *Whitehead Journal of Diplomacy and International Relations* (Summer/Fall 2005), pp. 179–94, which describes competing perspectives on health's rise in foreign policy.

6 Socrates Litsios, 'The long and difficult road to Alma-Ata: a personal reflection', *International Journal of Health Services* (2002), 32(4): 709–32.

contained as much continuity as novelty. The foreign ministers launching the FPGHI identified this problem in arguing that, despite more foreign policy attention, health remains 'one of the most important, yet still broadly neglected, long-term foreign policy issues of our times'.[7] This perspective was more sobering than claims made at the same time about health's ability to transform the nature of foreign policy and diplomacy. In many respects, the FPGHI echoed simultaneous efforts by policy-makers, academics and think-tanks to understand better how and why states incorporated health into their foreign policies and engaged in diplomacy on health problems.[8]

> 'The FPGHI's target is this episodic, erratic pattern in health as a foreign policy issue'

Such efforts were necessary because both the health and foreign policy communities had previously ignored the health–foreign policy relationship, mainly owing to a long-standing perception that health constituted part of the 'low politics' of international relations – problems that did not seriously affect the core interests of states in security, power and influence. States exploited health cooperation when useful in their foreign policies, but this pattern exhibited no belief that such cooperation was, by itself, strategic. Rather, such moves viewed health cooperation as 'low hanging fruit' with little risk but also limited benefit. Foreign policy and diplomatic responses to direct health threats – usually from a communicable disease – also did not keep health consistently high on political agendas; it was subject to brief bursts of foreign policy attention, followed by sustained marginalization and neglect.

The FPGHI's target is this episodic, erratic pattern in health as a foreign policy issue. The foreign ministers declared: 'We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda'.[9] This paper now turns to explore how the FPGHI proposed embedding health as a strategic foreign policy issue.

Building Oslo: the Oslo process strategy

The FPGHI's premise is that health will not become a strategic foreign policy issue without leadership from policy-makers. This position subordinates health to the politics of foreign policy and creates the need to frame it in ways that will sustain traction within such politics. Thus, the FPGHI had to explain *why* states should pay strategic attention to health and *how* such attention could be translated into action. It identified 'global health security' as its strategic concept, proposed health as a 'defining lens' for foreign policy and developed an 'Agenda for Action' to deepen the foreign policy contribution to global health.

Global health security

Aware of health's neglect in foreign policy, the ministers establishing the FPGHI knew they had to ground their initiative in concepts meaningful to policy-makers. The concept selected was 'global health security'. Its centrality is apparent in the Oslo Declaration, which emphasizes the importance of 'capacity for global health security', 'threats to global health security' and 'governance for global health security'.[10] The choice to frame health as a security issue is not surprising, but it is problematical.

Analyses of the rise of health as a foreign policy issue prior to the FPGHI had begun to assess how health problems were appearing more frequently in key functions of foreign policy – protecting national security, strengthening national economic power, assisting development in strategic regions and countries, and

7 'Oslo Ministerial Declaration', p. 1373.
8 As illustrated by the theme issue on health and foreign policy in the *Bulletin of the World Health Organization* in March 2007.
9 "Oslo Ministerial Declaration', p. 1373.
10 Ibid., pp. 1375, 1376, 1378.

promoting human dignity.[11] In descending order, these objectives form a hierarchy of foreign policy interests. Health issues historically tended to be part of the 'low politics' in international relations because they clustered in the development and human dignity agendas at the lower end of the hierarchy.

Efforts to connect health with security were under way before the FPGHI. For example, the World Health Organization (WHO) argued that revising the International Health Regulations – a process started in 1995 to improve responses to serious cross-border disease events – would strengthen global health security.[12] Efforts were also made to frame the HIV/AIDS pandemic as a threat to national and international security.[13] Concerns about biological weapons and terrorism elevated the security importance of public health.[14] Pandemic influenza came to be perceived as a national and international security threat.[15] This 'securitization' phenomenon laid bare the political calculations behind the elevation of health's foreign policy importance and exposed controversies created by linking health and security.[16]

Such controversies are evident in the Oslo Declaration: even though it uses global health security as its main organizing idea, it states that the 'concept of "global health security" has yet to be defined'.[17] It then proceeds to define global health security as 'protection against public health risks and threats that by their very nature do not respect borders'.[18] However, this definition is broad, potentially encompassing health risks that foreign policy-makers do not regard as security threats. This definition connects to the malleable idea of 'human security' mentioned in the Oslo background note – a concept that has featured in the securitization of health and generated its own controversies. The broad definition in the Oslo Declaration also perhaps reflects disagreement among the seven countries about what 'global health security' should mean, which may have resulted in a lowest-common-denominator definition to produce consensus.

A closer reading of the Oslo documents reveals that the ministers were, in fact, trying to establish health's importance in all the key functions of foreign policy. Although their use of security is ubiquitous, they were not simply relying on security arguments. In the background note, the foreign ministers argued that health is interconnected with national security, economic growth, development and human dignity – thus building a broad-based case for foreign policy action on health.[19] Global health security becomes an umbrella concept for this attempt to connect health concerns with numerous foreign policy interests.

In general, the FPGHI followed existing ideas in framing health as a foreign policy issue. The ministers linked health concerns with core functions of foreign policy and appealed to ideas of security to frame the overall approach. One reason why the FPGHI gained such attention was the prominent way it reflected already prevalent ideas.[20]

11 See, for example, David P. Fidler, *Health and Foreign Policy: A Conceptual Overview* (Nuffield Trust, 2005), http://www.nuffieldtrust.org.uk/ecomm/files/040205Fidler.pdf.

12 See, for example, World Health Assembly resolution WHA54.14, *Global Health Security: Epidemic Alert and Response*, 21 May 2001, which expresses support for revision of the International Health Regulations.

13 United Nations Security Council resolution 1308, 17 July 2000, which stressed 'that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security'.

14 See National Intelligence Council, *The Global Infectious Disease Threat and its Implications for the United States*, NIE99-17D (January 2000), pp. 59–60.

15 See Laurie Garrett, 'The next pandemic?', *Foreign Affairs* (July/August 2005): 3–23.

16 For recent analyses on the intersection of health and security, see the special issue of *Global Health Governance* (2011), 4(2): http://www.ghgj.org/Volume%20IV%20Issue%202.htm.

17 'Oslo Ministerial Declaration', p. 1375.

18 Ibid. Compare with the WHO's narrower definition of 'global public health security' as 'the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries'. WHO, *World Health Report 2007: A Safer Future – Global Public Health Security in the 21st Century* (Geneva: WHO, 2007), p. ix.

19 'Oslo Ministerial Declaration', p. 1373.

20 Ronald Labonté and Michelle L. Gagnon, 'Framing health and foreign policy: lessons for global health diplomacy', *Globalization and Health* (2010), 6 (14), http://www.globalizationandhealth.com/content/6/14.

However, this reflection did not include grappling with the problems of considering health as a foreign policy concern in security, economic, development and human dignity contexts. Nor did it include awareness of the use of health as an instrument of 'soft power' by states. Instead, the Oslo Declaration discusses the 'challenges of growing interdependence', the need for 'new paradigms of cooperation' and the importance of 'shared values' and 'a sense of shared responsibility'.[21] But, by this point, the rise of health within foreign policy had already demonstrated the difficulties of such rhetoric. Health's new prominence in foreign policy does not reflect the harmony of interests or values emphasized in the Oslo documents; rather, it demonstrates that the more policy-makers engaged on health issues, the more these activities revealed the divergence of these interests and values, at times producing obstacles to diplomatic action for health.

Health as a 'defining lens' for foreign policy

After locating health within core foreign policy functions to establish its importance, the ministers turned to the challenge of how to make health a 'stronger strategic focus on the international agenda'.[22] The strategy contains two parts: (1) 'making impact on health a point of departure and a defining lens'[23] for foreign policy, and (2) an Agenda for Action the seven countries agreed to pursue. The idea of health as a 'defining lens' deserves scrutiny because, at first glance, it appears to cut against framing health issues in foreign policy terms, which the FPGHI did.

Discussions of health within foreign policy often refer to the 'foreign policy lens' and the 'health lens'. The foreign policy lens means looking at health issues through interests in security, economic power, development and human dignity. By engaging policy-makers through the foreign policy lens, the argument goes, officials can facilitate action that health policy communities cannot achieve on their own. The FPGHI was launched by foreign rather than health ministers, underscoring that foreign policy wields power lacking in health policy. Thus, the foreign policy lens brings something potentially productive to health, strengthening claims that it should be a strategic activity.

The health lens means looking at the motivations and consequences of foreign policy in order to evaluate its impact on health conditions or determinants of health. The health lens can, the argument goes, identify health implications of different courses of action that foreign policy-makers would not otherwise have considered. Thus, the health lens adds value by subjecting foreign policy to a health-impact assessment.

> 'The health lens adds value by subjecting foreign policy to a health-impact assessment'

The FPGHI contains a pledge to apply the health lens. The foreign ministers agreed to make 'impact on health a point of departure' for evaluating 'key elements of foreign policy and development strategies'.[24] In this vein, the Oslo background note argues that 'health-impact assessments of all foreign, trade, and defence policies would do much to advance the cause of health across governments'.[25]

Here again, the FPGHI reflects ideas already circulating in analyses of health as a foreign policy issue. The ministers applied both the foreign policy lens and the health lens in order to make health strategically important. And, again, this approach avoids hard questions identified in previous analyses of health in foreign policy. Nothing about the application of the two lenses assures the outcomes will be the same, which raises the need to reconcile the resulting dissonance.

For example, the foreign policy lens might reveal that an issue, such as increases in obesity in low-

21 'Oslo Ministerial Declaration', p. 1375.
22 Ibid., p. 1373.
23 Ibid.
24 Ibid.
25 Ibid., p. 1375.

income countries, is not important to the security, economic power or development interests of a high-income country. The health lens would consider the rising obesity-related mortality and morbidity in such countries as something foreign policy-makers need to address. Even if the two lenses produce convergence (e.g. obesity in low-income countries is a development problem), a government has to prioritize scarce political and economic capital for foreign policy interests, meaning that it might privilege HIV/AIDS treatment over obesity prevention in development policy.

Indeed, as explored below, the Oslo action agenda excludes issues, such as leading non-communicable disease (NCD) threats, that are massive global health problems. How this outcome occurs when the foreign ministers pledged to use the health lens is not clear, unless we explain this omission through the foreign policy lens – NCDs do not at present register as particularly important foreign policy issues for many countries, despite the forthcoming UN Summit on NCDs in September 2011. These observations underscore the weakness of the FPGHI's appeals to shared interests and values as the foundation for making health strategically important to foreign policy.

Agenda for Action

The Oslo Declaration contains an Agenda for Action organized under three strategic themes containing 10 action items with action points (see Table 1). The Agenda is broad and ambitious, and reflects the effort to connect health with the key functions of foreign policy. It emphasizes issues frequently identified as security concerns, such as pandemic influenza, HIV/AIDS, health and conflict, and the impacts of natural disasters and humanitarian crises. The declaration highlights the International Health Regulations (2005) (IHR (2005)) – the leading global governance regime for global health security – by supporting its use and implementation.[26]

In terms of economic interests, the Agenda for Action highlights the role of globalization in creating health problems and focuses on the trade–health nexus, asserting that a 'universal, rule-based, open, non-discriminatory, and multilateral trade system, including trade liberalization, can support global health security'.[27] Health's importance to development is stressed, particularly the need to support the UN Millennium Development Goals (MDGs). The Agenda includes human dignity concerns by, among other things, asserting that foreign policy action on human rights affects whether countries achieve national and global health security.

The Agenda's strategic themes and action items reflect many problems that drove the rise of health within foreign policy, and it captures developments in this area rather than marking out new territory. Not surprisingly, concerns about communicable diseases dominate. The concept of global health security is most closely associated with communicable disease threats, and the Agenda targets emerging infectious diseases, pandemic influenza, HIV/AIDS, tuberculosis and malaria (as reflected in the MDGs) and neglected infectious diseases.

As noted above, what is missing is any specific action item concerning major NCD problems. NCDs were on the health–foreign policy agenda by the time the Oslo process began, as evidenced by the negotiation of the WHO Framework Convention on Tobacco Control (FCTC). Other NCD problems that caused controversies before the Oslo process but are not addressed by the Agenda include diseases related to obesity and alcohol consumption. Thus, the absence of NCDs is deliberate.[28]

The NCD risks encompassed by the Agenda involve chemical and radiological threats covered by the IHR (2005) and, less clearly, NCD problems associated with conflicts, natural disasters, humanitarian crises and environmental degradation. More generally, the FPGHI's emphasis on the health lens could point to a need for

26 Ibid., pp. 1375, 1376, and 1378.

27 Ibid., p. 1378.

28 The FPGHI outlined its future agenda in a September 2010 statement, which also did not target major NCDs despite the increase in foreign policy attention on NCDs after the FPGHI's launch. See Norway Mission to the UN, 'Statement: Foreign Policy and Health', 27 September 2010, http://www.norway-un.org/Statements/Other-Statements/Statement-Foreign-policy-and-global-health/.

Table 1: Oslo Agenda for Action

Action items	Examples of action points
Capacity for global health security	
1. Preparedness and foreign policy	'Make "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.'
2. Control of emerging infectious diseases and foreign policy	'Exchange experiences and best practices on preventive and emergency response measures toward the outbreak of pandemics.'
3. Human resources for health and foreign policy	'Encourage the development of national broad plans for human resources for health, including the use of alternative models for care.'
Facing threats to global health security	
4. Conflict (pre-, during, and post- conflict, and as peace is being built)	'Recognise that health can be a good entry point to initiate dialogue across borders and to spearhead the resolution of conflict, with the sincere intention of serving the public interest and building trust and legitimacy.'
5. Natural disasters and other crises	'Ensure that priority is given to restoring a functioning health system (workforce, infra-structure, and supplies) in the aftermath of a crisis.'
6. Response to HIV/AIDS	'Take up the challenges 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.'
7. Health and environment	'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	'Use the shared interest in global public health as rationale for giving health top priority in the national and international cross-sectoral development agenda.'
9. Trade policies and measures to implement and monitor agreements	'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.'
10. Governance for global health security	'Support policies for global health security in the various foreign policy dialogue and action arenas, such as the UN, G8, arenas for economics and trade issues, and within regional and bilateral arenas.'

more attention to NCDs, but the Agenda's neglect of NCDs undermines attempts to find much traction for them.

The Agenda also addresses the health-system capacities and determinants that were part of health and foreign policy debates. One of its strategic themes is 'capacity for global health security', under which fall action items on capacity concerning national emergency preparedness, the UN Secretary-General's office, and implementation of the IHR (2005). It also identified the threat to health-system capacities posed by the 'brain

drain' of health workers migrating from low-income to high-income countries, an issue that was causing tension in global health. In terms of health determinants, the Agenda proposes action items for conflict, environmental protection, trade, development, maternal and child health issues (through the MDGs) and governance.

The content of the Agenda raises questions about the ability of the seven countries behind the FPGHI, only two of which are in the high-income bracket, to pursue such an ambitious strategy effectively. Certainly, never before had foreign ministers collectively supported making health a strategic foreign policy issue,[29] and they were aware of the limitations facing an initiative involving only seven countries.[30] Experiences gained in addressing the rise of health in foreign policy had shown that the challenges of a strategy with the Agenda's scope were enormous and getting bigger, more complicated, contentious and increasingly expensive. The foreign ministers recognized the need for greater participation because they invited other foreign ministers to join, thus offering the FPGHI as a platform for more governments to recognize the strategic importance of health to foreign policy and contribute more effective foreign policy action concerning health.[31]

Because of Oslo? Assessing the impact of the Oslo process

Assessment challenges

The FPGHI issued a statement in September 2010 entitled 'Foreign Policy and Global Health – Responding to New Challenges and Setting Priorities for the Future: The Oslo Ministerial Declaration Three Years Later and Beyond'.[32] It indicated the foreign ministers had reviewed progress, renewed commitments and focused their efforts going forward. In a related document, the ministers stated that the FPGHI had

> made significant achievements in terms of global agenda setting, contributions to the facilitation in global negotiations, and building international awareness and commitment, such as through successful resolutions in the UN General Assembly on global health and foreign policy, joint statements, and engagements in dialogues with other countries on relevant issues.[33]

Assessing what the FPGHI has achieved is difficult because, surprisingly given its emphasis on raising awareness, it has no dedicated administrative body, website or mechanism providing regular information about its activities. With the exception of the General Assembly resolutions (explored below), the lack of publicly available information makes it difficult to evaluate (1) the FPGHI's involvement in negotiations and whether this involvement affected negotiating positions and outcomes;[34] and (2) where, when, with whom, how and on what issues the FPGHI has engaged in diplomatic dialogue, joint statements, increased awareness and commitment activities on health as a foreign policy issue. Complicating such assessments is the need to separate FPGHI-driven impacts from the heightened awareness of and activities on health in

29 Sigrun Møgedal and Benedikte L. Alveberg, 'Can foreign policy make a difference to health?', *PLoS Medicine* (2010), 7(5): http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000274.

30 See Norway Mission to the UN, 'World Health Day, Opening Remarks of Foreign Minister Jonas Gahr Støre', 29 September 2008, http://www.norway-un.org/News/Archive_2007/20070409_whd_St%C3%B8re/. The foreign minister of Norway stated that 'seven foreign ministers cannot "change the world" alone'.

31 The FPGHI invited 'Ministers of Foreign Affairs from all regions to join us in further exploring ways and means to achieve our objective'. 'Oslo Ministerial Declaration', p. 1373.

32 'Statement: Foreign Policy and Health'.

33 Norway Mission to the UN, 'Foreign Policy and Global Health Concept Note', 22 September 2010, http://www.norway-un.org/PageFiles/419904/FPGH_breakfast_Concept_Note_2_2.pdf. See also Møgedal and Alveberg, 'Can foreign policy make a difference to health?', p. 1, noting that the FPGHI approach 'has been practical and issue oriented, geared to capturing opportunities, engaging with each other, and seeking to communicate better and differently across traditional alliances, regions, and blocs'.

34 Sandberg and Andresen described the head of the Norwegian delegation to negotiations in the WHO Intergovernmental Working Group on Intellectual Property Rights as a 'bridge builder' between the positions taken by developing and developed countries, a role that utilized Norway's 'relationship with Brazil and Thailand as members of the Oslo Ministerial Group': Kristin I. Sandberg and Steinar Andresen, 'From development aid to foreign policy: global immunization efforts as a turning point for Norwegian engagement in global health', *Forum for Development Studies* (2010), 37(3): 301–25, p. 318.

foreign policy that occurred before, during and after the Oslo Declaration.

To my knowledge, neither the FPGHI nor any outside group or expert appears to have attempted a comprehensive assessment of the FPGHI.[35] The Oslo Declaration does not contain an accountability mechanism to track whether the seven countries have fulfilled the 'points for collaborative action'. The 'Oslo Ministerial Declaration Three Years Later' statement contains no information about the performance of the governments concerning the Agenda for Action. We do not know whether the foreign ministries have changed their policies, interactions or links with international institutions, funding priorities, internal processes or staffing because of the FPGHI. We have no 'best practices' distilled by the FPGHI on applying the health lens to foreign policy, or examples of how the health lens made a difference in foreign policy decisions. To date, no foreign ministers from other countries have joined the FPGHI despite the invitation to do so, raising questions about other governments' perceptions of the process.[36]

In terms of future efforts, the 'Oslo Ministerial Declaration Three Years Later' statement provided that the FPGHI would give particular attention to the MDGs, global governance for health, imbalances in the global health workforce market, protecting people's health during crises, establishing a better evidence base and supporting the WHO Conference on Social Determinants of Health in 2011. However, with one exception, the statement contains no new, specific action items in these areas. The new item is the call for 'better evidence about the policy impact of the interface between health and selected traditional foreign policy disciplines'.[37] For this objective, the foreign ministers committed to 'an analytical study' announced by the Norwegian foreign minister in December 2010.[38] In contrast to the attention the Oslo Declaration received in 2007, the FPGHI's statement on its three-year review and future agenda appears to have generated much less publicity, possibly indicating a lack of interest in the FPGHI.

The Oslo process and the General Assembly resolutions

The FPGHI's claim that it contributed to the development of a global agenda for foreign policy and health through the UN General Assembly has merit. To date, the General Assembly has adopted three resolutions on foreign policy and global health[39] and has requested two reports from the UN Secretary-General on the same topic.[40] The Oslo Declaration was a catalyst for raising the health–foreign policy relationship within the UN, as the foreign ministers intended.[41] The FPGHI's efforts revealed its ability to work with the WHO in Geneva and the UN in New York.[42] The General Assembly had previously often adopted resolutions on health issues (e.g. on malaria and HIV/AIDS), but never before had it focused on the interface between foreign policy and health. The resolutions have, generally, identified health issues requiring greater foreign policy attention.

35 Existing literature contains general descriptions and statements about the FPGHI. See, for example, Møgedal and Alveberg, 'Can foreign policy make a difference to health?', p. 1, and Sandberg and Andresen, 'From development aid to foreign policy', pp. 315–16. Initial attempts at critical analysis of the Oslo Declaration are Alexia J. Duten, 'The Oslo Declaration: flogging a dead horse?' (unpublished manuscript presented at the British International Studies Association meeting, 19 April 2011, cited with permission); and Steinar Andresen and Kristin I. Sandberg, 'The Oslo ministerial group (OMG): a forceful illustration of a new paradigm in global health or a passing fashion?' (unpublished manuscript presented at the International Studies Association conference, March 2011, cited with permission).

36 I have interpreted the FPGHI's invitation as one to join the Oslo process as a member, but it could represent an invitation to cooperate with the FPGHI without formally joining. If the latter interpretation is correct, then the lack of growth in the FPGHI's membership is understandable. However, no information is available on the frequency, level or content of FPGHI's engagement with other countries' foreign ministers.

37 'Statement: Foreign Policy and Health'.

38 Norway Ministry of Foreign Affairs, 'Norway Launches Research Collaboration on Foreign Policy and Global Health', 6 December 1010, http://www.regjeringen.no/en/dep/ud/press/news/2010/cooperation_health.html?id=627306.

39 See UN General Assembly resolutions A/RES/63/33 (26 November 2008), A/RES/64/108, 10 December 2009, and A/RES/65/95, 9 December 2010.

40 See UN General Assembly, Global health and foreign policy–strategic opportunities and challenges: note by the Secretary-General, A/64/365, 23 September 2009; and UN General Assembly, Global health and foreign policy: note by the Secretary-General, A/65/399, 22 October 2010.

41 'World Health Day, Opening Remarks'. The foreign minister of Norway argued that the FPGHI 'can act as a catalyst'.

42 Møgedal and Alveberg, 'Can foreign policy make a difference to health?', p. 1, noting that the FPGHI has from its inception been in communication with the WHO Director-General and the UN Secretary-General to link its efforts with these intergovernmental processes.

Whether General Assembly consideration of the foreign policy–health relationship constitutes a FPGHI accomplishment depends on the impact of the resolutions. Although such resolutions are evidence of heightened awareness, their impact on why and how countries approach health issues in their foreign policies is difficult to assess.

Three points need to be considered. First, the resolutions have been adopted without a vote, suggesting that, like many General Assembly resolutions, member states did not consider them particularly important. Whether any member states have changed their policies, processes, practices, funding and staffing because of these resolutions is unclear, which calls for better information and impact analysis.

Second, the resolutions repeat similar calls made in many other venues, such as the WHO, World Bank, the G8 and regional organizations, and do not provide any additional insights on why and how to increase effective foreign policy action. The marginal utility of more calls for more foreign policy action on many health problems frequently highlighted in multiple venues over many years decreases in the absence of new ideas on how to turn awareness into action. This problem perhaps explains why the FPGHI recognized the need for more research on the health–foreign policy relationship.

Third, the more seriously a government takes health as a foreign policy issue, the less likely it will be to take its cues from general, consensus-driven processes and resolutions not geared to advancing specific national interests. A May 2011 analysis of health diplomacy in a number of important countries (including three FPGHI members) concluded that 'many countries still prefer to build relationships around global health through bilateral channels as a way of ensuring overseas work is strongly associated with national interests'.[43] In addition, the FPGHI came after health had become a more important foreign policy issue for many countries. Other initiatives, processes, mechanisms and strategies developed that facilitated more foreign policy action on health, making the FPGHI and General Assembly resolutions merely parts of an increasingly crowded, complicated, uncoordinated and controversial field.

For example, the G8 became a major factor in the rise of health as a foreign policy issue, and carried significant weight because it, unlike the FPGHI, involved many of the world's leading economic powers. Unilateral and multilateral initiatives, such as the US President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria, focused foreign policy-makers on concrete, ground-breaking projects. Governments also faced challenges negotiating and implementing unprecedented regimes for global health, such as the IHR (2005) and FCTC, which required extensive foreign policy participation. Some countries focused on internal processes, producing national strategies to better coordinate foreign policy and health. In this new context, governments were adjusting to the increased participation and influence of non-state actors, particularly the Bill & Melinda Gates Foundation. Perceptions that health was a 'soft power' instrument provided more powerful countries with foreign policy possibilities not addressed by the FPGHI or General Assembly resolutions.

In other words, governments have had options in engaging in more foreign policy action on health before and after the FPGHI. In a recent report summarizing the health diplomacy of various countries, the sections on France and Norway only mentioned the FPGHI in passing, included no information on what the FPGHI had accomplished and devoted more attention to other initiatives and interests these countries pursue.[44] The report's section on Brazil did not mention the FPGHI at all.[45] An analysis of South Africa's involvement with

43 Katherine E. Bliss, *Health Diplomacy of Foreign Governments,* Report of the CSIS Global Health Policy Center (May 2011), p. 1.

44 Ibid., pp. 10–11 (analysis of French health diplomacy) and pp. 13–14 (analysis of Norwegian health diplomacy).

45 Ibid., pp. 6–8. A similar but more detailed analysis of Brazil's involvement in global health briefly mentioned the FPGHI but contained no information indicating that the Oslo process had been important to any specific Brazilian foreign policy effort concerning health. See Katherine E. Bliss, 'Health in all policies: Brazil's approach to global health within foreign policy and development cooperation initiatives', in Katherine E. Bliss, ed., *Key Players in Global Health: How Brazil, Russia, India, China, and South Africa are Influencing the Game,* Report of the CSIS Global Health Policy Center (November 2010), pp. 1–14.

global health likewise did not mention the FPGHI.[46] These observations suggest that the Oslo process is not particularly important within the foreign policies on health of these participating countries.[47] The FPGHI (along with the General Assembly resolutions it stimulated) has been only one of many developments leading to health's increased prominence in foreign policy, and has not been among the most important.

> 'The iconic status the Oslo Declaration achieved thus reflects recognition of how the seven countries captured, in a unique and high-profile manner, the rise of health within foreign policy'

Without better information on the FPGHI, its importance cannot be fully assessed, but the available evidence suggests it has been less significant than other developments. The FPGHI does not involve any great powers.[48] It has not generated financial commitments or innovative financing mechanisms.[49] Nor does it appear to have led to any breakthrough accomplishments, produced any new governance regimes, invited active involvement from important non-state actors or attracted direct participation from other middle- and low-income countries. Its only new action item after its three-year review was a call for academic research.

The iconic status the Oslo Declaration achieved thus reflects recognition of how the seven countries captured, in a unique and high-profile manner, the rise of health within foreign policy. However, the FPGHI did not cause this rise, nor has it contributed much to this phenomenon compared with the actions of other countries, the operation of other processes, the creation of other mechanisms and the launching of other initiatives. Its stature appears more symbolic than substantive in terms of the objective of making health a strategic foreign policy interest.

Beyond Oslo: a more difficult road ahead[50]

An assessment of the FPGHI must also address its relationship with current events and future trends. With the caveat of the lack of a complete understanding of the FPGHI's activities, the Oslo process, like all initiatives seeking stronger foreign policy action on health, faces a more difficult environment going forward. In fact, the terrain began shifting within a year of the Oslo Declaration when global energy, food, climate change and financial crises emerged in 2008. Each crisis prompted warnings about the dangers posed to health and pleas to political leaders to prevent the crises from marginalizing health in policy responses. The scale of these dilemmas required diplomatic processes involving the major economic powers, including the newly formed G20, which meant that a group with the limited size and composition of the FPGHI became, through no fault of its own, less important.

These crises engaged the health lens because of their actual and potential impact on health outcomes and determinants, but their size, complexity and political contentiousness have diluted the importance of health in policy solutions under the foreign policy lens. As the WHO Director-General argued, although health suffers in such crises, the health community has little influence

46 Jennifer G. Cooke, 'South Africa and global health: minding the home front', in Bliss, ed., *Key Players,* pp. 41–49.

47 See, for example, Sandberg and Andresen, 'From development aid to foreign policy', pp. 321–22, stating that Norway's participation in the FPGHI 'does not suggest that health has taken precedence in driving other areas of foreign policy' and that a 'recent government white paper and associated literature suggest health as a rather minor [foreign policy] issue'.

48 Some might argue France is a great power given that it is a permanent member of the UN Security Council. However, debate about France's claim to great-power status reveals its tenuousness. Even French President Sarkozy has argued that '[t]he challenge for tomorrow is to have France … recognized as a great power.' AFP, 'France to pursue Afghan mission: Sarkozy', 14 July 2009, at http://www.google.com/hostednews/afp/article/ALeqM5iDCVuTbb8bWADMykhqiXFcYOGsZQ.

49 Three members of the FPGHI – Brazil, France and Norway – helped establish UNITAID in 2006 as a new financing mechanism, but UNITAID is not a product of FPGHI activities.

50 This section draws on Fidler, 'Rise and fall of global health as a foreign policy issue'.

over how governments address them.[51] From a foreign policy perspective, these crises are strategic problems requiring systemic political and economic solutions for which the health lens is not particularly useful. Efforts to make health a strategic issue in responses to these crises did not gain traction, as illustrated by the failure to make health central to climate change negotiations and the G20 agenda.

Emerging with these global crises are structural, political, economic and epidemiological factors that make the FPGHI's objective of embedding health as a strategic foreign policy interest more challenging in the foreseeable future. The structure of the international system is undergoing change that will affect all global issues, including health. Health's rise as a foreign policy issue occurred in the post-Cold War system dominated by a United States that gave health significant foreign policy attention. In many respects, the FPGHI followed in the geopolitical wake created by the world's leading great power. What is transpiring now is a shift to a multipolar system characterized by the rise of emerging powers, particularly China, and the actual and perceived decline of US power and influence.

For health as a foreign policy issue, multipolarity will have multiple implications. It will intensify competition among the existing and emerging great powers, encouraging them to continue to use health as an instrument of 'soft power'. The dynamics of a multipolar system, especially one experiencing serious economic dislocation, will be more unforgiving concerning core state interests in security, economic power and development. Thus, sustaining the case that health is strategic to national security, national economic power and development strategies is likely to become more difficult. Already significant, scepticism about security-based arguments is likely to increase,[52] which places the FPGHI's emphasis on global health security in troubled waters.

In terms of political factors, a weaker United States means that its foreign policy probably cannot play the catalytic role it did for global health over the past 10–15 years. None of the major rising powers – Brazil, China, India or Russia – has the means or willingness to lead in global health as the United States did. In the near future, 'China is likely to continue to downplay its status as a donor while working bilaterally [on health] to secure access to raw materials and goodwill/political capital'.[53] Although Russia associates being a larger donor country with its desired re-emergence as a great power, its domestic health challenges significantly influence its global health priorities.[54] For India, the primary objective of its 'international engagement on health is to shore up the country's health performance'.[55] Of these emerging powers, only Brazil is a member of the FPGHI. Therefore, countries that are not part of the Oslo process will play a more major role in shaping the future geopolitical context for global health than the members of the FPGHI.[56]

Existing and emerging powers will continue to use health as a 'soft power' tool, but, in the midst of increasing geopolitical competition, the foreign policy payoffs for these efforts might diminish in the light of other increasingly serious challenges at home and abroad. As a result, harder and harsher questions will be asked, particularly in the context of foreign aid, about the benefits foreign policy action on health issues produces for priority state interests.

Economically, sustaining health prominently in foreign policy is becoming more difficult because the

51 Margaret Chan, Director-General, World Health Organization, 'Globalization and Health: Remarks at the United Nations General Assembly', 24 October 2008, http://www.who.int/dg/speeches/2008/20081024/en/index.html.

52 See, for example, Stewart Patrick, 'Why failed states shouldn't be our biggest national security concern', *Washington Post*, 15 April 2011, http://www.washingtonpost.com/opinions/why-failed-states-shouldnt-be-our-biggest-national-security-fear/2011/04/11/AFqWmjkD_story.html. The article argues that national security concerns about, among other things, disease problems in failed and failing states 'reflect more hype than analysis'.

53 Bliss, *Health Diplomacy of Foreign Governments,* p. 4.

54 Ibid., p. 5.

55 Uttara Dukkipati, 'India's approach to global health: innovation at home', in Bliss, ed., *Key Players,* p. 25.

56 Other emerging players, such as South Korea, also are not part of the FPGHI. See Victor Cha, 'Enhancing leadership on development and health as South Korea hosts the G-20', in Bliss, ed., *Key Players,* pp. 50–52.

international economic context and domestic fiscal crises adversely affect governments, societies, international organizations and non-state actors. In many ways, the life-blood of the rise of health within foreign policy has been the massively increased funding for global health, which went from $5.59 billion in 1990 to $21.79 billion in 2007.[57] Most of this increase came from countries, such as the United States, that now face long-term fiscal crises their governments have not adequately addressed.

Although fiscal travails in high-income countries have not yet gutted health components of foreign aid budgets, significant increases in health assistance are unlikely in the foreseeable future. The prospect of flat-lining or decreasing economic resources for global health will generate agonizing domestic and foreign policy choices about the allocation of increasingly scarce financial capital. Such choices will make any convergence of views through the foreign policy lens and the health lens more difficult to generate and sustain.

In epidemiological terms, foreign policy action will become harder because, as noted above, political and economic capital for existing efforts (e.g. HIV/AIDS) – widely recognized as inadequate – will be more scarce, forcing tough decisions about how to prioritize available political commitment and economic resources. In this deteriorating context, global health leaders are pushing for more focus on problems that appear to have weaker foreign policy 'pull', such as NCDs, or that represent more expansive and expensive projects, such as health-systems reform and progress on social determinants of health (SDH). In other words, more divergence between the health and foreign policy lenses is brewing.

High-level meetings scheduled for later in 2011 on NCDs (at the UN in New York) and on SDH (in Brazil) illustrate the push to make these global health problems more important to foreign policy-makers. However, experts recognize that the case for increasing foreign policy action on NCDs is difficult to sustain, even without considering growing fiscal constraints.[58] This pattern is apparent in the low amount of health assistance funding directed towards NCDs.[59] The FPGHI omitted the major NCDs of concern for the UN summit from both its original and revised agendas. The recognition that NCDs are a 'hard sell' for foreign policy and the fact that the FPGHI does not address them suggests that efforts to embed these health problems as strategic foreign policy concerns face an uphill battle in a forbidding climate.

Global health interest in health-systems reform and SDH reflects health policy's tendency to expand to get at underlying causes of health problems. Addressing these problems requires expansive, expensive efforts over several decades that, from a foreign policy perspective, raise concerns. Despite appreciation of the importance of functioning health systems, foreign policy practices demonstrate more rhetorical than real interest in addressing them, following the pattern seen with NCDs.[60] Like health-systems reform, attacking SDH requires 'horizontal' strategies that cut across policy sectors and need coordinated sectoral action. As is well known, foreign policy action favours more limited 'vertical' activities, such as disease- or problem-specific initiatives. Efforts to create serious foreign policy interest in horizontal strategies, such as the FPGHI's incorporation of health-system capacities and health determinants, have not had great success to date. The difficult environment in which the health–foreign policy relationship now operates means that the horizontal/vertical tension will continue and perhaps deepen, as funding for global health levels off or declines.

57 Institute for Health Metrics and Evaluation, *Financing Global Health 2010: Development Assistance and Country Spending in Uncertainty* (Seattle: Institute for Health Metrics and Evaluation, 2010), p. 15.

58 See, for example, Devi Sridhar, J. Stephen Morrison and Peter Piot, *Getting the Politics Right for the September 2011 UN High-Level Meeting on Noncommunicable Diseases,* Report of the CSIS Global Health Policy Center (February 2011).

59 Institute for Health Metrics and Evaluation, *Financing Global Health 2010*, p. 9. The report notes that NCDs 'receive the least amount of funding compared with other health focus areas'.

60 Ibid., p. 15: '[A]bout one nickel out of every DAH dollar went to health sector support'.

In sum, the FPGHI's activities and accomplishments will face great challenges as the scale and severity of problems confronting health as a foreign policy issue, including likely declining political commitment in and economic capital for global health, continue to increase now and in the foreseeable future. This reality can be sensed by comparing the interest in the Oslo Declaration when it was made in 2007 and the lack of interest that greeted its three-year review and renewed agenda announced in 2010. This perspective is consistent with the view that the FPGHI has been less significant to understanding and advancing health's place in foreign policy than its iconic status would suggest.

Conclusion

This analysis of the FPGHI reveals aspects of not only the Oslo process, but also the larger endeavour to embed health more firmly in foreign policy thinking. Driving these efforts is the belief that more deliberate attention to health issues in foreign policy and diplomatic processes can produce deeper convergence of interests and values among states, which will produce more effective action on global health. This spirit permeates not only the FPGHI but also efforts to improve global health diplomacy by, for example, training diplomats to be more aware of health issues. Given health's long-standing neglect in foreign policy and diplomatic practice, more awareness and education are both proper and prudent.

'Given health's long-standing neglect in foreign policy and diplomatic practice, more awareness and education are both proper and prudent'

However, foreign policy practices, including those within the FPGHI, reveal patterns that make health's place in foreign policy limited, unstable and vulnerable. These patterns suggest that differences in national interests and values concerning health persist and are not as amendable to awareness-raising, education and training as some believe. We continue to struggle with dilemmas created by the foreign policy lens and the health lens sending diverse, controversial and often contradictory images to foreign policy-makers in different countries. What is most required from the Oslo process now is more substantive information and insight on how, in practice, participating foreign ministers have individually and collectively managed these dilemmas.[61] Having this kind of information would make it possible to understand the meaning of Oslo wherever health intersects with foreign policy. The need for this deeper meaning is clear. After all, global health, it was once said, is a pressing foreign policy issue of our time.

61 See Sandberg and Andresen, 'From development aid to foreign policy', p. 323, arguing that, if Norway believes in the FPGHI as an approach to health as foreign policy, then 'it should work to strengthen it institutionally'.

The Chatham House Centre on Global Health Security examines global health issues from an international affairs perspective, focusing on their politically and economically sensitive determinants and implications. It seeks to inform policy by offering evidence-based, politically feasible solutions that help policy-makers, civil society, the private sector and other leaders reach decisions and take actions that improve global health. It does so by providing a neutral forum for debate in order to stimulate discourse between the international affairs and public health communities, and by contributing to knowledge through independent, rigorous analysis, research and new ideas concerning global health challenges and how they manifest themselves as foreign policy problems. Its work is focused on three often interlinked aspects of global health security:

- Disease threats and determinants that transcend borders;
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