Global public health: revisiting healthy public policy at the global level

We are in a period of significant change for public health. The Ottawa Charter for Health Promotion acknowledged this process through its subtitle: ‘the move towards a new public health’. Initially, the new public health debate focused on public health revival, intersectorality and citizen participation. It found its exemplar expression at the local level through the Healthy Cities approach (Ashton and Seymour, 1988). Recently a new discussion has emerged which focuses on public health at a global level. It reflects on the balance between national and international responsibility for public health, revisits the mandate of international organizations, the social responsibility of private companies and the role and legitimacy of non-governmental organizations.

This new global dimension of public health was at the center of the Jakarta Conference on ‘New players for a new era’. Tobacco, HIV/AIDS, environmental pollution, food safety, invasive lifestyles, none of these stops at national borders. Yet common action between countries is frequently neglected in favor of anxiously guarded national interests. The Jakarta Conference responded to the tension between globalization and governance with the call for a global alliance for health promotion—giving expression to the need for a new institutional form of global health action (WHO, 1997). How can we take this idea further?

GLOBALIZATION AND PUBLIC HEALTH: LOSS OF INTERNAL SOVEREIGNTY

Globalization was initially understood as a purely economic phenomenon, associated with rapid flows of capital, the growth of global corporations and extreme global inequities. Increasingly though the political, social and cultural dimensions of globalization are being discussed—most recently in the Reith Lectures by Anthony Giddens (Giddens, 1999). The lectures highlight the temporal, spatial and cognitive dimensions of globalization, and illustrate its pervasiveness both in the developed and developing world. Giddens identifies two schools of thought in relation to globalization: the skeptics who refute that significant change is taking place and the radicals who argue ‘that not only is globalization very real, but that its consequences can be felt everywhere’. He comes down firmly, as do the authors of this editorial, on the side of the radicals.

The public health community has only just begun to look at the impact of globalization on health. The contributions by Yach and Bettcher have described globalization as increasing interdependence rather than as a qualitatively new phenomenon (Yach and Bettcher, 1998). Lee has broadened the debate one step further by illustrating the impact of the spatial, temporal and cognitive dimensions of globalization on health concerns and disease patterns, but also defines globalization as increased interdependence (Lee, 1998). Kickbusch and Quick have drawn attention to the many new players in the health arena and identified the need for connecting in new types of partnerships (Kickbusch and Quick, 1998).

A key point this editorial wants to make is that globalization is more than increased interdependence and interconnectedness, be it of nations, people, capital or information. This distinction matters in relation to the policy response of countries. Globalization—contrary to interdependence—challenges the internal sovereignty of nation states. It implies ‘a new sphere of action independent of territory’, which restricts the policymaking capacity of individual governments within their own territory because the instruments at their disposal cannot reach into the operational sphere of many global players. Reinicke in his excellent book Global Public Policy illustrates this development using examples from finance, crime and trade (Reinicke, 1998). It is important
that we embark on a similar detailed analysis for the health arena.

Health, which at first instance seems to be the field most destined for joint action independent of territory (how often have we heard and used the phrase that disease knows no borders), remains a policy domain most protectively linked to the nation state. But even as countries defend their internal sovereignty over health care policy they are losing sovereignty over policies related to health determinants: the marketing, distribution and sale of consumer goods and lifestyles (e.g. tobacco and food), the growth of a global health industry (e.g. pharmaceuticals and insurance), the global spread of environmental pollution and infectious disease, the health impact of the global financial system. How then can governments respond other than through new forms of protectionism or extreme competition to attract the global players into their own front yard?

GLOBAL PUBLIC HEALTH

In order to emphasize the interaction between countries and trends in globalization, Frenk and Chacon have suggested the term ‘new international health’ (Frenk and Chacon, 1992). Having experienced the discussion around the ‘old’ and ‘new’ public health following the Ottawa Charter, we believe that this would be an unfortunate choice. It would also not reflect the essentially new dimension of globalization. We suggest to follow the reasoning developed by Reinicke for a global public policy, and propose the term ‘global public health’. The challenge before us is to develop a framework that defines its characteristics, and through a series of detailed case studies identifies forms of social organization, mechanisms and instruments for global public health action.

If we look at the present system of international health co-operation we see two key trends: a significant increase in the players in the international health arena; and subtle but systematic erosion of internal sovereignty. Countries maintain their internal sovereignty as a constitutional right within the specialized health agency of the United Nations: the World Health Organization. But ‘back home’, internal sovereignty in health is being significantly challenged if not eroded in a wide range of countries through a myriad of factors: the actions of transnational corporations, conditionalities set by the IMF, premises of the health care reform efforts of the World Bank, priorities set by bilateral aid agencies and the agreements reached at the World Trade Organization or the European Union. This erosion is not just directed at developing countries as a form of post-colonial interference but also significantly affects the developed world. It is a global phenomenon.

In response to this development, global public health would ‘aim’ to fill the governance gap related to those health issues and health development processes that are independent of territory, and to balance the impact of globalization on internal health sovereignty. It would in a novel way bring together the health agendas of the developed and the developing world.

What ‘form’ should global public health take? There are of course many schools of thought as to the appropriate response to these pressures. Reinicke postulates that the only response which will enable nation states to maintain their policy-making capacity is by voluntarily pooling internal sovereignty, others see a clear need to bring all key players—governmental and non-governmental—together in a process of ‘governance without governments’, and yet others wish to see a significant strengthening of the UN system. A new system will probably contain elements of all three strategic responses.

NETWORKS AND REGIMES

We are only at the very beginning of understanding the social organization and the new quality of the dynamics between actors that flows from globalization. Therefore, we need to experiment with the institutional response required. Just as the League of Nations was founded as a new mechanism to ensure the external sovereignty of nation states, mechanisms need to be created that allow countries to pool internal sovereignty and work together for a common purpose in a new form of governance while including other social actors beyond the state.

Manuel Castells has described the network as the new organizational form of governance for the 21st century, because it transcends space and time and shares and redistributes power and resources in a new form of social organization (Castells, 1996). This also increasingly means allowing other actors—non-governmental organizations and the private sector—to participate in an organized system of governance. The network approach is only beginning to take shape in
the health arena: the fight against HIV/AIDS can be seen as perhaps one of the first truly global public health networks (Gordenker et al., 1995), the Healthy Cities Movement as another (Kickbusch, 1999). A range of UN organizations, the World Bank as well as the new leadership of WHO are experimenting with partnership-oriented approaches, which could provide the nucleus for new forms of governance.

But governance would go beyond intensified co-operation. In the economic and environmental field, many authors argue for new forms of joint decision-making by regime formation involving a broad range of state and non-state actors, a case in point being the ozone regime (Young, 1997). Elements and components of such global regimes for public health exist with the international health regulations, the International Code for the marketing of breast milk substitutes, the Codex Alimentarius and the proposal to develop an International Framework Convention on Tobacco Control. In fact, regimes can be seen as a form to collectively operationalize internal sovereignty at the global level and indeed most regimes at this stage are state organized.

Following such a line of thought we could define global public health as the collective ability to conduct healthy public policy at a global level through a network of public, private, non-governmental, national, regional and international organizations by regime formation.

HEALTH AS A GLOBAL PUBLIC GOOD

We need to address the tension between globalization and global health governance with urgency. The focus of the debate so far has been more concerned with the ‘leadership’ of specific agencies or the usual call for more co-ordination between the various actors. It must look more systematically at how to strengthen countries in their health policy capacity at the global level and how to increase the accountability for the health impacts of global actors outside of the health arena. The duties and obligations at all levels of governance need to be mapped out with greater clarity, and mechanisms need to be devised that deal with non-compliance, all the more so because non-adherence at any level can have significant global health consequences.

But in order to move ahead, there is need of a common sense of purpose. Two—mutually not exclusive—frameworks can help to move the debate to a new arena. One is to follow in the footsteps of the debate on the environment and reframe health as a ‘commons’. International commons (Young, 1997) are ‘physical or biological systems that lie wholly or largely outside the jurisdiction of any individual member of international society but that are of interest to two or more of them—or their nationals—as a valued resource’. This relates well to the Ottawa Charter and its definition of health as a resource. The other approach is to define health as a ‘global public good’ (Kaul et al., 1999) whose benefits ‘reach across borders, generations and population groups’ and thus calls for a global public policy response.

Understanding healthy public policy at the global level as part of the move towards a global public health must tackle three challenges: the framing of health as a valued global commons/public good; the response to globalization through a new inclusive system of global health governance; and the development of global regimes, codes of conduct and mechanisms of accountability in pursuit of improved global health. This will imply new roles and responsibilities for all concerned: the international organizations, nation states, civil society and the private sector.

THE ROLE OF SCHOOLS OF PUBLIC HEALTH

Schools of public health should be at the forefront of analyzing these developments, mapping the emerging global public health patchworks and networks, and proposing new instruments and mechanisms for the global response. They need to provide public health professionals with the knowledge and skills to respond strategically and effectively. Research agendas and training curricula need to incorporate new global perspectives. We need to complement ‘international health’ with a global public health perspective, as outlined above. The policies and strategies that flow from this will be significantly different from today and require us to strengthen not only the science but also particularly the art of public health. They will transcend traditional disciplinary boundaries as much as they transcend national sovereignty. And they transcend a simplistic division of the world into global, national and local. Indeed, the term ‘glocal’ is now being used to express this intense interaction (Kickbusch, 1999). Law, economics, policy sciences, management,
network sociology and international relations need to be connected systematically with the global public health agenda. Joint degrees and research programs are pathways to enhancing our understanding of the driving forces and the possible avenues for intervention through global public health action.

We urge schools of public health and public health associations to recognize the dimensions of global public health action, and to integrate them into their teaching, research and daily practice.

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REFERENCES


