

Health Diplomacy as Political Negotiation
Health Diplomacy Conference Session III
Speakers: David Fidler, Delon Human, Vinh-kim Nguyen

Comments by Rapporteur
Randall Kuhn

I will approach my comments from the standpoint of someone who has spent the past year building a program in global health based in a school of international studies. Hopefully I will be able to add some knowledge from my experience and convey what I have learned more about in the past few days that I had not already been addressing.

But first a reality check. In spite of HIV/AIDS, obesity, substance abuse, war, and other emerging health risks that have led to the first observed sustained *mortality declines* at the national level in modern history, the overwhelming lesson of the past 50 years is that rapid improvements in health outcomes, in spite of haphazard, un-sustained investments and the gutting of centralized health care systems, are in fact far more readily achieved than development gains. If our interest as scientists and practitioners is the sustainable improvement of the human condition, then we have to ask ourselves, scientifically, how much social and political development is really possible in all societies, how much of this improvement can be driven by health, and given the repeated insults to the social, economic, and political systems of the African continent in the past 500 years, how much worse can HIV/AIDS really make things?

Taking the even longer view of history, we should remember that these past 60 years of improving health conditions are in some senses an aberration in a long history in which the substantial and mild improvements were all, at least for a time, undermined by massive epidemiological, agricultural, and political risks. These risks have all passed, and were followed by new ones. The reason these risks are less deeply felt with each passing era is the improvement of living standards, improvement of systems, and the increasing efficacy and transparency of governance.

Whatever the intentions of the organizers of this conference, our conversation has covered a far broader range of concerns than health diplomacy. What has been called global health diplomacy up to this point seems really to be a combination of global health policy, cooperation, organization. Governance to a lesser extent, with perhaps an impact on diplomacy. Global health politics are certainly an important sphere of emphasis as well. But the most likely and perhaps most appropriate impact of medical professionals, epidemiologists, planners, managers, and even the 95%+ of IR degree holders who don't go into diplomacy per se will be in contributing to the global health politics discourse through five core activities that I would continue to call "global health affairs", or just "global health".

- 1) the traditional activities of the programming, intervention, monitoring, and scaling up of new social, medical and biotechnological products – but with a more enlightened sense of individual, family, and community capabilities, resiliencies,

and involvement – not just their vulnerability – and an awareness of the startling social and ethical implications of new health and information technologies.

- 2) Through cross-national cooperation, communication, and knowledge transfer – recognizing the diversity of actors in this sphere both in terms of new national powers and interests coming to the table as negotiators or competitors as well as the arrival of the mega-philanthropies and private multinational corporations and their contractors. The quality of PhD programs at places like University of the Witwatersrand in South Africa, National University of Singapore, and Mahidol University in Thailand have implications for far more than who comes to our PhD programs. Since the liberalization of the government’s monopoly on medical education in Bangladesh in 2004, six MPH programs have been set up.
- 3) Addressing the impact of economic internationalization and political integration on epidemiological, environmental and behavioral health risks and treatment as well as the opportunities these trends present for improved cooperation, realization of and response to shared risks, and organized mechanisms of global governance.
- 4) Raising global awareness, knowledge, and democratic and civil discourse surrounding new and preexisting global health risks of cross-national impact, over global and national health inequity and its consequences, and of the moral, political, and economic consequences of health. This means disambiguating the self-interested prognostications of agencies vying for attention, governments pushing agendas, corporations wishing to sell products, media outlets looking to sell products, and wildly powerful advocacy groups pushing noble agendas through oversimplifying ends through relevant research and public epidemiology outreach; encouraging transparent data collection; speaking truth to governments and donors; and bringing that approach to lifetime education and discourage at all ages and across societies. I CALL THIS THE NARRATIVE-EVIDENCE GAP. As academics, we want to train folks from a wide array of interest groups to speak a common language, push their interests, and push back amongst themselves even as we push forward at incorporating new languages, interests, technologies, and approaches.
- 5) Addressing key interactions, intersectoralities, and crossovers between social, economic and political development programs, agent-based technological and socioeconomic change and health, including gaining a deep scientific understanding of the broader social, economic, and political impacts biosocial change, something which we understand as part of the industrial revolution and this black box of modernization but which we really don’t know scientifically.

The reason for starting from these core activities is not merely a question of how many jobs there are. The bigger concern I have lies in how we, as scientists and clinicians, should best contend with the central paradoxes of power, diplomacy, and the state of diplomatic and free-market anarchy that David described so well. As scientists we may

receive funding from our government to address global health risks engendered by the actions of that same government. The notion of Global Health Diplomacy brings us as scientists far closer to the burning heart of this contradiction than we ever could have imagined. All the more reason to, as David points out, be wise and well-versed in the perils of this place. Yet the dangers of this fire also give a compelling reason to make sure that our efforts at global health diplomacy are rooted, deeply and fundamentally, in the most robust and rigorous efforts possible at doing what we do best. Which is healing wounds, understanding what works, and negotiating the meaning morality of actions.

The questions of what is diplomatically expedient and what is in the self-interest of powerful nations are all relevant to the pursuit of health diplomacy, but a program in global health diplomacy must be anchored in the work that only academics can perform. In that vein, I think the greatest outcome of an interdisciplinary program in Global Health Affairs would be to build an integrated theory and science of the service, policy, and politics of global health that addresses the role of health central public and private good; as a field of innovation; as a key form of consumption and investment; and as a source of legitimacy in state, state-to-state, and multilateral initiatives. This field would be informed by medicine, epidemiology and the hard sciences, by political science and the mysteries of statecraft, by social history and anthropology, and by demography and economics. This science would with great humility speak backwards to the health sciences of epidemiology, therapeutics, pharmacology, immunology, and biotechnology and forwards to the study of social welfare provision, international negotiations surrounding a multiplicity of shared risks and opportunities, and the emergence of new approaches to a globalized, post-structural adjustment world that can live with peace and stability.

I think the breadth of this endeavor makes it possible only for a school like my alma mater, the University of California, to cover meaningful ground in all of these areas. In that sense you have garnered, from the inside and the outside, an exciting, relevant, and current set of concerns. The International Health Regulations and their place in the broader context of international diplomacy. The stunning growth in the traditional interface between anthropology and biology on issues ranging from the ethics of clinical trials, the biophysical consequences and antecedents of change. Given the great many topics available that are relevant to global health diplomacy but cover far more ground, it seems as if a course in global health diplomacy would have the potential to be self-limiting in terms of agenda, human resources, and contribution were it not rooted in a more general program in global health affairs.

So I urge you to think big and make your alumni proud. Create not just a center and a program, but a platform or a series of platforms for doing great work and bringing great people together. Yesterday I heard people suggest that the population- or community-based model of training and research may be infeasible, but the real answer should be that one is not enough, that UC must implement a dense network of population-based and actor-based platforms for research and training that draws on its deep base of existing resources and ability to raise new ones, its glistening reputation in Washington and abroad, and the full breadth of its base of intellectual and cultural resources. With such an

integrated program in global health affairs in place, it would seem difficult for Washington to ignore you. Of course we all know that's not the case, which is why the need for a program in global health diplomacy is so real. But before you invite the big bad wolf to come by, make sure you have a solid house.