

Editorial

The imperative of public health: opportunity or trap?

THE POLITICAL COMMITMENT TO HEALTH AND EQUITY

When the Ottawa Charter in 1986 had called on health promoters ‘to advocate for a clear political commitment to health and equity in all sectors’, foreign policy was not on the agenda. This changed as health promotion began to concern itself with the impact of globalization on health. Indeed, the recommendations from the 2nd international health promotion conference with a focus on ‘healthy public policy’ in Adelaide 1988 already stated: ‘in view of the large health gaps between countries, which this conference has examined, the developed countries have an obligation to ensure that their own policies have a positive health impact on developing nations. The conference recommends that all countries develop healthy public policies that explicitly address this issue’. That is a political agenda.

Twenty years later, a group of seven foreign ministers from around the world—Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand—declared global health a goal 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 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’ ([Oslo Ministerial Declaration, 2007](#)).

On the most part the responses of global health advocates to this initiative have been positive—after all the explicit goal of the new public health is to have health high on the agenda of policy makers, to integrate health into as many policy arenas as possible and to move it from ‘low’ to ‘high’ politics. Initially this was done through economic arguments which underlined the importance of investing

in health for overall social and economic development—arguments that are now very much at the fore when advocating for action in the area of non-communicable diseases (NCDs). In 2011, the World Economic Forum issued a warning to finance ministers and heads of state by calculating ‘that the estimated cumulative output loss over the next 20 years represents approximately 4% of annual global GDP’ ([Bloom *et al.*, 2011](#)). In parallel, there have been recurring global health security threats such as SARS and H1N5 which have also incurred significant costs, required the inclusion of many different policy sectors and pushed health up on the political agenda.

The Ebola outbreak in 2014 has seen heads of state and foreign ministries take the lead in the Ebola response, special Ebola ambassadors have been appointed to oversee and coordinate the responses and high level political bodies—including the UN Security Council—have discussed the political dimensions of this global health threat. Despite the high level of attention, there are considerable concerns in the health community that public health goals will be subsumed under foreign policy goals, and that development goals and the commitment to equity will be trumped by geo-political and economic interests and considerations of national security. But, when we look beyond our own epistemic community to others, we can find that they have concerns with the imperative of health entering an increasing array of policy arenas.

ADVANCING HEALTH IN ALL POLICIES

Health promotion takes a clear position that policies shape the determinants of health—this has been reinforced and strengthened by the work of the Commission on the Social Determinants of Health and its focus on the ‘causes of the causes’ of ill-health and health inequity. The importance attached to policy as an action area of health promotion is expressed by the fact that there have now been two global health promotion conferences which

deal explicitly with policy, the 1988 conference in Adelaide, Australia on ‘Healthy Public Policy’ and the 2013, global conference on ‘Healthy Public Policy’ in Helsinki, Finland. A review of the eight global health promotion conferences (WHO, 2013) shows that they have paid increasing attention to global determinants, global policy agendas, and to the interface between domestic and international policies as they shape health and health equity. Many of these determinants are critical for all dimensions of community health and impact on both NCDs and infectious diseases. Health promotion strategies are applicable to both, most recently this has again become glaringly obvious, as Ebola containment strategies neglected to build on the knowledge of community involvement developed by health promotion in many different settings around the world.

When reflecting on this, it is helpful to remember that the Ottawa Charter was adopted in the same period as the world began to fully understand both the consequences of smoking and the threat of HIV/AIDS, both domestically and on a global scale. Two defining reports were produced in the USA—February 1986, the Surgeon General C. Everett Koop was instructed by President Ronald Reagan to issue a Surgeon General’s report on AIDS, which he released at a press conference on 22 October 1986. It contributed to changing the trajectory of how the USA and how the international community dealt with the disease. From the very start, AIDS was high on the political agenda and embroiled in political controversy, but Koop prevailed. He had learned how to stand up to political pressure from the start of his tenure—his first official act after his confirmation was to issue the 1982 Surgeon General’s *Report on Smoking and Health*, a landmark for action on tobacco in the USA and all around the world. Tobacco and AIDS—through their deeply political nature—have spearheaded health promotion approaches in dealing with major public health challenges. Taylor *et al.* (Taylor *et al.*, 2009) show this in their comparison of the response of the South African Government to HIV and AIDS and to tobacco using the action framework of the Ottawa Charter for Health Promotion.

This is where we find the first seed of what Fidler (Fidler, 2004) has called global health’s political revolution. Tobacco and AIDS are defined by political firsts at the global level: the economic impact of tobacco-related diseases led countries to adopt the first international public health treaty and the fear of AIDS becoming a threat to ‘international peace and security’ makes it the first health issue to be discussed at the UN Security Council. Fidler’s analysis of the political revolution is focused on pathogenic threats and it examines how germs, norms, and power converge to protect health and become integral to 21st

century international politics through the concept of health security. But, since the adoption of the Framework Convention on Tobacco Control in 2003, global health’s political revolution has expanded to include the health threats that come from the industries connected to a broad range of NCDs, now frequently referred to as big tobacco, big food, big alcohol and big soda. Both need whole of government and whole of society responses.

MEDICALIZATION OF GLOBAL HEALTH

For Elbe (Elbe, 2010), global health’s political revolution and the shift towards ‘Health in All Policies’ are less benign. On the contrary: for him this expansion indicates that a much larger and deeper transformation is under way, indeed he claims that health is well on its way to become one of the highest political imperatives. He warns that such a process will lead to the medicalization of social life and that as a result ‘the body becomes the new battlefield of the 21st century’ at all levels of governance. This, he says, brings with it the danger to de-politicize the challenges at hand, and to rely on technological fixes.

I can only partially agree with Elbe, last not least because a public health imperative based on the principles of the Ottawa Charter is in my mind very different from medicalization, as developed in Michel Foucault’s seminal work on bio-politics and governance. The focus on the social, political and commercial determinants of health, developed in the recent decade explicitly set out to counteract any such development. Yet, I do think this position challenges us to reflect more on the difference between a technocratic and a political approach to global health and Health in All Policies. Did global health’s political revolution—because of the dominant paradigm of high level political players—actually lead to what Elbe suspects: expansion of medicalization, more technological fixes and an extension of medical surveillance? A glance at the many vertical global health programmes as well as the implementation of certain measures to ensure global health security would seem to underscore such an analysis.

Again, the Ebola response allows us to gain perspective. In the best tradition of Rudolf Virchow—‘Politics is nothing but medicine at a larger scale’—McCoy (McCoy, 2014) has provided an excellent illustration in his recent analysis of the ‘social, political and ecological pathologies of the Ebola crisis’. In a double twist, he applies the medical terminology of pathologies to call for action beyond the technological fix of disease control, vaccines and medicines and instead draws attention to deeply structural and political issues that need to be addressed: these include blood diamonds, conflict timber, land grabbing, corruption, illicit financial outflows and

arms dealing. A similar approach to address the political determinants of health has been chosen by the Lancet/University of Oslo Commission on Global Governance for Health (Ottersen *et al.*, 2014). It examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict. It is this kind of analysis which can highlight the difference between a public health imperative to global development based on determinants and an approach which promotes a medicalization of global health and Health in All Policies.

WHY A DISTASTE OF POLITICS?

From the health perspective, one of the key dilemmas of global health's political revolution is the tension between a public health issue gaining political currency on the one hand and it being subsumed under the goals that drive agendas other than health, such as national security, structural interests or broader ideological differences. This leads to another dilemma: if we are to address the structural determinants of health, we have no choice but to enter the political arena; yet as we advocate for 'Health in All Policies', we tend to neglect politics. Indeed as Hunter (Hunter, 2015) recently argued, we have a distaste of politics and tend to see it as an 'unhelpful intrusion into the process of finding optimal solutions to complex problems'. Politics is messy and once a health issue enters the political arena it becomes part of a larger agenda and the mix of evidence, interests and ideology can produce strange bed fellows and surprising compromises; health can bring political adversaries together or become an instrument to emphasize differences and gain popular support and votes.

Even matters of national health security can lead to different politics in new contexts: for example the national health security response in the USA after 9/11 crossed the political divide, while the US government's response to the Ebola outbreak was embroiled in political controversy and positioning. The democratic President and the technical agency responsible for guidance—the Centres for Disease Control—were both vehemently attacked by the Republican Party for not introducing travel bans and quarantines to protect the American people. While infectious disease threats frequently lead to a knee-jerk political reaction for more control of individuals and their movements (irrespective of public health evidence), the very same proponents will counteract any proposal for more health regulation in relation to NCDs with a defence of

the freedom of individuals to choose how they want to live. We must obviously not underestimate the complexities and pitfalls of the political environment.

A NEW POLITICAL AGENDA

We have a useful definition of Health in All Policies from the Helsinki Conference: 'Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity'. But in moving forward, we will need to overcome what has been called 'the temptation of the technical'. What Carothers and Gramont (Carothers and Gramont, 2013) say in their analysis of the politics of development aid also applies to Health in All Policies: 'it is inescapably, inevitably highly political and has always been'. There are no easy answers as health gets increasingly political and we need a better discussion of both political aims and methods. Just as we argue that others must be better attuned to health, we must become better politically informed. It is good to see an increasing range of initiatives that are developing the political economy of global health, that there are more attempts to apply political science to Health in All Policies and Global Health and that there is more debate in journals and at conferences on the role of politics. This should allow us to move forward.

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