

After the Revolution: Global Health Politics in a Time of Economic Crisis and Threatening Future Trends

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In 2008, global health's political revolution, which unfolded over the preceding 10-15 years, ended when four global crises damaged global health and altered the political, diplomatic, and governance contexts in which global health activities operate. The climate change, energy, food, and economic crises revealed limitations in global health's ability to shape large-scale political, economic, and environmental problems that adversely affect health or harm underlying determinants of health. In addition, projected trends in world affairs potentially threaten health and the ability of countries to craft effective collective action responses to global problems damaging health directly and indirectly. In the post-revolution period, global health faces the daunting challenge of making the re-globalization process necessitated by the global economic crisis as health-centric as possible.

INTRODUCTION

“We are meeting at a time of crisis. We face a fuel crisis, a food crisis, a severe financial crisis, and a climate that has begun to change in ominous ways. All of these crises have global causes and global consequences. All have profound, and profoundly unfair, consequences for health. Let me be very clear at the start. The health sector had no say when the policies responsible for these crises were made. But health bears the brunt.”—*Dr. Margaret Chan, Director-General, World Health Organization, October 24, 2008*¹

Over the past 10-15 years, global health experienced transformations that have been revolutionary. Developments in this period lifted global health from political neglect into more prominence among States, intergovernmental organizations (IGOs), and non-State actors. With this momentum, global health appeared poised to remain a high profile issue for years to come.

However, the global health revolution abruptly reached its terminus in 2008 after global crises changed the political, diplomatic, and governance contexts of global health. As if the crisis-riddled present was not bad enough, longer-term projections of political, economic, demographic, and ecological trends raise concerns that global health confronts challenges it could not have met even without the damage done by the crises of 2008. These crises, especially the global economic crisis, battered global health accomplishments of the past 10-15 years and bruised a reform agenda that sought, among other things, to achieve universal primary health care around the world.

This article probes global health's prospects in this post-revolution period. It begins by sketching what made the past 10-15 years revolutionary for global

health. This revolution was unlike prior breakthroughs because its engine was political rather than scientific and technological. The global health community greeted the transformations with optimism, leading one prominent commentator to proclaim health's potential to transform the nature of foreign policy.² But, the revolution had more sobering elements that remained underexplored in the enthusiasm global health's new prominence generated.

The article then surveys the damage done to the global health enterprise by four crises that emerged or worsened in 2008—the climate change, energy, food, and economic crises. The damage inflicted involved harm to health and to the reasons why global health had risen in prominence. The impact of these crises has left global health policy makers fighting rear-guard actions to ensure that recent progress is not overwhelmed and left in ruins.

The crises of 2008 are not the only challenges with which global health policy needs to come to grips after its revolution. The article analyzes trends expected to emerge over the next 20-25 years. These trends make the revolution in global health look incomplete, even without factoring in the setbacks produced by the crises of 2008. Individually and collectively, these trends describe potential shifts that could create greater challenges for global health but which global health strategies and policies have limited influence to affect.

The conclusion steps back from the crises and the trends in order to assess the prospects for global health politics, diplomacy, and governance. The crises of 2008 may have revealed the political limitations of global health policies, but this development does not mean global health has become as neglected as it was in the past. A key question is whether global health policy can inform and shape the re-globalization that will occur once the global economic crisis subsides and the wheels of global commerce begin turning again. Global health's role in that re-globalization process will determine how global health policy, diplomacy, and governance fare in the next phase of world affairs.

GLOBAL HEALTH'S POLITICAL REVOLUTION

Evidence of a Revolution

The proposition that global health has undergone a radical transformation over the past 10-15 years is not controversial. Global health today differs so dramatically from what existed in the mid-1990s and before that labeling the change revolutionary is not hyperbole. The evidence is everywhere, including the:

- Billions of additional funds States, IGOs, and non-State actors have devoted to global health;³
- Re-conceptualization of health as more than a technical, humanitarian concern and as relevant to the vital interests of States in security and economic well-being;
- Unprecedented new governance regimes adopted by the World Health Organization (WHO)—the International Health Regulations 2005 (IHR 2005)⁴ and the Framework Convention on Tobacco Control (FCTC);⁵

- New initiatives, mechanisms, and partnerships to address global health threats (e.g., Global Fund to Fight AIDS, Tuberculosis, and Malaria);⁶
- The willingness of the world's leading economic powers—the Group of 8—to feature global health in its summit agendas and action plans;⁷
- The proliferation of new actors, including rising great powers (e.g., China), influential IGOs (e.g., World Trade Organization (WTO)), non-governmental organizations (NGOs) (e.g., *Medécins sans Frontières*),⁸ and individual policy entrepreneurs (e.g., Bono);⁹
- Rise of one philanthropic entity—the Bill and Melinda Gates Foundation¹⁰—as a global health power in its own right; and
- The explosion of interest in global health in policy and academic communities previously not very interested in global health matters (e.g., development of global health programs at some of the world's leading foreign policy think tanks).¹¹

Political Capital

Conceptually, global health's political revolution has been marked by sustained commitment of political, economic, and intellectual capital to addressing global health problems. In terms of political capital, over the past 10-15 years, States, IGOs, and NGOs engaged seriously in the global health politics. Such engagement was not always harmonious, as illustrated by controversies over the HIV/AIDS pandemic, WTO rules, China's handling of the SARS outbreak, and the impasse over sharing avian influenza virus samples and the technological benefits derived from research on such samples. Nor was the manner in which some States engaged in global health universally applauded, as evidenced by controversial policies pursued by the Bush Administration. In addition, not all global health problems received equal political attention and some remained neglected amidst the new political prominence of global health. Nevertheless, one would be hard pressed to find a prior period when the various actors in world affairs devoted so much attention to global health.

Economic Capital

The increased resources devoted to global health underscored the willingness of States and non-State actors to expend economic capital on global health. The sums dedicated to global health reached unprecedented amounts between 2000 and 2008.¹² The new funding went, among other things, to provide antiretroviral treatments to persons with HIV, purchase vaccines for preventing childhood diseases, distribute insecticide-treated mosquito bed nets, improve maternal and infant health, produce clean water and improve sanitation, prepare responses to avian and pandemic influenza, and strengthen disease surveillance and response systems. In addition to increases in foreign aid for health, many governments increased national spending on health services and systems.¹³ Although the funding increases benefited some global health efforts more than others and skewed health expenditures towards particular challenges (e.g., HIV/AIDS), the first eight years of the 21st century witnessed in global

health “an era of historic generosity as the wealthy world has committed substantial resources to tackle poverty and disease in developing countries.”¹⁴

Intellectual Capital

Global health also witnessed sustained commitment of intellectual capital during the past 10-15 years. The expenditure of intellectual capital made its clearest mark in how States, IGOs, and non-State actors re-conceptualized health as a policy issue. In the past, health was mainly viewed as a technical, humanitarian concern not connected with the vital security and economic interests of States. The idea that global health problems could constitute security threats had, in past times, rarely been articulated. Economically, the prevailing perspective had long been that wealth created by macroeconomic development led to improved health. Thus, in terms of national economic policy and overseas development assistance, the focus was on growing economies rather than on investing in health as a driver of economic growth.

Intellectual ferment in the late 1990s and early 2000s changed the conventional thinking on health as a foreign policy and diplomatic issue. Global health problems, particularly communicable diseases, were formulated as threats to human, national, and international security.¹⁵ The threat of biological weapons and bioterrorism raised the security profile of disease surveillance and response capabilities.¹⁶ Weak or non-existent health systems and disease spread were linked with failed and failing States, which gave public health more stature in the security field.¹⁷ Providing health services to local populations became part of counterinsurgency strategies to “win the hearts and minds” in the conflicts in Iraq and Afghanistan.¹⁸

The macroeconomic losses caused by pandemics, such as HIV/AIDS, and outbreaks, such as SARS and avian influenza, caused governments to view public health as more important to their economic self-interests. Efforts were made to demonstrate that investments in health would contribute to macroeconomic growth.¹⁹ Thus, health moved closer to the center of thinking about development policy than historically had been the case.

Intellectual capital was also spent revitalizing health’s place in human rights and humanitarian agendas. These efforts included authoritative delineation of the right to health,²⁰ emphasis on a human rights approach to the HIV/AIDS pandemic,²¹ strategies to minimize infringements of civil and political rights when drastic measures (e.g., quarantine) are required to control an outbreak,²² and activities designed to increase access to essential medicines in developing and least-developed countries.²³

A Political Revolution

Health as an international political, diplomatic, and governance issue has undergone significant developments in the past, but science and technology drove the prior changes that had the most lasting impact. For example, the late 19th and early 20th century application of “germ theory” produced national public health reforms that reduced infectious disease morbidity and mortality and

provided a stronger basis for international cooperation on infectious disease control. In the mid-20th century, the scientific and technological breakthroughs of antibiotics and vaccines ushered in a new age of public health.

By contrast, the latest developments in global health have largely been political in nature and have not been precipitated by leaps in medical science and health technologies. Certainly, science and technology played a role, particularly in efforts to make anti-retrovirals accessible to populations in developing and least-developed countries. The objective of increasing antiretroviral access depended, however, on political strategies and advocacy campaigns the likes of which had never been seen before in efforts to make health technologies more available in poor countries.

In addition, the past 10-15 years have been haunted by failures to develop new, needed health technologies. Research and development efforts have yet to produce a vaccine for HIV, and public health experts increasingly worry about antimicrobial resistance in many pathogenic agents, including those that cause much of the global damage done by communicable diseases—HIV, tuberculosis, and malaria. Such resistance signals declining utility in antibiotics and antivirals that once constituted the vanguard of science-led progress in public health.

Moreover, advances in medical sciences and health technologies do not explain the progress made during the past 10-15 years, including the global response to the SARS outbreak,²⁴ adoption of the IHR 2005,²⁵ collective action against avian influenza,²⁶ the reduction in malaria morbidity and mortality through distribution of bed nets,²⁷ negotiation of the FCTC,²⁸ increased efforts against non-communicable threats (e.g., obesity-related diseases,²⁹ road traffic injuries³⁰), and renewed commitment to achieving universal primary health care.³¹

One of the most influential technological aspects of global health's political emergence has been the use of new communication technologies. These technologies were not developed by the health sciences, but they had significant epidemiological and political applications for global health. States, IGOs, and non-State actors have harnessed the Internet and electronic mail to improve disease surveillance and response—a strategy that has affected political calculations of States with respect to sharing information about disease outbreaks. Health advocacy groups have exploited these technologies to form networks to push for reforms or create initiatives. The accessibility, global scope, and speed of new communication technologies that emerged in the 1990s transformed the politics of global health in ways previous advances in communication technologies never achieved.

Understanding Global Health's Political Revolution

Acknowledging that global health underwent a sea change is easier than understanding why this change happened when it did. Underneath health's political rise are developments that reveal how and why this transformation occurred. Global health's revolution flows from the convergence of unprecedented changes and events in international relations. Understanding this convergence communicates that global health's rise emerges from factors that

reshaped how States, IGOs, and non-State actors think about and incorporate health into their foreign policy, diplomatic, and governance agendas.

First, the relationship between foreign policy and health undergoes transformation in the post-Cold War period. The end of the bipolar system, characterized by superpower competition for security and power, altered the context in which States constructed their national interests. This change opened space for countries to think about security, economic power, development, and humanitarian objectives differently. This new political space helps explain, for example, the many attempts made in this period (including in global health) to re-conceptualize “security” to include threats not emanating from military violence perpetrated by enemy States.

Second, the post-Cold War acceleration of globalization challenged conventional thinking about sovereignty and collective action. Globalization upset traditional distinctions between the domestic and the international in all policy fields, not just health. Globalization created and illuminated new forms of interdependence and interconnectedness, which forced countries to reconsider the scope and substance of the national interest in making foreign policy, conducting diplomacy, and devising collective governance strategies.

Third, the breakdown of the Cold War system and the speed and scope of globalization gave non-State actors more political space and material means to play a larger role in international relations. Non-State actors, including multinational corporations, NGOs, terrorist groups, and criminal syndicates, escaped from the margins of the superpower system to have impact on foreign policies, diplomatic processes, and governance regimes. This development rendered anachronistic State-centric perspectives on international relations and forced States to address these new actors and their influence.

Fourth, as these global changes emerged, a proliferation of serious health problems occurred that heightened the epidemiological, political, and economic awareness of States, IGOs, and non-State actors. These problems included emerging infectious diseases, and the threats of non-communicable diseases related to harmful products (e.g., tobacco), pollution, and changes in diet and lifestyles (e.g., obesity). Such a parade of problems in such a short period was unprecedented, and the parade kept global health on political agendas when otherwise it may have fallen to the margins. From a public health perspective, this development was unnerving because it meant that global health’s heightened stature flowed, to a large extent, from failures to prevent and control diseases and their causes. “Nothing succeeds like failure” is not a motto consistent with public health principles and ethics.

The changes created by the end of the Cold War, globalization, and the increasing influence of non-State actors enabled global health issues to gain political footholds within countries and in relations between them. Without the convergence of these developments, the political transformation of global health may never have occurred. These developments underpin the political, economic, and intellectual capital expended on global health in the past 10-15 years. The larger message is that the political, diplomatic, and governance status of global health is dependent on how structural, substantive, and epidemiological factors

align in international relations. Changes to the alignment would affect, perhaps dramatically, global health politics. And that is what happened in 2008.

2008—GLOBAL HEALTH'S *ANNUS HORRIBILIS*

In whatever context, revolutions end, giving way to different patterns of politics. In 2008, global health's political revolution ended. Four crises involving climate change, food, energy, and the global economic system worsened or emerged that changed the foreign policy, diplomatic, and governance contexts for global health. These crises not only generated health risks but they also exposed fragilities in global health's rise in world affairs. Unlike over the past 10-15 years, worsening global health conditions caused by the four crises have not produced more political traction for global health. Instead, the crises re-directed political, economic, and intellectual capital away from global health as countries and IGOs struggled to manage them. In short, 2008 was a very bad year for global health.

This section discusses each crisis and its epidemiological and political impacts on global health. I do not comprehensively analyze the crises or their health and policy impacts. My purpose is to demonstrate how and why these crises have shifted global health into a post-revolution environment that poses new difficulties for foreign policy, diplomatic, and governance action against global health challenges.

Climate Change Crisis

In 2008, concerns about climate change again became prominent. Climate change is not new, nor is global health a stranger to analyzing the potential impact of climate change on health. WHO has, for years, examined health consequences that global warming could stimulate, such as the spread of vector-borne diseases.³² Climate change became more ominous in 2008 because evidence began to mount that the effects of climate change were happening faster than anticipated. The most dramatic evidence came from research on the rate of melting sea ice in the northern polar region.³³ These accelerated effects, and their projected trajectories, underscored the need to mitigate the impact of climate change and not focus exclusively on reducing greenhouse gas emissions.

The evidence that climate change was affecting ecosystems more dramatically than expected confronted global health with three interconnected dilemmas. First, the projected continuation of climate change's adverse effects on the global environment could accelerate health harms. Such increased risks of disease and damage to determinants of health might give health a higher profile in climate change diplomacy,³⁴ but this profile would arise in a scenario of harm mitigation rather than prevention. Scrambling to meet mitigation challenges would reveal that global health arguments had little to no impact on prior climate change diplomacy that focused on slowing down and preventing global warming. In other words, health concerns would only become more important to climate change diplomacy when threats to health became more dangerous.

Second, global health's suggestions for mitigating global warming's adverse consequences cluster around improving national public health and

health care systems so that such systems can contain health risks. Achieving such resilience would require responses on a scale never before achieved, even during global health's rise to prominence. In addition, health impacts from climate change will, in all likelihood, most dramatically affect the most vulnerable populations in developing and least-developed countries, replicating this unfortunate but familiar pattern of global health politics. Given this track record, trying to motivate States to address the mitigation problem primarily through a "health lens" lacks credibility for a problem on the scale of climate change.

Third, acceleration of climate change's effects raised the disturbing possibility that health risks might not be the most pressing problems global warming might create. Climate-change damage to fresh water resources, arable land, agriculture productivity, and coastal cities and communities could create destabilizing population movements, domestic and cross-border conflicts, growth of organized black market and criminal activities, and erosion of government authority. Against these possibilities, health claims for priority in the expenditure of political, economic, and intellectual capital might not be persuasive. Put another way, building better public health systems does not increase access to fresh water, create defenses against violence perpetrated by starving populations, or bolster government authority against criminal exploitation of societal vulnerability.

As with much in the climate change context, these dilemmas for global health rest on speculations the prescience of which is, at present, unknowable. However, the sense of urgency that appeared in 2008 confronts global health with greater challenges but potentially less credibility for the "health lens" as a policy lodestar. The same conclusion holds for the continuing need to reduce greenhouse gas emissions. Global health supports reductions, but this sector has little to contribute to formulating strategies to convince countries to reduce emissions significantly beyond demonstrating that reductions benefit health.

Global Energy Crisis

In 2008, the world also experienced a global energy crisis. Oil prices increased during 2007 and even more sharply in the first half of 2008. In July 2008, the price for a barrel of oil reached a peak of U.S.\$ 147.³⁵ Even more abruptly, oil prices collapsed to around U.S.\$ 40 per barrel by December 2008, largely because of the global economic crisis. Although the global energy crisis came and went during 2008, it had negative repercussions for global health.

To begin, the increase in oil prices during 2008 contributed to the global food crisis (see below). The global energy and food crises were interlinked and, together, damaging to global health. Independent of its connection with the food crisis, the global energy crisis negatively affected public health nationally and internationally in direct and indirect ways.

In terms of direct impact, the increase in oil prices put some countries under macroeconomic stress, producing energy shortages that contributed to negative health outcomes, particularly among vulnerable populations. WHO reported on conditions in one hard-hit country, Tajikistan, which simultaneously confronted one of its worst winters and the rise of energy prices: "The current

energy crisis has . . . a significant impact on already poor health care services, on essential drugs and vaccines supply and on the access to health care facilities. Vulnerable groups including pregnant women, children, elderly and mentally disabled people are particularly at risk.”³⁶ Such health impacts of higher energy prices in Tajikistan and other countries revealed fragility in health systems, underscoring the lack of progress made on improving such systems during global health’s political revolution.

Higher energy prices more generally contributed to negative health outcomes by forcing governments and people to allocate more money to energy than to food, public health, and health services. The impact of higher energy prices at the household level threatened to push millions of people into poverty, which is the most significant determinant of poor health. Fortunately, the energy price surge ended in mid-2008, but only because an even greater calamity struck the global economy.

However, without the global economic crisis, energy prices would have remained high, perhaps unsustainably so for increasing numbers of poor and vulnerable people in all countries. The negative effects of sustained high oil prices could have been devastating for national and global health. This episode revealed macroeconomic vulnerability for global health created by the world’s increasing dependence on oil—a dependence that has not disappeared despite the decline in oil prices in the latter half of 2008.

The global energy crisis also highlighted other aspects of the relationship between health and energy. Prior to the 2008 crisis, experts argued that many people in developing and least-developed countries suffered “energy poverty,” or the lack of access to modern energy services, such as electricity.³⁷ As a result, these people used fuel sources that created adverse health consequences, such as respiratory ailments caused by indoor pollution generated by burning biomass materials.³⁸ The prevalence of energy poverty in the developing world even during eras of cheap oil signals that cheap oil is not the answer to this problem.

However, high prices for oil and energy produced from it stress the ability of developing-country governments to fund sustainable, alternative sources of energy for populations in the energy poverty trap. The end result is the continuation of significant health harms produced by consumption of pollution-producing biomass materials. Failure to reduce energy poverty contributes to the continuation of poverty, with all the health problems persistent poverty creates.

The shock of the oil price escalation, combined with the longer-term problems of increasing demand and dwindling supplies, triggers discussion about the need for other energy sources. From the global health perspective, the most worrying sources identified were coal and nuclear power. Coal’s attractiveness to many countries, including China, India, and the United States, led to interest in burning more coal or developing so-called “clean coal” technologies.

Burning more coal raises problems for efforts to reduce greenhouse emissions and to reduce health-harming emissions from coal-burning plants. More coal consumption is not good for global health from any perspective, but, at the same time, in the absence of any sustainable energy source capable of fueling modern economies, energy-stressed countries will find coal attractive. Global

health experts have nothing to contribute to the search for alternative energy technologies other than encouragement, which is not in short supply.

The other energy source identified as having a more promising future is nuclear energy. From a global health perspective, increased use of nuclear power is worrying because of the prospects for nuclear accidents and illicit diversion of nuclear materials by States for developing nuclear weapons or by terrorists for crafting radiological “dirty bombs.” But, as with coal, global health nervousness about or opposition to nuclear power is easily discounted because of the lack of other feasible energy options. The prospects for “green” technologies (e.g., solar and wind power) operating on the needed scale remain distant, leaving near-term options—oil, coal, and nuclear—that create serious global health problems.

The global energy crisis revealed global health policy as vulnerable to energy price volatility and unhelpful for figuring out how societies can prevent the problems carbon-based energy sources create. As with the climate change crisis, the global energy crisis made global health’s political revolution look irrelevant to one of the most pressing issues facing societies, vulnerable populations, governments, and the planet’s ecosystem.

Global Food Crisis

In 2008, a global food crisis emerged that forced global health policy makers to scramble to construct responses.³⁹ The factors causing this crisis are complex, but, as noted above, an important feature was the increase in oil prices. Skyrocketing oil prices made petroleum-based inputs into food production (e.g., fertilizer) and distribution (e.g., gasoline for transportation) dramatically increase, which helped force food prices higher around the world. Other factors also played a role in sharply rising food prices, including increasing demand for food and damage to food production caused by droughts and other weather-related events.

Higher prices created problems with affordable access to food in many countries, some of which experienced civil unrest because of escalating prices.⁴⁰ The actual and projected impacts of the global food crisis are disturbing. The UN High-Level Task Force on the Global Food Crisis (UN Food Crisis Task Force) stated in July 2008 that the rise in global food prices:

poses a threat to global food and nutrition security and creates a host of humanitarian, human rights, socio-economic, environmental, developmental, political and security-related challenges. This global food crisis endangers millions of the world’s most vulnerable, and threatens to reverse critical gains made toward reducing poverty and hunger as outlined in the Millennium Development Goals (MDGs).⁴¹

WHO indicated that the global food crisis created immediate and longer-term threats of malnutrition, which could: deepen poverty; increase child and maternal morbidity and mortality; make people more vulnerable to communicable diseases; impair mental development, learning ability, and work productivity; and increase prevalence of chronic diseases.⁴² In addition, the

global food crisis threatened to set back attempts to achieve the MDGs on poverty and hunger reduction, child health, maternal health, and combating HIV, malaria, and other diseases by potentially driving 100 million people into poverty and hunger.⁴³

Fortunately, as happened with the energy crisis, food prices eased in the latter half of 2008, partly as a result of the decline in the cost of oil. By December 2008, the food price index of the Food and Agriculture Organization (FAO) indicated that prices had retreated to levels last seen in August 2007.⁴⁴ This development was a mixed blessing. On the one hand, the reduction provided relief from the urgent crisis that came to a head in the summer of 2008. On the other hand, August 2007 food prices were still high enough to cause food access problems in many countries. Policy makers realized that the world still remained susceptible to another spike in food prices.

WHO was involved in the diplomacy the global food crisis created, and the potential health harms, as described above, were discussed. Health-responsive items were included in the Comprehensive Framework for Action (CFA) produced by the UN Food Crisis Task Force in July 2008, particularly advocacy for (1) emergency food assistance, nutrition interventions, and safety nets, and (2) longer-term building of resilient social protection systems.⁴⁵ However, the CFA crafted no blueprint for achieving its objectives or for raising the billions of dollars the plan claimed was needed to address the food crisis and initiate reforms to avert another one.

CFA implementation also suffered from three problems. First, the height of the global food crisis occurred exactly at the time oil prices reached their peak, making it difficult for those working on the food crisis to be heard over the din of anxiety about the energy crisis. Second, funding and coordinated follow-up for the CFA's ambitious and expensive agenda did not materialize. In October 2008, Oxfam argued:

The global response to the food prices crisis has . . . been inadequate. . . . Countries suffering from the food crisis received promises of just \$12.3bn at the Rome FAO conference in June 2008, well short of UN estimates of the \$25bn–\$40bn needed (and five months on, little more than \$1bn has been disbursed). The international community has failed to organise itself to respond adequately: developing countries are being bombarded with different initiatives and asked to produce multiple plans for different donors.⁴⁶

Third, food prices declined as the global economic crisis emerged in the fall of 2008, making it more difficult for those concerned about the food crisis to gain traction with, and resources from, governments and IGOs scrambling to deal with a global economic meltdown. The health-related concerns about the continued existence of higher than normal food prices did not give the global food crisis more prominence once the crisis slipped in perceived urgency. Global health's political revolution had no influence in the events that produced the food crisis and that caused it to fade from the spotlight. As the WHO Director-General put it, "We face a dilemma. Better nutrition is essential for health. Yet the factors

that determine the adequacy and quality of the food supply lie outside the direct control of the health sector.”⁴⁷

The climate change, energy, and food crises all generated potential harms for health on a massive scale. Each crisis revealed that global health is deeply dependent on increasingly interdependent macro-level ecological, political, and economic systems and phenomena over which health interests and concepts have limited influence. These three crises found global health policy makers functioning as unprepared, overwhelmed “first responders” engaging in humanitarian triage to mitigate damage done by forces beyond their control.

Global Economic Crisis

In 2008, a global economic crisis erupted in the final four months of the year. The crisis began in the United States with the meltdown of the sub-prime mortgage industry, but it spread through the U.S. financial system and then to the rest of the world. The economic carnage this crisis has caused is staggering. The world economy has not suffered this kind of damage since the worldwide depression of the 1930s. A few statistics from a March 2009 World Bank report give some indication of the disaster still unfolding:

- Global industrial production decreased 20 percent in the fourth quarter of 2008.
- Industrial production in developed and developing countries decreased 23 percent and 15 percent respectively in the fourth quarter of 2008.
- Global gross domestic product will decline in 2009 for the first time since World War II.
- World trade is anticipated to suffer its most significant decline in 80 years, with the biggest losses occurring in East Asia, which reflects falling volumes, declining prices, and depreciation of currencies.⁴⁸

High-, middle-, and low-income countries have all been hit hard, as evidenced by International Monetary Fund (IMF) interventions to help Eastern European countries crippled by the crisis.⁴⁹ But developing countries are more vulnerable because of their lack of economic and financial resources and their less resilient governance systems and public services. For example, in March 2009, the IMF “warned that the global financial meltdown is threatening to wipe out the financial successes recorded by African countries in the past decade.”⁵⁰ As the World Bank’s President stated in connection with the global economic trauma, “a human crisis is rapidly unfolding in developing countries. It is pushing poor people to the brink of survival.”⁵¹

The dire and worsening nature of the global economic crisis provoked the G20 countries at their London summit in early April 2009 to pledge \$1.1 trillion for restoring credit, generating growth and jobs, and contributing to social support and protection.⁵² Whether these pledges of the G20 countries prove of sufficient scope and substance in overcoming the global economic crisis will not be known for some time.

As with the crises examined earlier, global health policy makers responded to the global economic crisis by warning about the potential health impact and sketching out strategies to mitigate the damage to health. In October 2008, the WHO Director-General observed: “No one can predict how the financial crisis will evolve. Will funding for health development run dry? Will our hard-won progress in health development be set back, as happened in some parts of the world following the emergence and spread of HIV/AIDS?”⁵³ In January 2009, WHO convened a consultation to (1) build awareness of how the global economic crisis might affect health spending, services, behavior, and outcomes, (2) argue for sustaining investments in health, and (3) identify strategies to mitigate the negative impact of economic downturns.⁵⁴

The WHO consultation concluded that “[a] grave human crisis is already happening” and that the global economic crisis threatens to reverse gains made on (1) achieving poverty reduction and the health-related MDGs, and (2) increasing public and private spending and aid dedicated to health.⁵⁵ Further, the global economic crisis is absorbing ever larger amounts of capital to keep governments, financial institutions, and corporations afloat, which drastically reduces the availability of resources for addressing the growing costs of providing adequate public health and health care for populations around the world.

Even before the global economic crisis hit, experts argued that the unprecedented increases in national spending and development assistance for health were inadequate and, even worse, that many developed donor countries had not fulfilled existing aid pledges.⁵⁶ Thus, maintaining existing levels of domestic spending and development assistance on health would not be sufficient, but increased expenditures seem unlikely for years while the global economy recovers. The more likely scenario is reductions in health spending within national budgets and in foreign aid programs. Such reductions, even if short-lived, will have a severe impact on global health activities already desperately in need of more financial resources.

Perhaps the cruelest irony of the global economic crisis is its emergence in the year WHO and global health stakeholders renewed the push for achieving primary health care for all. The report of the Commission on Social Determinants of Health advocated for primary health care in 2008.⁵⁷ The *World Health Report 2008* focused on primary health care,⁵⁸ and the WHO Director-General connected the new emphasis on primary health care to the Declaration of Alma-Ata, which first launched the “health for all” strategy based on universal primary health care in 1978.⁵⁹

However, 30 years ago, the Alma-Ata strategy was derailed by developments in the energy and economic sectors that sound ominously familiar, as the WHO Director-General recognized in September 2008:

Nor could the visionary thinkers in 1978 have foreseen world events: an oil crisis [that began in 1979], a global recession [in the early 1980s], and the introduction [in the 1980s], by development banks, of structural adjustment programmes that shifted national budgets away from the social services, including health. As resources for health diminished, selective approaches using packages of interventions gained favour over

the intended aim of fundamentally reshaping health care. The emergence of HIV/AIDS, the associated resurgence of tuberculosis, and an increase in malaria cases moved the focus of international public health away from broad-based programmes and towards the urgent management of high-mortality emergencies.⁶⁰

The effort to rejuvenate the primary health care movement in a year in which global food, energy, and economic crises emerged proved ill-timed, and the worsening nightmare of the global economic crisis threatens even more damage to the political, economic, and social conditions needed to achieve progress on universal primary health care. Put another way, political, economic, and intellectual capital for advancing the primary health care agenda will, for the foreseeable future, be in short supply. Instead, as with the energy and food crises, global health finds itself scrambling to address an emergency with potentially devastating consequences for the health of individuals and populations, health services and systems, and the social determinants of health.

From Revolution to Rear-Guard Actions

The four crises that worsened or emerged during 2008 radically changed the conditions in which global health politics, diplomacy, and governance take place. These changed conditions ended global health's political revolution and created the immediate need for global health policy makers to fight rear-guard actions against crises that threaten harm at all levels, from global governance regimes to local households.

Signature features of global health's political revolution now appear vulnerable to the effects of these crises, particularly the on-going global economic crisis, including:

- Progress towards achievement of the health-related MDGs;
- Implementation of the IHR 2005;
- More robust collective action against non-communicable diseases, including strengthening of the FCTC; and
- Needed increases in foreign aid and development assistance devoted to global health.

In addition, claims that global health problems constitute threats to a nation's vital security and economic interests have a less persuasive texture in light of the actual and potential damage to such interests the four crises have created. Arguments about health's importance retain more resonance with development and humanitarian objectives. However, the crises have generated not only more difficult conditions for achieving such objectives but have also made more urgent the need for actions outside the health sector (e.g., preserving employment rather than expanding primary health care) to prevent development and humanitarian goals from imploding. Claims about global health's importance will face more scrutiny, deeper skepticism, and intensified competition for political and economic capital in light of the crises of 2008.

As global health moves from the headiness of its political revolution to fighting rear-guard actions against global ecological and economic crises, the center of gravity for political, diplomatic, and governance activity for global health shifts from the health sector to political, economic, and environmental contexts in which health policy's voice remains weak because the health sector does not necessarily have persuasive input into how climate change, energy, food, and economic crises should be prevented in the future.

In reflecting on the 2008 crises, the WHO Director-General argued, "there is no sector better placed than health to insist on equity and social justice"⁶¹ in how globalization operates. Why health experts are better placed than human rights advocates, economists, environmentalists, or national security analysts to promote equity and social justice in world affairs is not clear. Further, equity and justice are features of a political end-state not blueprints for how societies tackle global warming, energy crises, food insecurity, or global economic meltdown.

Put another way, progress towards universal primary health care will not slow global warming. Countries that embrace the right to health or pursue universal access to health care emit greenhouse gases in increasing quantities and seem no better at reducing emissions than countries that do not share these ideals. Reducing the prevalence of non-communicable diseases in developing countries will not lessen the world's increasing thirst for oil, other hydrocarbon resources, or nuclear energy. Implementation of the IHR 2005 will not affect any of the factors that caused the food crisis of 2007-2008. The global economic crisis could have been avoided by regulatory changes in the United States unrelated to, and uninformed by, any strategy to fulfill the health-related MDGs. Prevention strategies for the kinds of crises that made 2008 an *annus horribilis* for global health have to emerge outside the health sector, which means those areas require more political, economic, and intellectual capital to make progress.

ON THE HORIZON: FUTURE GLOBAL TRENDS AND GLOBAL HEALTH POLITICS

Just as revolutions end, so too do crises. Thinking through global health's post-revolution prospects requires looking beyond the current rear-guard actions. For this analysis, trends identified by the U.S. National Intelligence Council (NIC) in a November 2008 report prove useful (see Table 1).⁶² My purpose is not to analyze these trends comprehensively but to describe how they might affect global health politics in the next 20-25 years.

The NIC trends can be divided into trends that (1) affect the determinants of health (globalizing economy, demographics of discord, scarcity in the midst of plenty, and growing potential for conflict), and (2) influence the context in which global health politics, diplomacy, and governance take place (the new players, multipolarity with multilateralism, and power-sharing in a multipolar world).

In broad terms, these two categories communicate that, by 2025, threats to health determinants will grow and that the context in which States, IGOs, and non-State actors must address such threats will become more difficult for crafting collective action. Continuing globalization will tighten interdependence, making countries vulnerable to macroeconomic shocks, as occurred in 2008 with the global energy, food, and economic crises. Whether the shift of economic power to

Asia, and towards a model of “state capitalism” characterized by greater government involvement, would prevent or mitigate such shocks is not clear. From a health perspective, neither China nor India is a paragon, so their models of state capitalism do not necessarily augur well for global health’s resilience in the globalizing economy of 2025.

Table 1. *Global Trends 2025: Seven Global Trends*

Global Trend	Summary Description
<i>The globalizing economy</i>	Economic power and wealth will shift from West to East, with “state capitalism” gaining more influence as a model of economic development and management. The “global middle class” will grow as millions (mainly in China and India) escape poverty.
<i>Demographics of discord</i>	The world’s population will increase significantly, with Asia and Africa accounting for most of the growth. The demographic changes will produce diverse challenges, including dealing with aging populations and persistent “youth bulges.” Population growth will place stress on resources, create migration, accelerate urbanization, and perhaps encourage ethno-religious identity politics.
<i>The new players</i>	The number of important actors in global politics will increase, and the new key players will include China, India, Russia, Indonesia, Turkey, and Iran.
<i>Scarcity in the midst of plenty</i>	The international system will increasingly confront constraints on vital energy, food, arable land, and water resources. Climate change will exacerbate the stress on food, land, and water resources. Hydrocarbon resources still dominate energy production, but a transition to a post-petroleum world might begin to occur by 2025 through use of new technologies.
<i>Growing potential for conflict</i>	The potential for conflict within countries, between states, and perpetrated by terrorist groups will be significant in 2025. Iran’s pursuit of nuclear weapons could trigger a nuclear arms race in the Middle East; conflicts over natural resources might occur, with climate change potentially playing a role; and terrorist groups might make more use of advanced technologies (e.g., biotechnology).
<i>Multipolarity without multilateralism</i>	The international system will increasingly exhibit multipolarity from the emergence of influential new state and non-state actors, but this multipolarity will make achieving multilateral solutions to traditional and transnational problems increasingly more difficult.
<i>Power-sharing in a multipolar world</i>	The United States will remain the most powerful actor in the international system, but its power in a multipolar world will be less and its policy options fewer. Countries will still look to the United States to show leadership, but the military and economic capacities of the United States to bear leadership roles will shrink.

Projected demographic trends, resource scarcities, and potential for conflict also spell potential trouble for global health over the next 20-25 years, especially because these trends may develop a harsh interdependence. Growing populations will require more scarce resources (food, water, land, energy), which

may feed into State and non-State actors' (e.g., terrorist groups or organized crime) efforts to secure access to resources, leading to conflict. The NIC expects climate change to affect adversely the availability of, and affordable access to, important scarce resources, such as food, water, and arable land. The global food and energy crises of 2008 emerged and faded rapidly because of rising and falling prices. By 2025, the world might face more chronic, pervasive population, food, water, land, and energy crises that will threaten health on a significant scale, especially health for vulnerable populations in developing countries.

For harm to health from such trends to be prevented or mitigated, the global community would need to engage in intensive cooperation across a range of issues in order to produce coordinated, sustainable collective action that can manage the impact of growing populations on resource scarcities and avert conflict. However, the NIC trends that relate to the context in which global politics will take place (the new players, multipolarity without multilateralism, and power-sharing in a multipolar world) suggest that effective cooperation and collective action might be increasingly hard to achieve and sustain.

Global health's political revolution occurred in a particular political context and structure—the post-Cold War period—that created space for global health to rise in importance. Significant changes in the structure and dynamics of global politics would affect global health policy, diplomacy, and governance, perhaps in profound but unsettling ways. The NIC argued that “[t]he international system—as constructed following the Second World War—will be almost unrecognizable by 2025” and that “the next 20 years of transition to a new system are fraught with risks.”⁶³ These risks might well emerge from increased and sustained divergence of national interests among a larger number of great powers engaged in heightened competition for power, influence, and resources. This reality would make new, long-lasting diplomatic initiatives and governance mechanisms on collective action problems, including those facing global health, more difficult.

The prospect of conditions for global health deteriorating over the next 20-25 years happening at the same time the political context for collective action becomes more challenging is sobering in contemplating global health's post-revolution future. As the NIC emphasizes, its trends for 2025 might be wrong, or the trends may converge or diverge in ways that produce different permutations of the future. After the battering global health took from the global crises of 2008, the NIC's trends represent serious potential threats to global health's place in international politics, the prospects for global health diplomacy, and the effectiveness of global health governance mechanisms.

CONCLUSION: FROM REAR-GUARD ACTIONS TO HEALTH-CENTRIC RE-GLOBALIZATION

The end of global health's political revolution does not signal the end of global health as an important global political objective or activity. Both the revolution and the rear-guard actions should be kept in perspective. The global crises of 2008 revealed fragilities and vulnerabilities in global health that suggest its political revolution, however impressive, was incomplete and inadequate. Health

as a political value and interest did not transform foreign policy, diplomacy, or global governance or secure a permanent place in the “high politics” of international relations. Similarly, the climate change, energy, food, and economic crises have not rendered global health policy completely impotent or banished the health sector to the neglected depths of “low politics” in world affairs.

Instead, the crises of 2008 reveal global health operating as a type of meso-politics in which policy makers use science and epidemiology to synthesize and translate risks and opportunities between the worlds of hard power and normative values. Prior to its political revolution, global health had developed no serious linkages with, or credibility in, the policy communities tasked with protecting a country’s vital national interests in security and economic well-being. Global health now interfaces with these communities and interests, but its influence in these areas is limited, particularly when crises are not caused by the sudden, severe, and large-scale disease threats.

The heightened profile global health achieved in development, human rights, and humanitarian policies gives global health a more prominent and credible voice in efforts to improve human welfare. The interventions global health policy makers made concerning the crises of 2008 demonstrate global health’s higher profile in defending health perspectives on development, human rights, and humanitarian issues. However, with respect to threats to political, economic, and social determinants of health, this influence is limited because the needed policy fixes fall outside the health sector, as the global crises of 2008 illustrate.

Global health’s post-revolution path will be determined by how policy makers exploit global health’s meso-political space in world affairs. The global economic crisis has produced severe contractions in leading indicators of globalization, such as trade and capital flows, encouraging some commentators to sense the emergence of “deglobalization.”⁶⁴ Looking forward, global health as meso-politics has an opportunity to heighten health promotion and protection across policy areas as the world gropes its way back to a new version of globalization.

The Leaders’ Statement issued at the G20 London summit in early April 2009 identified the need for the global economy recovery to provide social support, reflect fair labor standards, and stimulate a transition to a green economy,⁶⁵ but the Statement did not specifically mention health protection as a benchmark for economic recovery. Herein lies the coming challenge for global health. At this turning point, the global health community must “evaluate how [it] can most effectively respond to the crises of 2008 and take advantage of this moment of extraordinary attention for global health[.]”⁶⁶ Global health’s grand strategy for its post-revolution future should be a relentless effort to make the process of re-globalization as health-centric as possible.

In many ways, global health’s political revolution represented the health community’s attempt to harness globalization in two senses—to take advantage of opportunities globalization generated, and to devise strategies to prevent and mitigate health problems globalization created or exacerbated. In both realms, global health tried to influence a phenomenon that exploded after the Cold War’s demise without much involvement from health experts.

Although battered and bruised from its *annus horribilis*, global health stands better positioned than ever before, after its political revolution, in the political, diplomatic, and governance spaces where the world will shape the processes of re-globalization. This time the global health community will not have the excuse that its neglect and marginalization in international relations leaves it unprepared to try influence the course of world affairs.

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