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# Health and politics

*Michael 2011;8:251–257.*

*This paper reflects on the significance on the Baltics as a historical case that illuminates key dilemmas of contemporary discussions of global health. At stake in the Baltic region post 1989 as well as in today's global efforts to improve population health, is the interplay of internal political dynamics and international influences and pressures: Viewing governance as the practice of politics, the paper uses the Baltic case to illustrate how politics at the international and national level together shape health care.*

Beyond the localities of people's daily lives, what broader conditions and decisions determine health care? The nation-state is in modern history the most visible of boundaries that delimits the scope and jurisdiction of health care and public health. Nation-states, however, are not static or isolated entities. On the contrary, they are subject to both internal dynamics and external forces. Few regions of the world illustrate this better than the Baltic Sea Region, which in the period between 1985 and 2005 went from being part of the Soviet Union, to become independent states, and finally part of the European Union. Toward the end of that period, these countries were also part of new international collaborations to curb the spread of infectious disease. Focus on the Baltic states thus enables us to observe how changing national and international political circumstances affects the health care sector.

This paper is a reflection on the interconnectedness of health and politics. While the connection is hardly new, it receives current attention by academics and by policy makers alike, it is integral to the relation between global and national health governance. Public health is inextricably linked to the moral and instrumental objective of a government to maintain a healthy population, essentially promoting health and protecting against disease. Obviously, there are large variations in states' attentiveness to equity

and fair distribution of the means to health. However, the state remains at the core, in need of legitimacy from the people it seeks to govern, enforcing a social contract to justify its rule. From the public health perspective, there is also an age-long conviction that effective governance is a necessary companion to science in order to reach health goals (1) . Increasingly, local and national politics are influenced by decisions taken beyond their own national boundaries, in regional and international forums, or even in other states. Thus, the link between politics and health requires attention on a domestic and international level.

The paper draws from ongoing research on global health at the University of Oslo which applies a political science and international relations perspective on ways in which current global and national health governance blend and mutually constitute each other. As academic discipline, political science is engaged in revealing the relationships underlying political events and conditions. Otto von Bismarck coined politics as the art of the possible, and the practice of public health should indeed be familiar with the recognition that gold standards are good ideals, but seldom attainable in practice given the realities of conflicting interests and positions, uncertain science and disputed knowledge.

Questions about the dynamic relationship between global health initiatives and countries own health systems in the protection of individual and population health are at the heart of contemporary discussions about global health governance.

## The global-national interface as a conceptual frame for studying politics and public health

The interaction of global and national efforts in the protection of individual health can be understood as two overlapping realms of governance.

In general terms, the global governance realm is the collective action or cooperation that takes place outside the realm of the state: It normally includes the work of the World Health Organization and other international organizations, and what we also term international institutions – generally understood as the rules and norms governing interaction. Cooperation between countries, within regions or across, also forms part of this realm.

The concept of *global health security* gained foothold since the turn of the millennium as a distinct international political project to control the cross-border spread infectious disease. This kind of cooperation has historical roots in intergovernmental agreements to contain the spread of infectious disease in the mid-17$^{th}$ century. Still, a renewed focus on health as part of national security rose back up on political agendas in the late 1990s

as part of an increased focus on emerging infectious diseases, of which HIV/AIDS was an 'early' example, as well as tuberculosis (as re-emerging), and later followed by the severe acute respiratory syndrome (SARS) outbreak and the potential of highly virulent influenzas. Observers have noted that there was an international build-up of scientific and political attention to the 'return of the microbe', with responses modeled on the smallpox disease eradication model; surveillance, outbreak investigation and containment, striving "…to transcend certain limitations posed by the national governance of public health" (2, p. 61). In the 1990s, the emerging disease problem was part of US national security discussions, linking also to the bio security issue (2, p. 69).

The effort to build a global response-network has been firmly established as a global collaborative effort anchored in the WHO, emphasizing that global public health security would not just stop infectious disease at national borders, but seek to prepare for outbreaks in advance and ensure rapid action through an early warning system, sought implemented in member states (3). A study reviewing country policy documents on global health, found that the fear of pandemics as part of a health security argument recurred most frequently (4). Health security is in other words a very powerful driver of international health collaboration.

The national health governance realm spans from central decision-making to district-and community-level health care services, or simply put, a system for public health to both protect against health risks but also to provide services. The state's role as provider varies along a continuum from political control to market liberalization. As global health governance efforts seek a deeper integration and wider reach, national governments become the gatekeepers to their health care systems and populations, for better or worse. Sometimes, populations represent a potential impact-factor for international projects, a potentially valuable asset to both governments and international initiatives. At other times, governments may be wary of imposed limitations on their sovereignty and control, but also mindful of their need for legitimacy both domestically and internationally. This is obviously a balancing act for governments. In any case, the current reality is that the national health governance realm works in relation to a widening group of state and non-state actors where the separating lines between domestic and international health is increasingly blurred.

The new form of country-global interaction can be captured analytically in the concept of interfaces, as "…socio-political spaces of recurrent interactions (…) in the handling of transnational and international affairs" (5). The term is an adaptation from sociology (6,7), and recently used to analyze the participation of South Africa and Brazil in international trade negotia-

tions over access to hiv/aids medicines as two emerging developing countries increasingly able to set and influence global agendas (5,8). Wogart et al propose a typology of interfaces that captures ways in which domestic actors interact with global arenas: One relates to the framing and influence over discourses, where for instance media and expert commissions shape perceptions of influential persons on important political issues. The second type of interface relates to resource transfers, where funding of multilateral organizations and country interventions play an important part. The third point of interaction is organizational and decision-making interfaces, capturing the range of initiatives, partnerships and alliances as meeting places between country and global constituencies. Depending on the issue area, the organizational interface may also include legal interfaces between international and domestic law (5, p.10). While a conceptual focus on interfaces sees governance as a relational phenomena, it still emphasizes the need to understand the participating actors "… in their original structural context, their sets of reference points and constraining/enabling properties" (7, p.62). The importance of understanding what goes on at the interfaces, is to identify the conditions under which international collaboration succeeds in improving the protection of individual health.

## The Baltic region as example

The efforts to combat infectious disease in the Baltic Sea Region are a particularly interesting case because of the political changes this region went through over a course of 15 years. Even if a detailed examination of the Baltic case is beyond the scope of this paper, it serves as an illustration of how changes in a national health governance realm must also respond to international initiatives.

As the Soviet Union fell apart in 1989, Latvia, along with the other former Soviet states of the Baltic region, entered a decade of political liberalization and rapid changes. The reflections of Kilkuts (9) on the transitions from Soviet to post-Soviet health care in Latvia gives a good view of the changes in the national health system, transitioning from public health *control* to *services*. From a prevailing paternalistic Soviet health care system, the market economy was now driving decisions about patient care (10). Latvia introduced a primary health care system in 1996, which also opened up for private practice. Kilkut also reflects on what the newly gained freedom from 'totalitarian paternalism' entailed for the health system: Well-functioning health information systems with screening information and specific long term follow-up of certain conditions, was for instance not maintained (10). This suggests that from a public health perspective, there were both

gains and losses with the transition to freedom and democracy. A system characterized by control and oversight, was replaced by one that was liberal, pluralistic and centered on individual responsibility.

The Task Force on Communicable Disease Control in the Baltic Sea Region entered in 2000 as one of the first examples of an interface between national health systems and a global health security paradigm. The Task Force was established as a high-level political initiative with a mission "… to reduce through concerted action the risk and burden of communicable diseases in the region" (11, p. 1). The Task Force was a response to observations of sharp increases in infectious disease in the Baltic Sea and Barents regions since 1990 (11, 12) From an international perspective, the re-emergence of tuberculosis with increasing virulence and drug-resistance, and the rapid spread of HIV was undoubtedly causing concern the corridors of health authorities in neighboring countries as national borders were opening up.

Of the 11 countries in the Task Force, six were donor countries (Denmark, Finland, Germany, Iceland, Norway and Sweden) providing a total exceeding 10 million Euro in funding (11). An evaluation of the political dimension of the initiative describes how the Task Force was a Norwegian initiative, coming from the Norwegian Prime Minister Jens Stoltenberg and his adviser at the time, Jonas Gahr-Støre(13). Gahr Støre had just returned from Geneva as Executive Director of WHO, inspired by new conceptualizations of health as part of a whole, and inextricably linked to international relations between countries in a globalizing world. The Task Force thus embodied health as an international political project (13).

If we focus attention on the kinds of interfaces that the Task Force created, the arenas of exchange between professional networks stand out as of particular importance. The Final Report of the Task Force stresses the achievements of "(t)he establishment of a wide network of experts and health and other officials", among others (11, p. 11). The report stresses collaboration on improving surveillance systems, the setting up of early warning systems, bringing tuberculosis control in alignment with WHO standards, and setting up low-threshold support centers for diagnosis, treatment and prevention of HIV, and putting in place hospital infection conrol procedures, for instance through the enhancement of laboratory capacity (11). The report concludes that "A wide and well-functioning network has been established, at the political as well as the practical and professional levels" (11, p. 27). Moreover, the contacts established were considered a necessary basis for other aims to succeed. The evaluation report also notes that the Task Force was seen as a useful third party in easing relations between medical expertise in Russia and Baltic states, which had been strained

since the independence of the Baltic states. To sum up, the Task Force embodied the ambition to fight infectious disease through more, instead of less, contact across borders (13, p.2).

## Concluding discussion

In the case of the Baltic states, changes in national health systems as part and consequence of the break-up of the Soviet Union appear substantially different from the changes sought through the Task Force. The period following independence was essentially a change in the national political system, which in turn led to economic liberalization and rapid modernization. This, as we have seen, affected the national health governance realm in profound ways. With internal political changes came a new form of integration with the international community, giving rise to initiatives like the Task Force. The Task Force was a political process initiated by a typical donor country with strong links to the global health governance realm. The projects that formed the core of the Task Force, however, diverged from its high-level political take-off to collaboration based through funding and networking of scientific expertise, academics and professionals.

A closer examination of the interfaces between the national and international governance realm in the case of the Baltic states would require further empirical research. What can still be said, however, is that the two realms certainly meet in the day to day work in laboratories, hospitals and government health administration. Here, the interplay between various actors and resulting decisions constitutes politics in practice. This would be interesting to examine, also in the context of EU membership after 2004, where the EU Northern Dimension Partnership in Public Health and Social Well-being took over after the Task Force. The questions that could be asked include: Under what conditions does the global health governance realm focus on public health security contribute to the protection of individual and population health as part of primary health care?; Do targets of the international health governance realm coincide with the needs of national health systems?

If viewed in a broader context of global health governance, the Task Force was ahead of its time in addressing health issues from a foreign policy platform. A few years later, in 2007, The Norwegian Minister of Foreign Affairs, together with six colleagues, issued a declaration in the Lancet, titled 'Oslo Ministerial Declaration: Global Health – a pressing foreign policy issue of our time'. This initiative was an affirmation that global health had become a concern of high politics, reflecting a broader notion that foreign policy was no longer just about protecting ones own borders, but cooperating to reduce shared vulnerability (*14*).

In closing, national governments have important roles as mediators of changing contexts that are simultaneously international and domestic. A key lesson from the Baltic states case is that the study of politics may learn from the focus on health governance, and public health may also benefit from examining a range of political determinants.

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