Why Health Is Important to U.S. Foreign Policy

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Table of Contents

FOREWORD

This report describes why it is important to raise the priority accorded to health in the foreign policy of the United States and recommends policies and procedures to achieve this goal. It is the result of conversations and meetings initiated by the Council on Foreign Relations and the Milbank Memorial Fund beginning more than a year ago. This publication is one of a series of activities through which the Council and the Fund will communicate the findings and recommendations of this report to a variety of audiences.

The Council and the Fund have each worked for many years to bring the best available information and ideas to bear on the development and implementation of policy in their respective fields: the Council in foreign policy and national security matters; the Fund in health care and public health. Peter Gottsegen, a member of both the Council and the board of the Fund, convened leaders of the two organizations and suggested that they co-sponsor the project.

The Council and the Fund each designated a co-chair of the project. Princeton Lyman retired from the Foreign Service after holding positions that included Assistant Secretary of State for International Organization Affairs, U.S. Ambassador to Nigeria, and U.S. Ambassador to South Africa. He currently serves as Executive Director of the Global Interdependence Initiative at the Aspen Institute. Jo Ivey Boufford has been a practicing pediatrician, President of the New York Health and Hospitals Corporation, Director of the King's Fund College, London, Principal Deputy and Acting Assistant Secretary of Health in the U.S. Department of Health and Human Services, and U.S. representative on the Executive Board of the World Health Organization. She is currently Dean of the Robert F. Wagner School of Public Service at New York University.

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EXECUTIVE SUMMARY

The United States can gain significant domestic and international advantages by placing health squarely on its foreign policy agenda. Supporting public health worldwide will enhance U.S. national security, increase prosperity at home and abroad, and promote democracy in developing countries and those in transition.

Emerging risks to the health and security of Americans make it prudent policy to grant higher priority to health in these countries. In addition to the threat of the deliberate spread of disease through biological weapons, Americans may now be at greater risk than at any time in recent history from recognized and emerging infectious diseases. These diseases are resurgent everywhere and spread easily across permeable national borders in a globalizing economy. The proliferation of drug-resistant organisms makes diseases more difficult to treat. The rising incidence of life-threatening chronic diseases in developing countries adds to the problem. Lack of attention to the burden of disease in these countries, which receive 42 percent of U.S. exports, may depress demand for those goods and services and thus threaten the jobs of Americans.

Deteriorating health conditions also create political risks in countries of strategic importance—for example, throughout the former Soviet Union. Poor public health increases the likelihood of political instability, disenfranchises persons with inadequate social capital, limits economic growth, and exacerbates the human damage caused by social and economic dislocation.

Responding to these health and political risks requires the addition of new tools to an integrated foreign policy. These new tools include debt relief, improved global disease surveillance systems, investment in health education and information technology, workforce training, immunization and other methods of disease prevention, building and equipping facilities for prevention and treatment, and increasing access to affordable treatment and care.

The annual cost of such a health initiative on behalf of the two billion people who now live on less than $2 a day is estimated to be $15 per recipient. By comparison, an average of $4,000 is spent annually for health care for each American. With strong leadership by the United States, other donors in the public and private sectors, as well as developing countries themselves, should be able to assume a significant portion of the costs.

The new administration has a strong interest in programs that help bring the nation together because these enjoy support that cuts across partisan lines. Improving the health status of people in developing countries can build on at least two precedents: bipartisan support in 2000 for a bill providing $435 million to relieve debt owed by poor counties, and the 28 percent increase in support for global health initiatives in the federal budget for FY2001.

Improving the health of people in other countries makes both strategic and moral sense. Beyond enhancing security, prosperity, and democracy—and addressing the criticism that the benefits of globalization leave out the poor—a vigorous international health policy provides an opportunity for leadership that is grounded in the United States' strength in biomedical science and its applications. In sum, a foreign policy that gives higher priority to international health is good for the United States and good for the world, and it is a principle that can attract widespread agreement.

RECOMMENDATIONS FOR U.S. POLICY

Policy and Program Commitments

1. The president and the secretary of state should make a commitment to place global health squarely on the agenda of U.S. foreign policy in order to protect both the health of Americans and major U.S. interests.
2. The administration should fully support pending bills before Congress that call for a $1 billion increase

to support global health programs that improve maternal health and child survival, expand family planning options, decrease the incidence of infectious diseases (including tuberculosis and malaria), and fight the global HIV/AIDS pandemic.
3. USAID should be funded to increase support for AIDS treatment and prevention in India, China, and Russia.
4. The United States should invest $400 million over the next five years to support a Global Health Security-Epidemic Alert and Response surveillance system in order to protect Americans from the direct threat posed by the global resurgence of infectious disease.
5. The administration should support the work of the United Nations, the World Bank, and the International Monetary Fund as they continue to strengthen their investments in health systems development and should work to encourage other donors and the development community to do the same.
6. The administration should work with all stakeholders to find innovative ways to provide incentives for research on new interventions, while ensuring that patients in need everywhere have access to drugs and vaccines within effective health care systems.
7. To assure the safety of the "shared food supply," the administration must increase support for the same type of fundamental infrastructure commitments that health improvements will need—improved sanitation, potable water, and health education.

Implementing the Policy

In order to make these recommendations effective foreign policy:

1. An interagency structure should be created, headed by a special assistant to the president and senior director of international health affairs at the National Security Council, with strong representation from a wide variety of departments and agencies.
2. The administration should work closely with Congress to identify priorities for global health that will gain bipartisan support.
3. Together with partners in business and nonprofit organizations, the administration should create a strategic action plan and multiyear budget projections to address global health issues.
4. U.S. health attachés should be assigned to U.S. embassies and missions or made available through secondments to work within government bureaucracies in South Africa, Nigeria, Russia, India, China, Ukraine, Mexico, and Brazil to improve attention to health issues in these critically important countries.
5. Research and analysis to inform policy should continue, including:

    a. Further knowledge of how health and health care affect political stability in countries of clear U.S. interest with current major health risks, such as Russia, India, China, Mexico, and South Africa.
    b. Assess health risks in countries deemed critical to U.S. national security and determine potential effective interventions.
    c. Identify projects in which investments in improving and maintaining health can spur development, in conjunction with the World Health Organization's Commission on Macroeconomics and Health.
    d. Support research for vaccine and other health technology.

INTRODUCTION

During the 1990s, the nexus between foreign policy and international health became increasingly apparent. Early signs of this connection included a special session of the United Nations Security Council on the issue of HIV/AIDS, huge debt relief packages tied to investment in health, and liberalized trade policies to improve access to drugs. Policymakers and the global health community can strengthen this link by framing global

health priorities in terms of a broad set of interests that include national security as well as economic, political, and humanitarian concerns. This should encourage the U.S. government to make global health a more central component of its foreign policy agenda as part of its work to produce stable governments, peace, democracy, economic development, and free trade.

It is no longer possible to dismiss health problems in other countries as a "soft" factor in U.S. foreign policy. These problems have come to the fore as the global transmission of disease becomes a risk for Americans and with increasing documentation of the links between health problems in other countries and American security, prosperity, and interest in economic development abroad.

Aside from rapid advances and diffusion of biotechnology and material sciences that add to the capabilities of U.S. adversaries to engage in bioterrorism, Americans are at great risk from emerging and reemerging infectious diseases. Infectious diseases are resurgent globally; they spread more easily as national borders become more porous under economic globalization; and they are more difficult to treat because of the alarming proliferation of drug-resistant microorganisms.

In the international arena, these diseases threaten ordered existence by exacerbating political instability, disenfranchising those without social capital, and stunting economic growth. The result is to make countries more vulnerable to violence and war and to aggravate their effects. The importance of these threats is reflected in the addition of health issues to bilateral agendas between the U.S. and other countries and to multilateral summits like the G-8 and OECD. As a result, these issues now demand more U.S. foreign policy resources in terms of both money and the time of senior officials, as well as increased expertise and coherence in the U.S. approach to its international health policy.

These challenges offer a great opportunity. In many regions of importance to the United States, U.S. leadership is resented or resisted. Public health, however, is a unique site in foreign policy. Here U.S. leadership in international health affairs can provide an unequivocally positive framework for pursuing what is in our interest as well as that of the world. This can be an important component of a response to the inequities of globalization.

Leadership, not unilateral action, is essential because this is an enormous global problem that can be managed only through concerted international action. The United States must appreciate the centrality of partner governments, the United Nations system, development banks, foundations, the private sector, and NGOs. Success will require financial and scientific action by all these stakeholders. It also requires collaboration with the UN system, especially in the developing world.

Global health challenges present the makers of U.S. foreign policy with serious questions. How should America respond? What, realistically, can be achieved—and for how much money? Which arms of government should be mandated to take action? How much of the work should be left to nongovernmental organizations (NGOs) and multilateral organizations? Answering these questions provides a barometer for the reality, rather than the rhetoric, of a post-Cold War foreign policy that broadens the notion of national security to include transnational issues like health.

In this report, we make the case for alternative strategies based on three different justifications for the U.S. government to consider health in its foreign policy: narrow self-interest, enlightened self-interest, and humanitarian interests. We conclude that only by blending these approaches will we be able to properly address global health crises and to play our appropriate role to promote health in the international community.

NARROW SELF-INTEREST

As the AIDS pandemic and the appearance of West Nile virus in the U.S. Northeast have made abundantly clear, infectious diseases do not respect borders. Ignoring the spread of infectious disease will increase the danger that these global health problems will become a domestic security issue. Diseases do not need visas, as a recently declassified National Intelligence Council risk assessment makes clear: "New and reemerging infectious diseases will pose a rising global health threat and will complicate U.S. and global security over the next 20 years," it concludes. "These diseases will endanger U.S. citizens at home and

abroad, threaten U.S. armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which the United States has significant interests" (National Intelligence Council 2000).

Resurgent and Emerging Diseases

There are several reasons to believe that the *direct* threat to Americans is rising. First, infectious diseases that once appeared to be well controlled are resurgent globally. This can be attributed to factors including a global breakdown in public health infrastructure, increased environmental degradation, and increased urbanization. In the past 20 years, approximately 30 new diseases have emerged, including HIV/AIDS, Ebola virus, hepatitis C, Hanta virus (in the southwestern U.S.), and the virulent "flesh-eating" version of Group A streptococcus. Simultaneously, several of humanity's oldest and most lethal scourges—tuberculosis, malaria, and cholera—have gathered strength. For example, in 1999 there were 8.4 million new cases of tuberculosis worldwide, up from 8 million in 1997 (Vidyashaankar 2001). Six infectious diseases—HIV/AIDS, tuberculosis, malaria, pneumonia, diarrheal infections, and measles—account for half of all premature deaths worldwide (World Health Organization 1999). In total, 54 million people died of infectious diseases in 1998.

Globalized Disease Transmission

Second, borders are becoming more porous, and this facilitates the spread of disease. Borders are going to become increasingly meaningless over the next several decades for both people and goods. The health problems faced by people in distant countries are increasingly going to be felt here. As Dr. Gro Harlem Brundtland, director-general of the World Health Organization, states, "There are no health sanctuaries." For example, with new DNA fingerprinting technology, scientists have been able to identify drug-resistant TB strains originating in eastern Europe, Asia, and Africa and to track them as they appear in more and more patients in western Europe and North America.

Increased trade and travel, population movements, and a shared food supply spread health risks across the globe and the socioeconomic spectrum. People are more mobile: 57 million Americans traveled abroad in 1998, and tourism now claims to be the world's largest industry, accounting for 11.7 percent of global GDP in 1999 (World Travel and Tourism Council 2000). There are significant movements of populations in the other direction, too: 70,000 foreigners enter the United States every day, and the nation had 26.3 million foreign-born residents in 1998 (Population Reference Bureau 1999).

The global movement of goods and services has also increased rapidly; U.S. imports more than trebled between 1980 and 1997 (World Bank 1999). In particular, U.S. food imports doubled in the five year period 1995–1999, to more than 4.1 million foreign food items (Winter 2001), increasing the risk of new food-borne illnesses and creating a politically fraught intersection between public health and international trade (National Intelligence Council 2000). Recently, European officials complained that the Bush administration was overreacting when it banned imports of animals and animal products from all 15 countries in the European Union after learning that foot-and-mouth disease has spread to France from Britain (Marquis and McNeil 2001).

The economic and political damage caused in Europe by bovine spongiform encephalopathy ("mad cow disease") is a sobering reminder for the United States. The British beef industry suffered losses of between $10 and $40 billion. Furthermore, public concerns about how their governments responded to food-safety crises played an important role in the fall of two governments in Europe in the last few years: the Majors-led government in Britain in response to mad cow disease and the Belgian government in response to dioxin contamination of animal feed in 2000.

Treatment Challenges

Third, many diseases are becoming more difficult to treat. This is due in large part to the misuse of antimicrobial medications. A WHO report issued in June 2000, "Overcoming Antimicrobial Resistance," warns that increasing drug resistance could rob the world of the ability to cure illnesses and stop epidemics. The report describes how almost all major infectious disease organisms are slowly but surely becoming resistant to existing medicines. The disastrous results range from the death of otherwise healthy babies from common ear infections to the increased incidence of drug-resistant "flesh-eating" bacteria. In the United States alone, about 14,000 people die each year from infections by drug-resistant microbes acquired during hospital stays. In 2000, 80 percent of *Staphylococcus aureus* isolates in the United States were penicillin-resistant and 32 percent were methicillin-resistant. This forces doctors to switch from first-line drugs to

dramatically more expensive second- or third-line drugs.

Paul Farmer, in *Infections and Inequalities,* describes how neglecting tuberculosis allowed it to reemerge from impoverished populations in new, resistant forms. "By failing to curb tuberculosis before the advent of these truly novel problems," he writes, "it seems clear that a window of opportunity has slammed shut" (Farmer 1999). The United States had 18,266 reported TB cases in 1998, of which 41 percent occurred in foreign-born people (Ruggiero 2000). Countries of origin contributing the highest number of TB cases to the United States include Mexico, the Philippines, Vietnam, China, and India. New York City alone traced cases back to 91 countries (Fujiwara and Frieden 2000). Drug-resistant TB flared alarmingly in the early 1990s, especially in New York City, which accounted for one-third of all U.S. multi-drug-resistant cases in 1991, costing the city $1 billion to control. Nineteen percent of those infections were resistant to the two most effective TB drugs, isoniazid and rifampin (Fujiwara and Frieden 2000). Unless a more serious effort is mounted to fight infectious disease, antimicrobial drug resistance will increasingly threaten to send the world back to the pre-antibiotic era.

Present and Future Risks

It is possible to put figures on some of the present risks that infectious disease poses to the United States. The nation's annual death rate from infectious diseases has doubled from its historic low in 1980, reversing the decrease of the preceding 15 years. Treating these diseases costs $120 billion (in 1995 dollars) annually, accounting for 15 percent of the total U.S. health expenditure. The U.S. military, meanwhile, faces a direct threat: disease accounted for more than 60 percent of hospital admissions in the Korean, Vietnam, and Gulf wars, and the military is deeply concerned about the lack of effective vaccinations for many diseases.

Estimating future risks is more difficult, depending as it does on transmission patterns, the unpredictable emergence of new diseases, technological advances in the dissemination of biological agents, and the "arms race" between the development of new drugs and that of drug resistance. With as many as 1.6 billion people predicted to travel abroad each year by 2020 (Micklethwait and Wooldridge 2000), a fast-moving new lethal disease, a catastrophic flu epidemic, or a drug-resistant "superbug" could abruptly increase the level of risk Americans face. Such "new" risks are precisely those that are most difficult to manage (Zagaski 1992).

ENLIGHTENED SELF-INTEREST: FIRST AMONG EQUALS

A broader global health perspective accepts that sovereign states have a greater interest in absolute than in relative gains. As Robert O'Keohane argues, states may be "situationally interdependent…where improvements in others' welfare improve their own, and vice versa, whatever the other actor does" (O'Keohane 1990). In this view, world health improvements strengthen the global system, and this in turn benefits the United States as the dominant power and main supporter of that system.

Health and Social Capital

Health affects relations within and among nations in several ways. First, there is a strong interrelationship between health and social capital. In Russia, life expectancy began declining in the early 1960s, reaching a low of 64 years in 1995. Although this figure is now improving, a male Russian born in 2000 can expect to enjoy just 56.1 years of healthy life, with similar rates in some other former Soviet territories, including Ukraine and Belarus (World Health Organization 2000). The current survival rate of 16-year-old males to age 60 is just 58 percent. Major causes of this decline are cardiovascular disease, injuries, and violence—with alcohol a consistent factor (Shkolnikov and Meslé 1996). Increasing pollution, a rapidly deteriorating health care system, and burgeoning epidemics of TB and AIDS compound the crisis. Bruce Kennedy, Ichiro Kawachi, and Elizabeth Brainerd have shown that, across regions of Russia, poor health correlates strongly with distrust in local government, level of crime, and conflict at work—all indicators of declining social cohesion. "Those who have access to social capital get ahead," they comment. "Those who do not get sick and die" (Kennedy, Kawachi, and Brainerd 1998). The Russian poor explicitly associate this social

breakdown with capitalism and are nostalgic for Communist certainties. "In former times, the majority lived well, now we live in misery" (Levinson et al. 1999).

Health and Political Stability

Research shows that low or declining average health status correlates over time with a decline in state capacity, leading to instability and unrest (Price-Smith 1999). According to Andrew Price-Smith's research, high prevalence of disease in a state undercuts national prosperity, generates inter-elite conflict, exacerbates societal income inequality, and significantly depletes human capital.

A 1998 study commissioned by the CIA identifies the variables that best predict state failure as level of infant mortality, openness to trade, and level of democracy (Esty, Goldstone, Gurr, et al. 1998). The inability of a government to deliver such basic needs to its electorate erodes trust and may lead to repeated cycles of instability and failure. Furthermore, as the National Foreign Intelligence Board's report *Global Trends 2015* states, "AIDS, other diseases, and health problems will hurt prospects for transition to democratic regimes as they undermine civil society, hamper the evolution of sound political and economic institutions, and intensify the struggle for power and resources" (National Foreign Intelligence Board 2000). This is of particular concern in volatile nuclear regions such as Russia and South Asia where the AIDS crisis, if left unchecked, has the potential to undermine the overall health system.

Ill health may also strike at the heart of a state's political system, impairing prospects for stable governance. Early AIDS epidemics in sub-Saharan Africa, for example, disproportionately affected urban centers, the leadership elite, the educated, the mobile, and the influential. In 1997, a pregnant Rwandan had a 9 percent chance of being HIV positive if her husband was a farmer, a 22 percent chance if he was in the army, and a 38 percent chance if he worked for the government (McNeil 1998). Loss of skilled government officials, highly trained military leaders, and members of the entrepreneurial class undermines political leaders' capacity to govern. The same patterns could easily be repeated in countries where the United States has more profound security concerns—Russia, India, the Ukraine, or China—as their rising AIDS epidemics erupt.

HIV/AIDS holds another concern for the future: by 2010, the disease is expected to have created over 42 million orphans worldwide. Few of these children will receive adequate care from family or community. Those who do not receive such care face limited opportunities for education and employment; rather than becoming productive members of society, they are likely to turn to crime, join militias, and fuel political instability in other ways.

Health and the Economy

There are strong, well-documented links between health and economic growth and stability. Health is now clearly seen as *both* an economic input *and* an output. An illustrative finding by Robert Fogel suggests that improvements in health and nutrition accounted for at least 20 percent of Britain's income growth in the period between 1780 and 1979 (Fogel 1997). Health helps create wealth in several ways. Longer life expectancy changes people's decision-making time frame and encourages smaller families, greater investment in education, more female workforce participation, and higher rates of domestic investment as people save for retirement. Declining fertility lags behind declining mortality, and so such a demographic transition is characterized by an enlarged cohort of children. Such a "baby boom" generation can make a significant economic impact as it reaches working age. In East Asia, for example, the working-age population grew much faster than the dependent population from 1965 to 1990, resulting in a "demographic dividend" that accounted for as much as one-third of the region's "economic miracle" (Bloom and Canning 2000; Bloom, Canning, and Malaney 2000; Bloom and Williamson 1998). By contrast, poor health combined with an economically unfavorable age structure helps to explain sub-Saharan Africa's dismal economic performance (Bloom and Sachs 1998).

Empirical evidence at the microeconomic level also demonstrates that improved health status is associated with economic growth. The most direct mechanism that explains this effect is the fact that improved health increases productivity and reduces worker absenteeism. Most notable, research suggests that the effects of improved health are probably greatest for the most vulnerable—the poorest and the least educated. This can be explained by their dependence on work that requires manual labor.

Conversely, poor health reduces economic productivity by creating labor shortages and heightening absenteeism, redirecting resources from education and infrastructure toward increased spending on health care, and reducing individual resources by diminishing savings and imposing higher health care costs, thus

leading to isolation from the global economy where connectivity is the key to prosperity. For example, illness is the leading reason why families in China fall below the poverty line (Rosenthal 2001).

Of course, there are also strong effects of wealth on health—achieving good health costs money—alongside well-documented interactions of health with education and social policy. In the right circumstances, therefore, "virtuous spirals" can develop, leading to rising opportunity, prosperity, and security. Ill health, however, leads to vicious spirals, aggravating insecurity and decreasing the return on all forms of investment in the future.

In sub-Saharan Africa and Russia with their poor life expectancies, economic and political stasis (or decline) seems almost inevitable for as much as a generation. The *Global Trends 2015* report states that projections for sub-Saharan Africa are even more dire than those in *Global Trends 2010*, largely because of the spread of AIDS. In South Africa, for example, the HIV/AIDS pandemic is predicted to depress gross national product by 17 percent over the next decade, a dangerous burden for a fragile democracy. In Russia, HIV/AIDS is spreading faster than anywhere else in the world.

Health and War

A fourth way in which health affects the international system is through the direct links between health and war. The link from war to health is clearer: wars kill and injure soldiers and civilians, but they also destroy infrastructure and social structures, in both cases with adverse effects on the population's general health. In the eastern Democratic Republic of Congo, for example, war and ill health are tightly entwined. Of 1.7 million excess deaths between August 1998 and May 2000, only 200,000 were attributable to acts of violence, and wherever the war worsened, infectious disease and malnutrition followed (International Rescue Committee 2000). Medical facilities are often singled out for attack in "new wars" because they provide valuable loot, easy victims, and a way to demoralize civilian populations. War also causes exceptional mobility, and armies, peacekeepers, and refugees act as vectors for the transmission of disease.

In fact, the spread of HIV/AIDS by UN peacekeepers has become a contentious issue in the debate over peacekeeping. Therefore, the UN has proposed Resolution 1308, which urges member states to screen their soldiers voluntarily. The resolution asks the secretary general to take steps to provide predeployment orientation and ongoing training for peacekeeping personnel on the prevention of HIV/AIDS. Some countries resist this testing and training on the grounds that it marks their peacekeepers with the social stigma associated with HIV/AIDS. Moreover, nations that contribute peacekeepers fear that testing will reduce their ability to field a full unit of troops. This is particularly problematic in view of the finding that, in some African regions, the higher one's rank, the greater the likelihood he is HIV-positive.

There is also evidence of the reverse effect, that of health on war. Combatants in new wars are often the socially excluded, even if they only act as proxies for more socially advantaged groups. Poor health shortens people's time horizons, making them more likely to engage in risky behavior; conversely, strong democracies with broad support from healthy populations are less likely to engage in conflict, at least with each other (Doyle 1983).

Analyzing U.S. Risks

Viewing world health through the wider lens of economics and politics enables the United States to analyze the extent of indirect risks (and opportunities) it faces relative to global health. First, there is the potential for entanglement in areas where plummeting social indicators and endemic conflicts have removed the legitimacy of the state. As Robert Cooper notes, these "zones of chaos" may not have law and order, but they still have airports. "Where the state is too weak to be dangerous," he observes, "non-state actors may become too strong." In this case, a form of "defensive imperialism" may be necessary when the United States is forced to respond to (often linked) threats from drug, crime, or terrorist syndicates (Cooper 1996). Active news media and a sporadically concerned public increase pressure on rich countries to intervene. Experience shows how hard it is to meet military and political objectives successfully in these complex emergencies.

Second, there is the potential for the emergence of nondemocratic regimes hostile to the United States, especially in the former Soviet Union. In Russia, declining state capacity in the coming decades could threaten control of nuclear weapons and major security arrangements in Europe. The popular association there between the arrival of democracy and increasing economic deprivation is fertile ground for populist politics, nationalist sentiment, and anti-American feeling.

Third, in an increasingly interdependent global economy, there is the potential for damage or stagnation to U.S. economic interests where ill health and other falling social indicators condemn a country or region to the "poverty trap" of high fertility and high mortality. Lack of attention to the burden of disease in developing countries—which receive 42 percent of U.S. exports—could depress demand for U.S. goods and services and thus threaten the jobs of Americans, even though U.S. economic links are strongest with prosperous, healthy countries. Healthy populations are a prerequisite for healthy economies, and healthy economies make for stronger trading partners in search of U.S. goods and services. It is in our long-term economic interest to foster the health and prosperity of future trading partners. Moreover, this policy of economic integration may ultimately create a more stable global society.

GLOBAL ENGAGEMENT: THE GOOD LEADER

The broadest perspective on global health problems posits that the United States, as a rich and dominant nation, bears some responsibility for problems faced by those beyond its borders, just as it does for those of disadvantaged populations at home. This appeal to "moral solidarity" results from what the philosopher Mary Midgley describes as "the immense enlargement of our moral scene—partly by the sheer increase in the number of humans, partly by the wide diffusion of information about them, and partly by the dramatic increase of our own technological power" (Midgley 1999).

U.S. Leadership

Thus viewed, global health issues have a range of implications for U.S. foreign policy. First, there is a unique opportunity to lead in the area of cooperative international engagement by placing health on the agenda of global public goods. It is not beyond the reach of political will to tip the scales toward a healthier world. The history of the Marshall Plan, a clear example of how a balance of motives can underlie U.S. foreign policy, illustrates that political leadership is necessary to raise the salience of international issues and to galvanize public support for cooperative engagement. One essential ingredient of such an initiative is leadership to match our unprecedented technical capacity and to allow us to apply this capacity to its logical extent. That means providing health care as a global public good: one that benefits everyone, but that no single country yet has the incentive to provide.

The provision of health as a global public good requires investment in basic public health infrastructure to detect threats and protect the population. Access to safe food and proper nutrition, clean water, and proper sewage disposal has been and will continue to be the major contributor to efforts to control endemic disease, along with efforts to control disease vectors. There is broad international agreement that a significant role for states is to ensure conditions that allow their citizens and other legitimate residents to enjoy the highest attainable level of health. This broad agreement acknowledges the variability in human capacity to achieve the WHO ideal of "complete physical, mental and social well being, not just the absence of disease." It also clarifies the principle that a nation's health policy must be focused more broadly than on access to health care and must accord high priority to population-oriented public health.

Health, Ethics, and Human Rights

Health is also linked to ethics and the concept of human rights. The Universal Declaration of Human Rights, Article 25, states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family." The first expression in an international legal instrument of health as a human right came in the 1946 WHO Constitution, which states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Others have used ethics to justify a strong program to improve the health of populations. Such a program is provided for in the development objectives of the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD). Alongside a target of halving poverty by 2015, DAC also calls for "a reduction by two-thirds in the mortality rates for infants and children under age 5 and a reduction by three-fourths in maternal mortality, all by 2015" and "access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and

no later than the year 2015." DAC has set a target that its members should spend 0.7 percent of GDP on achieving these goals; the United States currently devotes 0.1 percent of GDP to them (Faure 2000).

Research and Development

The United States is in an excellent position to lead vigorous efforts to create drugs and vaccines that would have their greatest immediate effects in poor countries. Of the $56 billion spent worldwide on health research, less than 10 percent is devoted to the diseases that account for 90 percent of the global disease burden (Global Forum for Health Research 2000). The traditional foundation of public trust in science is progress in tackling major health issues, because such work is so clearly for the greater good. U.S. "orphan drug" legislation, which offers incentives to the market to develop new drugs for rare diseases, has shown the possibility of creating such products at the national level (Lang and Wood 1999).

The nation seems interested in exploring this approach internationally. President Clinton's Millennium Initiative, for example, focuses on buying existing vaccines and developing new ones for the benefit of the international community as a whole. It offers increased funding for basic research to the National Institutes of Health, an institution that explicitly mentions enlightened self-interest in justifying its work on an AIDS vaccine. AIDS, claims NIH, has already depressed the GDP of developing countries, and this is expected to have "macroeconomic effects worldwide" (Office of AIDS Research 2001). The initiative aims to harness the drive and innovation of the private sector by offering incentives for the pharmaceutical industry to invest in vaccine research. Tax credits of up to $1 billion are also promised for sales of any future HIV/AIDS, malaria, or tuberculosis vaccine. This is a creative way to engage industry in a win-win context to develop drugs and vaccines for the global community. It also helps the pharmaceutical industry adapt to a changing world and keep the profits that drive innovation. Unless such efforts are strengthened, the market is unlikely to persist in developing orphan drugs.

Foreign policy leaders are also confronted with the issue of unequal access to existing medicines. These drugs could have a profound positive impact on millions in the developing world. The furor over access to AIDS treatments has brought this issue to light. AIDS is now a disease of the poor, with 95 percent of HIV infections in developing countries, and rich-country epidemics increasingly confined to deprived communities (UNAIDS 2000). Even though scientific innovation has been impressive, with 40 AIDS therapies currently approved by the U.S. Food and Drug Administration (FDA) (for a complete list, see Food and Drug Administration 1999, 2000), very few of the benefits of that science now reach the poor. While AIDS deaths have fallen dramatically in the United States, advances in treatment have yet to help developing countries. It is important to note that the lack of access is a result of inadequate infrastructure and insufficient financing as much as the high price of drugs and vaccines.

It is essential that all stakeholders find innovative ways to both provide incentives for research on new medicines and to ensure that patients in need, everywhere, have access to drugs and vaccines within effective health care systems. Many leading pharmaceutical companies have acknowledged that tiered pricing is a fundamental part of the solution to the problem of unequal access. They believe the challenge is primarily economic and that it also depends on the political will and national commitment of governments to invest in health care and social welfare services. Therefore, five of the largest drug companies have linked their promise to reduce the prices of HIV/AIDS drugs to commitments by national governments and the global community to invest in health delivery systems (Bloom and River Path Associates 2000). Patients in developing countries are unlikely to gain better access to medicines without adequate investment in public health infrastructure and a strong political will on the part of national governments to provide treatment.

The case of access to prescription drugs is an excellent example of how health-related issues will become increasingly important in trade and related policies in the future, and of why it is essential for U.S. policymakers to ensure that public health issues are given a higher profile in trade deliberations. The U.S. government must stress the need to foster new partnerships among relevant multilateral organizations—for example, the United Nations, the European Commission, WHO, the World Bank, national governments, NGOs, and the pharmaceutical industry—and to build a broad political consensus on ways to improve access to medicines and to increase investment in public health infrastructure in the developing world.

Debt Relief

Debt relief offers another opportunity for action by the United States to improve health in developing countries. As the leading contributor to the development banks, the U.S. government will play a critical role in the Highly Indebted Poor Countries (HIPC) Initiative. This initiative aims to channel funds from debt relief repayments to social needs like health. This debt relief would be most effective if tied to specific, measurable

objectives in the health system, such as developing the public health infrastructure, strengthening primary care, reducing infant and maternal mortality rates, or controlling malaria, TB, and AIDS. Each goal should have a timetable and a clear budget at the country level. Former Secretary of the Treasury Lawrence Summers endorsed a policy of including such health indicators as vaccination rates among the performance criteria for debt reduction programs.

The United States is owed a total of $6 billion by the 41 countries covered by the HIPC Initiative. Given that the amount owed the United States is already held in official accounts at around 10 percent of face value, Congress would have to allocate a total of $600 million to complete a write-off of the HIPC debt owed to the United States. Recently, a $435 million debt relief package won bipartisan support in Congress. America must continue to rethink debt structure. We have done it before with success: the Brady bond was a kind of debt relief and debt restructuring for Latin America. There are encouraging parallels between contemporary Africa and the Latin America in the late 1980s. Many Latin American countries were then heavily burdened with debt and were just emerging from periods of military rule and civil war. A dozen years after the implementation of this sophisticated plan, there are numerous success stories in Latin America. It can be done.

Partnerships

American leadership can make a critical difference in ensuring effective public-private partnerships for health development. It is important to recognize that the determinants of health are so broad and the health agenda so large that no single sector or organization can tackle them alone. Bridges will need to be continually built and expanded. In the health sector, a WHO report describes partnerships as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles" (Buse and Walt 2000). The public sector must continue to play a leading role in the area of health, where markets are often inefficient and equity is hard to achieve. Simultaneously, it should engage the private sector (both for-profit and not-for-profit) to bring private-sector efficiency and advantages to the delivery of services and programs, even in publicly sponsored programs. The U.S. government must promote public-private partnerships as a way to enhance our ability to mobilize social, political, and concomitant financial support for health development and international health cooperation.

Improving health also demands close partnerships between the United States and such multilateral institutions as WHO, UNICEF, UNAIDS, and UNDP. Cooperation with these institutions can maintain or develop the surveillance, health delivery, and sanitation systems to ameliorate the effects of declining health status in many parts of the world.

CONCLUSION

Adopting a foreign policy stance that gives greater priority to health issues would require reassessing the way the U.S. relates to the rest of the world. We need to be humble with our power. At present, international goodwill toward the United States is rapidly diminishing. Brent Scowcroft, national security advisor to the Reagan and Bush administrations, is succinct in his diagnosis: "We don't consult, we don't ask ahead of time. We behave to much of the world like a latter-day colonial power. It's a very dangerous thing that's happening" (Marshall and Mann 2000). We have to be interested in what others think about their own future, rather than projecting our solutions onto them.

Furthermore, ethical or humanitarian motives suggest that the United States should see itself in a facilitative role, prepared to engage with state and non-state partners in changing perceptions of what the global system should and can achieve for the disadvantaged. This requires a reassessment of the rights and responsibilities of nation-states, transnational businesses, an increasingly globalized civil society, and multilateral organizations. All need to work more closely together and transcend their traditional weaknesses, while looking to the United States for a steady commitment, the ability to listen as well as to lead, and clear signals that it is looking for results over the long term.

Much higher levels of expenditure will be needed. Various bills pending in Congress recognize this, proposing new U.S. investment of $1 billion to $2 billion to help leverage, from the broader donor

community, the $30 billion thought necessary to cover the most urgent health needs of the world's poorest people. Passing these bills requires a demonstration of "moral solidarity" from the U.S. government and from the American people. Jeffrey Sachs of Harvard University recently called for such a commitment, asking if each American would "be ready to provide $8 per year as part of a global campaign to control and turn back a wider range of killer diseases, thereby saving millions of lives in sub-Saharan Africa." He answers his own question: "In the America I know, the answer is surely yes" (Sachs 2000).

The current administration will be expected to help ensure peace and free trade in order to continue to strengthen the market-based economies that lead to open, democratic societies. As we have argued, improving the health of people in other countries makes both strategic and moral sense as an integral part of future U.S. foreign policy. Beyond enhancing security, prosperity, and democracy, a vigorous international health policy will provide an opportunity for leadership grounded in the United States' strength in biomedical science and its applications. Giving higher priority to international health in foreign policy is good for the United States and good for the world—an issue on which there can be widespread agreement.

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