NUFFIELD TRUST GLOBAL PROGRAMME ON HEALTH, FORIEGN POLICY AND SECURITY

HEALTH, AND FOREIGN POLICY IN THE UK: THE EXPERIENCE SINCE 1997

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Department of International Politics, University of Wales Aberystwyth

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Foreword

The Nuffield Trust's UK Global Health Programme examines implications of globalisation for the health of the people of the United Kingdom and the contribution the UK makes to improving global health. The programme consists of a number of commissioned research projects to improve understanding of the relationship between health, foreign policy and security. The aim of the projects is to strengthen the evidence base, develop ideas for policy and encourage dialogue between the relevant stakeholder communities.

This research project consists of a number of case studies on health and foreign policy, commissioned by the Nuffield Trust. The case studies aim to examine the manner in which health and foreign policy have interacted over the years. The research focuses on UK policy and attempts to analyse how policy has developed; what have been the drivers in the development of that policy, in particular the role of security concerns; the impact both on and of public health; and the role of the UK internationally. The project aims to draw out lessons for future policy and this paper summarises the findings of the case studies, and a number of tentative recommendations are made at the end of the paper.

The case studies were:

Population movements and acute and chronic infectious diseases
Dr Richard Coker,
Health Services Research Unit, London School of Hygiene & Tropical Medicine

The work Richard Coker conducted for this paper was undertaken before being seconded to the UK Department of Health. He did not contribute since his secondment, and the views expressed do not reflect those of any government department.

HIV/AIDS
Harley Feldbaum,
Centre on Global Change and Health, London School of Hygiene & Tropical Medicine

Tobacco Control
Dr Jeff Collin
Centre on Global Change and Health, London School of Hygiene & Tropical Medicine

Copies of the case study reports are available from the Nuffield Trust and can be found on the website at www.nuffieldtrust.org.uk

Olivia Roberts
Policy Manager, The Nuffield Trust

Executive Summary

Over the past decade the links between health, particularly public health, and foreign and security policy have developed into a new international policy agenda. This study is concerned with how this agenda has developed in the UK and particularly in relation to three key policy areas: migration and infectious disease; HIV/AIDS; and tobacco control. Its conclusions are:

1. Public health does not appear to be a dominant force in driving this policy agenda in the UK. Public health therefore faces a difficult task in shaping what issues are on the UK's international agenda.

2. Tensions between narrow national interests, enlightened self-interest and global engagement are apparent in the emergence of health issues on the UK foreign policy landscape. A tentative conclusion appears to be that when a clear national interest can be articulated, this tends to take precedence over other concerns. Nevertheless, caution should be used here as the role of the national interest is somewhat more nuanced than this general observation might suggest.

3. Despite the widespread perception that security concerns are a driving force in this new agenda globally, for the most part international security concerns do not appear to have driven UK policy. However, more narrowly focused domestic security concerns do play a role, as seen in bio-terrorism and infectious disease/migration.

4. The policy process in the UK appears to be dominated by Whitehall Departments with occasional interventions from the Prime Minister's Office but little from the EU. When more than one government Department has a direct interest, then policy can become inconsistent; but equally there may be occasions when a lack of engagement by Whitehall Departments translates into inaction.

5. International organisations have played important roles in policy development internationally, particularly the WHO and World Bank in the FCTC. Similarly the UN and G8 have both provided important forums for raising awareness of issues and for limited policy initiatives. However, there is little evidence of movement towards, or UK support for, a new era of world health governance during the period under study.

6. Multinational companies have proved to be important blocks on developing policy in the UK, though neither in negotiating the FCTC nor in the TRIPS-related dispute over anti-retroviral drugs were their reservations ultimately successful in preventing policy development.

7. Charities and NGOs have the potential to frame the popular consensus on issues, but their impact on the policy process varies.

8. The UK is supportive of international efforts in this policy area and occasionally at or near the fore. But the UK was rarely an outright leader during the first two Blair administrations and the effectiveness of policy was on occasion limited by incoherence, ambiguity or a lack of full commitment.

9. Evidence is usually necessary but rarely sufficient for the development of policy. Public health's expectation that evidence should lead policy is not borne out. Rather evidence is used in a more nuanced manner, interpreted and used in accordance with other social and political priorities.

10. The relationship between the range of interested policy communities does not readily fit into existing models, but rather seemed to be a complex mix of relationships.

Introduction

Over the past decade the links between health, particularly public health, and foreign and security policy have developed internationally into a new policy agenda.[1] This paper is concerned with how this agenda has developed in the UK. Its focus is retrospective and concentrates on the recent past – roughly the period of the first two Blair administrations from 1997-2005. It is based largely on three commissioned case studies (migration and infectious disease; HIV/AIDS; and tobacco control),[2] though it also draws from other examples (notably bio-terrorism and SARS) and is informed by earlier conceptual work undertaken under the auspices of The Nuffield Trust on the relationship between health, foreign policy and security.[3] It is structured around eight key questions derived from the case studies:

1. To what extent has public health been able to shape the policy agenda?

2. To what extent has the agenda reflected concerns over the national interest?

3. To what extent have international security concerns driven the policy agenda?

4. What is the policy process?

5. What role has evidence played in formulating policy?

6. How important have non-state actors been in policy development?

7. Has the UK been an effective leader in this new agenda?

8. What has been the relationship between the various policy communities?

Throughout the paper foreign policy is considered in broad terms: it is not simply the relationship between the Department of Health (DoH) and Foreign Office (FCO), but rather includes a variety of government Departments with direct interests in international policy – including the Department for International Development (DfID), the Ministry of Defence

1. Prominent examples of this linkage include the UN Security Council session of January 2000 which was devoted to the threat in Africa from HIV/AIDS; UN Security Council Resolution 1308 of July 2000 which addressed the need to combat the spread of HIV/AIDS during peacekeeping operations; United Nations Special Session on HIV/AIDS held in June 2001 which declared the disease a security issue; the Millennium Development Goals agreed in 2000 in which three out of eight goals, eight of the 18 targets and 18 of the 48 indicators related directly to health; World Health Assembly Resolution 54.14 adopted in May 2001 on "Global health security: epidemic alert and response" which focused on revision of the International Health Regulations; the G8 Summit held in Genoa in July 2001 which agreed to the creation of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; WHO's adoption of the first international health treaty, the Framework Convention on Tobacco Control, in May 2003; and the inclusion of infectious disease as a global security threat in the report of the UN Secretary General's High Level Panel on Threats, Challenges and Change.
2. This paper is also informed by the comments made by participants in a seminar hosted by The Nuffield Trust to discuss the case studies, and by comments made on earlier drafts by Anne Coles, Alan Ingram and Kelley Lee.
3. Colin McInnes and Kelley Lee, 'A conceptual framework for research and policy' in Alan Ingram ed., *Health, Foreign Policy and Security: towards a conceptual framework for research and policy* (London: Nuffield Trust 2004), pp.10-18. See also Colin McInnes and Kelley Lee, 'Health and security', *Tiddsskriftet Politik* vol.8 no.1 (March 2005), pp.33-44.

(MoD), the Department of Trade and Industry (DTI) and the Home Office. It would however be wrong then to term this 'international' policy – that term could equally refer to the international dimension of a Department's work and would not necessarily involve cross-Departmental relations.[4] This new agenda is inherently cross-Departmental and much of the interest is in the extent to which health issues have interacted with the other issues as part of the UK's foreign policy more generally.

4. Although I have on occasion used the term 'international policy' in a general sense, usually to contrast with domestic policy on issues such as HIV/AIDS where 'foreign policy' would be misleading since the policy originates with DfID not the FCO as might be otherwise inferred.

Public health as a driver for policy

A key issue of concern is the extent to which public health has been able to shape the foreign policy agenda. More specifically, what is of interest is the extent to which the UK public health community has been able to secure support from ministries other than the DoH for significant international initiatives.[5] The picture here is not encouraging. Perhaps the greatest success has been in the area of tobacco control, and in particular the Framework Convention on Tobacco Control (FCTC). But as Jeff Collin notes, much of the impetus for this came from WHO, who in turn sought the support of member states (in the UK, the DoH). Although the DoH was supportive of the WHO initiative and of tobacco control more broadly, UK policy as a whole has been somewhat ambivalent. Moreover Collin suggests that, despite WHO's hagiography of a successful partnership between public health and foreign policy in tobacco control, the reality has been more of an uphill struggle on the part of public health to secure the interest of foreign policy. What is perhaps most dispiriting is that this is an area where the evidentiary base is overwhelming.

The picture for infectious disease and migration is much less clear, not least because of the cloak of secrecy surrounding much of what has happened in the UK. Richard Coker argues that policy on migration has not been led by public health but is rather a 'heady political mix'. In some instances public health's involvement has tended to be technological and downstream rather than in dealing with upstream factors causing the spread of such diseases. Moreover the evidence base has been used selectively, or even ignored to fit in with broader political concerns.

On HIV/AIDS, international policy is the departmental responsibility of DfID, though with occasional (and significant) involvement from the Prime Minister's Office. Indeed the suspicion is that of the Prime Minister's Office having on occasion to spur action on with regard to developing an international HIV/AIDS policy. Feldbaum makes the important point that in the UK the link between health and development is much stronger than between health and foreign policy. Although UN Security Council Resolution 1308 forced the FCO into an engagement with HIV/AIDS as an international issue, and that this engagement has been reinforced by the Prime Minister's agenda for the G8 and EU presidencies in 2005, nevertheless policy has been victim of Whitehall turf wars. Not least DfID's 2004 policy paper on HIV/AIDS, *Taking Action*, has more than a hint of ensuring walls are put up over Departmental responsibilities. As a result the DoH has not taken the lead in developing UK international policy on HIV/AIDS, but it has nevertheless been influential in shaping DfID's HIV/AIDS programmes. One potentially problematic area however is that DfID's focus is on poverty reduction, whereas HIV/AIDS prevalence does not necessarily match levels of extreme poverty. Therefore there is a danger that public health's interests in ameliorating the HIV/AIDS crisis may not match DfID's interests in poverty reduction. The international

5. The use of the term 'community' here is intended to imply a broad definition to include a variety of interested parties, including government, NGOs, aid agencies an academia. In so doing however it must be acknowledged that this community is neither a coherent nor cohesive whole. Rather it is likely to adopt a variety of positions on any given issue. But in this it is no different from many other social groups and what matters is the extent to which (elements of) the community may be able to secure support for initiatives.

dimensions of the HIV/AIDS crisis are not limited to the inability of the poorest countries to deal with the crisis, thereby prompting a humanitarian response from the UK. Rather they extend to the potentially disastrous effects of the pandemic on the economic growth and stability of middle income countries. If other departments fail to play an effective role, some of the wider international implications of the pandemic may be missed.

Of all the health issues which are now on the international agenda, public health has played the least role in securing the place of bio-terrorism. Rather this appears to have been generated principally by the national security community and given particular prominence after 9/11. Although public health has been important in advising on technical aspects, policy appears to be dominated by security concerns. Nevertheless the DoH has played a role in the development of the UK's international policy on the issue .

Overall however the impression is one of some uncertainty over the mechanisms whereby health issues become international political issues, but that public health does not appear to be a dominant force in determining this, at least in the UK. As tobacco control demonstrates, even when the evidence is overwhelming, securing the support of the foreign policy community remains difficult while in other areas the evidentiary base is subordinated to political concerns. Only when crises are on top of the UK – as with bio-terror in 2001 and SARS in 2003 – do public health issues come to the fore, while with longer term issues such as HIV/AIDS and tobacco control it is perhaps the scale of the problem which has demanded attention. In other words, public health appears to face a difficult task in shaping what issues are on the UK's international agenda.

The role of the national interest

The national interest figures prominently in most statements on foreign policy, including the FCO's 2003 White Paper *UK International Priorities*. But the traditional notion of foreign policy as the amoral realm of *realpolitik* inhabited by statesmen such as Chatham, Bismarck and Kissinger,[6] and where President Carter could be chastised as 'naïve' for attempting to incorporate a normative element to his foreign policy, now appears dated. Rather, narrow concerns over the national interest are tempered by an awareness of humanitarian responsibilities and of the impact of globalisation. Both of these suggest at the very least an enlightened approach to the national interest, where problems elsewhere may have ramifications 'back home'; more progressively, it has led to arguments for global engagement based on moral solidarity.

In the UK, Labour's foreign policy has evidenced these tensions between a narrow national self-interest, enlightened self-interest and global engagement. These tensions are apparent in the emergence of health issues on the UK foreign policy landscape. In terms of infectious disease and migration, the rhetoric of global engagement appears to have been subordinated to a more narrowly conceived self-interest. In particular the focus on at-border screening suggests a narrow focus on national self-interest. Although this is somewhat mitigated by development aid addressing upstream causal factors (suggesting more of an enlightened self-interest approach), nevertheless the focus of the Home Office and DoH in this area appears to be very much on the immediate impacts on the national interest. Migration also received particular prominence in the run-up to the 2005 UK general election when the Conservative Party announced plans for expanded screening of long term migrants to the UK.[7]

The manner in which HIV/AIDS has been approached however is rather different. Although an element of enlightened self-interest is apparent in UK policy (particularly in the possible impact of HIV/AIDS on macro-economic growth), global engagement and humanitarianism appears to have held sway. This was not always so, and DTI concerns over TRIPS, together with Home Office concerns over immigrants and asylum seekers who are HIV positive, demonstrate how narrow self-interest could feature prominently in the policy arena. Although these concerns have been overcome, more problematic has been the funding for HIV/AIDS programmes. Here the UK has taken the lead in suggesting additional funding mechanisms that could support AIDS programmes (particularly the International Finance Facility), but with limited success to date in gaining broad international support. As a result international initiatives to combat HIV/AIDS have suffered from under-funding.

Most interesting however appears to be the case of tobacco control. Here narrowly conceived national interest appeared to suggest promoting the international commercial success of the

6. This is not to say that values were absent in the foreign policy of Bismarck, Kissinger etc, merely that they were less explicit and not always grounded in moral concerns for the improvement of others.
7. See BBC News, 'Tories plan migrant health checks', http://news.bbc.co.uk/1/hi/uk_politics/4265461.stm, accessed on 15 April 2005; and politics.co.uk, 'Conservatives would turn away immigrants with TB', http://www.politics.co.uk/election-2005/conservatives-would-turn-away-immigrants-with-tb-$13008625.htm, accessed on 15 April 2005. Conservative plans focussed on health checks for migrants wishing to work in the UK, but not for asylum seekers.

British tobacco industry. However, by demonstrating that the economic case was in favour of tobacco control, along with a more supportive (if nevertheless sometimes precarious) government attitude towards tobacco control as a public health issue, these reservations were overcome.

Drawing a clear lesson from the above is problematic given that policy on HIV/AIDS and particularly migration is still developing.[8] Nevertheless a tentative conclusion appears to be that when a clear national interest can be articulated, this tends to take precedence over other concerns. Thus with immigration controls and infectious disease, and initially with tobacco control, narrowly conceived national interests proved powerful factors in formulating policy. When the national interest is less clear, then other factors can come into play. This appears to have been the case when the economic case for tobacco control was persuasively made and with HIV/AIDS when reservations over TRIPS were eventually overcome. In both instances however economic factors proved to be major hurdles in developing policy.

8. Although the outlines of both are clear, namely increased aid for HIV/AIDS and restrictions on migration.

International security concerns as a policy driver

The perception that international security concerns are a driving force in determining the agenda globally is widespread. This is particularly so in the case of the US, where reports such as the CIA's *Global Infectious Disease Threat and its Implications for the United States* (2000) successfully highlighted the perceived security implications of certain diseases. Similarly the UN special session on HIV/AIDS, the UN Security Council session and subsequent Resolution 1308 all drew attention to a link between HIV/AIDS and international security. In the UK however, the evidence appears to suggest that international security concerns have not been a particularly strong driving force in this agenda.

The paper by Coker suggests that there is a powerful association in the public mind between migration and infectious disease, resulting in fears that the health of the UK is at risk. Thus, domestic security appears to have played a part in this policy area, despite the evidence for this belief being far less certain. Internationally, however, although policy on chronic infectious disease is driven somewhat by security concerns, particularly the stability of states, policy on acute infections is more a result of concerns over sovereignty. On HIV/AIDS, Feldbaum suggests that the UK security policy community has played little or no role in policy development. Indeed the MoD appear to have almost totally ignored the issue, while the FCO have been happy to see DfID take the lead in policy development on an issue more central to its mandate (and perhaps influenced by DfID's greater resource base in Africa). As a result, UK international policy on HIV/AIDS has not been heavily securitised; rather it has reflected the concerns of DfID in focusing on the relationship with poverty. This changed somewhat in 2000-1, in the wake of UN activity and reports from the US drawing links between infectious diseases such as HIV/AIDS and security. Security concerns expressed in the UK at the time closely matched those elsewhere: for peacekeeping operations; for security forces in high prevalence states; and for the destabilising effects of high HIV/AIDS infection rates. This strongly suggested that the UK was reacting to an international security agenda set elsewhere. But DfID has yet to follow this through with subsequent actions and the focus of policy appears to have remained rooted in development concerns. Indeed Feldbaum notes that in 2004 a senior DfID official was publicly questioning a direct link between high HIV/AIDS infection rates and predictions of political instability – one of the cornerstones of the securitising move.

It is perhaps useful to see the impact of international security concerns not as a binary issue, but rather a spectrum of influence where certain health issues are more susceptible to securitisation than others, and at different times. At one end is tobacco control, where UK policy appears to have little or no links to security concerns. At the other is bio-terror, which has been posed as a security issue because of the perception of a clear and present danger post-9/11 of such attacks (though here it is difficult to disentangle international security concerns from domestic). For the most part however, international security concerns do not appear to have driven UK policy, although more narrowly focused domestic security concerns do play a role as seen in bio-terrorism and infectious disease/migration.

What has been the policy process?

The previous sections have largely been concerned with how health issues may (or may not) become part of the foreign policy agenda. This section discusses how policy develops once issues are on the foreign policy agenda and in particular the relationship between the various elements of government, particularly the relevant Whitehall departments but also the Prime Minister's Office and the EU.

Migration and asylum have been high on the political agenda in the UK for a number of years. This attention is only slightly a result of fears over the spread of infectious disease (including TB and HIV/AIDS). But this highly charged political atmosphere has had consequences for the control of infectious disease and in particular for the development of policy. As Coker notes, policy on the link between infectious disease and migration in the UK has been developed behind closed doors, lacking transparency and an engagement with outside experts. He cites the example of the Cabinet Office-led working group on imported infections and immigration (IIWG) announced in 2003 which, although drawing on a number of Government departments, did not engage with outside experts as might have normally been expected. Nor has there been much enthusiasm for engagement with the EU on developing policies for infectious disease, despite the internal market for labour facilitating cross-border movement. The innovation of the European Centre on Communicable Disease is limited by its surveillance role, with no mechanisms for control, and is significantly smaller than its US counterpart. Significantly, policy is not developed at an EU level but by individual member states. European policies on TB and migration have therefore lacked coherence, some member states having no policies, others demonstrating different policies and/or interpretations of policy. Within the UK, Coker argues that policy has been incoherent and inconsistent. Policy responses have been ill-defined, partly due to the failure to develop a common conceptual understanding of the issues, but also due to the highly charged political atmosphere surrounding migration and asylum, and the limited range of tools available to policy makers in the UK.

Policy on HIV/AIDS has centred on DfID with little engagement by the FCO and MoD. DfID's pro-poor focus however meant that initially HIV/AIDS received relatively little attention within the Department. By 2001 however the international climate was changing, not least because of developments at the UN and with the G8 post-Seattle. Nevertheless in 2004 the National Audit Office (NAO) was unflattering in its assessment of DfID's lead on policy, arguing that it had consistently failed to address the international problem of HIV/AIDS. It was only in 2004, with the Prime Minister's attention increasingly turning to the problems of Africa, that DfID appeared to develop a greater sense of urgency. The 2004 initiative Taking Action proposed a policy for the entire government, but in reality strengthened DfID's lead role on the issue and limited the involvement of other players. Crucially the FCO did not appear to be fully engaged despite its potential diplomatic role in promoting coherent international action on HIV/AIDS, particularly during the UK's presidency of the EU and chairing of the G8. Although *Taking Action* pointed out that the FCO had given its Ambassadors and High Commissioners objectives on HIV/AIDS, the prior comparative

insignificance of this had already been revealed in the FCO's 2003 white paper *UK International Priorities* which failed to mention this role in its section on diplomacy.

Whereas the FCO (and even more so the MoD) appear to have been ready to acquiesce to DfID's lead on HIV/AIDS policy and gave the issue little if any attention, the relationship with the DTI was much more tense. This was principally over TRIPS and the balance between trade and development. Conflicting priorities led to a requirement for compromise and coordination in policy development. Much more positive was the relationship with the Treasury, and in particular the Chancellor's attempts through initiatives such as the International Finance Facility (IFF) to secure funding for development aid.

In contrast to policy on migration and infectious disease, which was marked by considerable political attention but also incoherence and inconsistency, policy on HIV/AIDS has been marked by a lack of enthusiasm outside the very top echelons of the policy process. DfID's focus has been on poverty reduction and it required prompting from No.10 for it to become more heavily involved in HIV/AIDS; the FCO has given the matter little attention, despite its potential role in coordinating international efforts; despite UN Resolution 1308 and the links drawn elsewhere between HIV/AIDS and security, the MoD has largely ignored the issue; and the DTI has kept to its departmental mandate in protecting trade and intellectual property rights.

The scale of the economic interests involved unsurprisingly made tobacco control highly politicised. As Collin notes, although the Blair administration was broadly committed to tobacco control, it did demonstrate certain 'schizophrenic' tendencies, reflecting the competing interests at play. Thus despite positive developments such as its public commitment to curbing tobacco consumption, its leadership role in nicotine replacement therapies, the decision to limit the role of government agencies in promoting tobacco sales abroad and a series of legislative initiatives, more worrying signs were evident in its decision to allow continued tobacco sponsorship of Formula One events and the access to the Prime Minister and Department of Trade and Industry (DTI) enjoyed by senior officials of British American Tobacco (BAT). The policy process therefore was dominated by the competing interests and priorities of the different government agencies involved, with (broadly speaking) public health and development agencies lining up against employment, trade and electoral concerns. In particular, during the first Blair administration the DoH and DfID recognised the role of tobacco control in promoting Departmental interests. Both Departments made an early, formal commitment to an international convention on tobacco control and the FCTC process was dominated by DoH with significant support from, and involvement of, other government Departments. That public health triumphed in this area of policy can be explained by the permissive atmosphere created by the political leadership. Despite occasional wobbles and its 'schizophrenic' tendencies, the Blair administration appeared to recognise the importance of tobacco control as fitting, not only its public health stance, but its doctrine of international community and its priorities for international development.[9] This cluster of priorities, coupled to the empirical evidence

9. Although internationally it was WHO Director-General and former Norwegian Prime Minister Gro Harlem Brundtland, rather than Blair, who was prominent in raising the issue higher on foreign policy agendas. The UK (via DfID) had a close relationship with WHO after Brundtland came to office, most notably through the head of the HPN Division within DfID (David Nabarro) going to Geneva to be one of Brundtland's key advisers.

over the impact on health, trade and jobs, appear to have been sufficient to ward off the concerns of the DTI.

This suggests four not entirely surprising conclusions about the policy process. First, that when more than one government Department has vested interests then consistency in policy becomes more difficult. This is particularly the case if interests clash. This to some extent explains what Collin sees as 'schizophrenia' in government policy on tobacco control, and what Coker sees as a lack of policy coherence on migration and infectious disease. Since the policy agenda under consideration here tends to involve more than one Department, then this inconsistency or lack of coherence is to be expected, if regretted. Second, that there may be occasions when there is a lack of widespread engagement across government Departments, as was the case with HIV/AIDS. Indeed, in this instance policy developed slowly because government Departments were largely disinterested. Feldbaum suggests that for much of the first two Blair administrations, international policy on HIV/AIDS was a low priority for DfID compared to poverty reduction, and that no other Whitehall Department was sufficiently energised to become involved. Third, that political leadership from the very top can energise a policy, as happened with HIV/AIDS, but that policy initiatives from the very highest level do not necessarily translate into sustained action on an issue. Finally, the EU was a relatively low-level policy actor in all three of the case studies (and it appears in bio-terror and SARS as well). There was no sense of an EU presence in this developing agenda, nor much of an effort on the part of the UK to develop one.

The role of evidence

The three case studies display what initially appear to be very different attitudes to evidence. Coker is highly critical of the manner in which evidence has been used or even ignored over migration and infectious disease. Although DfID seems to have accepted the available evidence which suggests very firmly that poverty causes poor health (including susceptibility to infectious disease) regardless of immigration status, and vice versa, the use of evidence concerning infectious disease elsewhere in government has been selective and politicised. There is little questioning of the assumption that TB originates from outside the UK, but as Coker points out there is 'little correlation between the prevalence of tuberculosis in countries from which people originate and their risk of active disease on entry to the UK – which means that one of the fundamental foundations upon which the notion of targeting screening sits is shaky'. Despite this, the two issues have continued to be linked by senior politicians and the mass media.

In contrast, evidence appears to have played a crucial role in tobacco control. In particular, the World Bank produced evidence which suggested that tobacco control would be *economically* desirable as well as advantageous to public health. This was crucial in undermining arguments against control based on its impact on trade, tax revenues and employment. Smoking had been known to be harmful to health for decades but no concerted international action had been taken. It was not until other non-health data came to fore that pressure for change came about. This included economic data on impacts on national economies, and tobacco industry documents which demonstrated unethical and illegal practices of industry. Similarly the evidence on 9/11 of the willingness of terrorists to undertake attacks on the West aimed at causing mass casualties, together with the subsequent appearance of anthrax in the US, provided an evidentiary base to support policies on bio-terrorism (although evidence beyond that of the likelihood and scale of attack has not been apparent in the public realm).

Whereas evidence appears to have been used selectively over the links between migration and infectious disease, but was crucial in successfully negotiating the FCTC, there is a lack of evidence over the impact of infectious disease (including HIV/AIDS) on stability. This has nevertheless failed to prevent the case from being made. This is particularly so in the United States, though at least one DfID official has questioned the link between the prevalence of AIDS and political instability on the grounds of a lack of available evidence. The picture is also complicated because, whereas for tobacco there is a good understanding of what works to curb tobacco use (for example price increases, health warnings and advertising bans), for HIV/AIDS the evidence is not entirely clear about what constitutes the best form of intervention and therefore the ability to act is constrained.

What this suggests is that evidence is usually necessary but rarely sufficient for policy. Rather it will be interpreted and used in accordance with other social and political priorities. This does not mean that evidence is unimportant but as efforts to control climate change demonstrate, even an overwhelming evidentiary base is no guarantee of political success.

Evidence can be subject to distortion, misinterpretation, decontextualisation or selective use. This has been seen in the efforts of the tobacco, food and oil industries to distort public debate around tobacco control, dietary control and global warming. The public health community cannot let 'facts speak for themselves' but must recognise the political context within which evidence is used. Effective communication of evidence to policy makers and public, as well as evidence with advocacy, is needed.

The role of non-state actors

Three types of non-state actors appear to have played a role in policy development, though their role and influence varies and appears to be issue-dependent. The first group of non-state actors are international organisations such as WHO and the World Bank. In tobacco control, WHO played a central role while the World Bank's support proved crucial in offsetting concerns over the impact on trade and employment. The World Bank also fended off efforts by the tobacco industry to use the WTO rules against the FCTC, arguing that they should take precedence. WHO was central in both coordinating the global response to SARS and eventually in taking a lead in issuing advisory notices on travel to SARS-affected regions. Such cooperation however is fragile, and a reaction to WHO's assumption of a more proactive stance appears to have set in. Not least, negotiations on revising the International Health Regulations (IHRs) saw member states reasserting their sovereignty and demonstrating an unwillingness to allow WHO a greater role in the control of disease. In terms of HIV/AIDS, the UN, G8 and other institutional actors (notably the Global Fund and public-private partnerships) have proved to be important both in terms of highlighting issues and in developing international responses (though the funding of such initiatives remains problematic). However the EU has proved to be a less significant actor. In terms of infectious disease and migration, despite the EU's role in developing policy on migration more generally, it has been largely sidelined in favour of national policy, while Collin argues that its role in the FCTC negotiations was opaque and chaotic. Finally, policy responses to bio-terrorism appear to remain rooted at the state level with little involvement from international organisations.

The second group of non-state actors are those from the corporate sector and in particular large multinational companies who can exert considerable political influence. This influence is particularly apparent in two of the highlighted policy areas – HIV/AIDS and tobacco control. In terms of HIV/AIDS policy, large pharmaceutical companies initially attempted to protect drug patents on HIV anti-retrovirals through TRIPS. This inflated the cost of treating HIV/AIDS patients, with potentially devastating consequences in poorer areas of the world where prevalence rates may be astonishingly high. In terms of tobacco control, economic globalisation has expanded markets and profits for tobacco companies during the 1990s. Attempts at tobacco control threatened this and were therefore resisted by the large tobacco companies (although they did publicly welcome the FCTC, their reservations over tobacco control led to efforts to undermine the FCTC process). In both policy areas, multinational companies proved to be important blocks on developing public health policy, though in neither were they sufficient on their own.

The third group is that of civil society, particularly charities and NGOs. These appear in some cases to be peripheral to the policy process and their involvement is often only the result of lobbying. This is particularly so with migration, where civil society appears to play little role in the policy process. On the other hand the Framework Convention Alliance was able to play an extremely important and innovative role in FCTC negotiations, while with HIV/AIDS NGOs have had direct involvement with the policy process. In other words, charities and

NGOs have had a differential impact. The reasons for this are probably multiple, ranging from the degree of funding and professionalism of organisation, through individual agency (the impact of a recognisable and respected individual in raising popular consciousness of an issue), to the extent to which they can tap into the popular gestalt. On occasion they may be vitally important in framing the popular consensus on an issue; sometimes they may have direct access to the policy process; while on other occasions they may be largely peripheral. A 'one-size fits all' analysis is therefore probably inappropriate and much depends on individual circumstance.

The UK as an effective leader

At first glance the UK appears to have been a good leader in dealing with the international effects of infectious disease, including HIV/AIDS. This has been particularly the case within the context of the G8 where its finance initiatives have led the way. However the picture is somewhat more nuanced than this. Richard Coker for example detects a lack of coherence between policies on infectious disease associated with international development and those linked to migration. This has an effect on the ability of the UK to portray itself as an international leader in dealing with the effects of infectious disease; but more crucially it undermines policy effectiveness. Moreover policy effectiveness on HIV/AIDS has been limited by the lead Department (DfID) having as its focus poverty relief not the promotion of good health. Although poverty relief and the promotion of health are often closely related, they are not the same. This is especially the case with HIV/AIDS since the disease is not limited to the poorest individuals or countries. Given the poor performance globally in dealing with the HIV/AIDS pandemic, there is more than a suggestion in Feldbaum's paper that the UK's leadership role has been by default. Moreover this role was not so much pro-active as a reaction to the considerable campaigning and advocacy on HIV/AIDS related issues. Feldbaum raises serious reservations over the extent to which aid on HIV/AIDS has increased in real terms over the course of the Blair administrations. What is clear is that even in the most positive light, levels of aid fall far short of those promised by the US, although the latter's overall contribution is subject to wide-ranging international criticism.[10] More positively however, the establishment of DfID did much to raise the profile of development issues within the UK policy community and to establish the UK's position as a leading player in international development worldwide. By association this should have assisted in the promotion of health amongst the poorest and often most needy states. However DfID's effectiveness, especially in dealing with the crisis of HIV/AIDS, has been the subject of criticism not least from the NAO. Thus on infectious disease, in some areas the UK can claim to be a leader, and arguably *the* leader in terms of financing arrangements for aid. But policies too often lack coherence or focus for it to claim to be as effective as it might be.

This mixed picture is also apparent on tobacco control. Although broadly supportive of international efforts to regulate the tobacco trade, the UK did not play a leading role in the negotiations on the FCTC. Moreover UK tobacco control policy lags behind that of other high-income countries, such as US, Australia and Canada, and behind some LMICs such as Thailand, Brazil and Singapore. Collin notes the suspicion of some states over the UK's commitment, and although the Blair administration was instrumental in removing the blocking minority on tobacco control in the EU, it failed to mobilise the EU in the FCTC and appeared at times happy to hide behind German reservations. Finally, as regards bio-terrorism, the UK's role has been dwarfed by US efforts and the resources allocated to the problem by Washington. In this the impression is of the UK as a bit-player, important in its support of the US but having little role as an independent actor.

Overall therefore the picture is of the UK as supportive of international efforts and

10. This may of course be at least partly a result of the vociferous and active HIV/AIDS civil society in the US

occasionally at or near the fore. But the UK is rarely an outright leader in international efforts and the effectiveness of policy is too often limited by incoherence, ambiguity or a lack of full commitment.

The relationship between policy communities

An earlier study examined the possible forms relations between the various policy communities involved might take (Lee and McInnes, 2004). In particular it looked at how public health might approach cooperation with other sectors. It suggested four types of relationship or metaphors (see box).

(i) Supplicant
A number in the public health community have seen the opportunity for increased funding via a relationship with other communities – notably by making the case of the benefits of health investments for stability and economic growth. Such relationships might also secure the political leadership required to help resolve global public health issues. Thus public heath is a supplicant looking to other policy communities for assistance.

(ii) Trojan Horse and Trojan Mice
In a Trojan Horse relationship, public health plays to the traditional concerns of foreign policy to secure a 'place at the table'. Once it has secured a seat at the table, it can then begin to promote its own agenda, or enjoy spin offs and collateral gains. A related alternative is that of 'Trojan mice': that small issues may creep onto the agenda at the margins but slowly lead to a paradigm shift.

(iii) Partnership
This relationship sees the tools and skills of various policy communities – development, security, public health and foreign policy – brought together for the greater good. In this, no one policy community is necessarily privileged.

(iv) Public Health as an independent actor
Whereas the position of supplicant is one of 'what can public health do for foreign and security policy, this turns the tables to ask what can be done for public health?

In none of the three case studies could the relationship be satisfactorily described solely by reference to one of these four metaphors. Rather the pattern seemed to be at best a complex mix of the four. The most difficult area in which to discern the nature of the relationship concerned infectious disease and migration. This was largely because much of the policy development work was conducted behind closed doors. Coker suggests that, from what evidence is available, a number of different relationships appeared to be going on simultaneously. Of the four metaphors however perhaps the one that best fit the role of public health and the DoH was that of the independent actor, albeit that the DoH's position was under considerable pressure from other Departments. The metaphor which fitted least well was that of the Trojan Horse.

With HIV/AIDS, Feldbaum argues that the traditional foreign and security policy community as represented by the FCO and MoD has been little involved in policy development. Rather DfID has taken the lead and policy has been generally framed within the context of international development rather than foreign policy in the UK, although this has not been the case elsewhere. Within this context public health has played a traditional role of informing activities and policy development.

Perhaps the most interesting example however is the relationship which has developed over tobacco control and especially the negotiations over the FCTC. As Collin notes, public health and in particular the WHO portray this as an example of partnership: that public health used the skills of the foreign policy community to assist in the negotiation of its first international health treaty. For Collin however there is a hint of hagiography about this. Although he does not detect much of the Trojan Horse in the relationship, there is some limited evidence of the supplicant metaphor in the manner in which public health attempted to gain the support of economic and financial organisations, especially the World Bank. Perhaps the most fitting metaphor however is that of public health as an independent actor. This is particularly the case at the global level where WHO took the lead and sought the support of other organisations for its agenda, but also at the domestic level in the UK.

Conclusion

This paper began by articulating eight questions regarding the development in the UK of a new policy agenda bringing together health, foreign policy and security. In answer it suggests the following:

1. *To what extent has public health been able to shape the policy agenda?* Public health does not appear to be a dominant force in driving the policy agenda in the UK. As tobacco control demonstrates, even when the evidence is overwhelming, securing the support of the foreign policy community remains difficult. Only when crises are on top of the UK – as with bio-terror in 2001 and SARS in 2003 – do public health issues come to the fore, while with longer term issues such as HIV/AIDS and tobacco control it is perhaps the scale of the problem which has demanded attention. Public health therefore appears to face a difficult task in shaping what issues are on the UK's international agenda.

2. *To what extent has the agenda reflected concerns over the national interest?* Tensions between narrow national interests, enlightened self-interest and global engagement are apparent in the emergence of health issues on the UK foreign policy landscape. A tentative conclusion however appears to be that when a clear national interest can be articulated, this tends to take precedence over other concerns. Nevertheless caution should be used here as the role of the national interest is somewhat more nuanced than this general observation might suggest.

3. *To what extent have international security concerns driven the policy agenda?* Despite the widespread perception that security concerns are a driving force in this new agenda globally, for the most part international security concerns do not appear to have driven UK policy. However more narrowly focused domestic security concerns do play a role, as seen in bio-terrorism and infectious disease/migration.

4. *What is the policy process?* The policy process appears to be dominated by Whitehall Departments with occasional interventions from the Prime Minister's Office but little from the EU. When more than one government Department has a direct interest, then policy can become inconsistent; but equally there may be occasions when a lack of engagement by Whitehall Departments translates into inaction.

5. *What role has evidence played in formulating policy?* Evidence is usually necessary but rarely sufficient for the development of policy. Public health's expectation that evidence should lead policy is not borne out. Rather evidence is used in a more nuanced manner, interpreted and used in accordance with other social and political priorities.

6. *How important have non-state actors been in policy development?* International organisations have played important roles in policy development, particularly the WHO in the FCTC. Similarly the UN and G8 have both provided important forums for raising awareness of issues and for limited policy initiatives. However, there is little evidence of movement towards, or UK support for, a new era of world health governance during the period under study. Multinational companies have proved to be important blocks on developing policy

in the UK, though neither in negotiating the FCTC nor in the TRIPS-related dispute over HIV anti-retrovirals were their reservations ultimately successful in preventing policy development. Charities and NGOs have the potential to frame the popular consensus on issues, but their impact on the policy process varies.

7. *Has the UK been an effective leader in this new agenda?* The UK is supportive of international efforts and occasionally at or near the fore. But the UK was rarely an outright leader during the first two Blair administrations and the effectiveness of policy was on occasion limited by incoherence, ambiguity or a lack of full commitment.

8. *What has been the relationship between the various policy communities?* In none of the three policy issues examined in this study could the relationship be satisfactorily described by reference to one of the four metaphors previously identified. Rather the pattern seemed to be a complex mix of the four.

In conclusion, the picture is somewhat mixed in terms of the development of a satisfactory policy agenda, that is at least an agenda which is satisfactory from the perspective of public health. On the negative side, public health in the UK appears to have made only a limited impression upon the agendas of the foreign and security policy community. DfID appears much more amenable to health issues, but this remains largely from a development rather than cross-sectoral perspective. Selected health issues can also be used to further other policy agendas such as security and immigration. Evidence, the bedrock of public health methodology, may be necessary but is not sufficient in this new policy world. More optimistically, the agenda does not appear to have been excessively securitised; reservations of multi-national companies to policy developments can be overcome; charities and NGOs have been effective on the periphery in shaping public consciousness; and although the UK may not have been as effective as it might, it has nevertheless demonstrated a capacity for leadership in this field, albeit a limited one.

Recommendations

A number of tentative policy recommendations follow from this study:

- Public health in the UK has limited ability on its own to force health issues onto the foreign policy agenda. It will therefore benefit from alliances with international organisations (most obviously the WHO, but also the World Bank) and other Whitehall Departments. Charities and NGOs may be influential in shaping the public consciousness and on occasion in influencing policy directly, but this role varies from issue to issue. The EU has played little role, even when it has had an opportunity to do so, and therefore appears to be of limited utility in this area.
- Securing support at the highest political level will be successful in placing an issue on the policy agenda, but may not be able to guarantee a continued focus on the issue unless that political support remains constant.
- The link between health and development in the UK is strong and has been beneficial. But it is also limiting in that global health is seen largely (even solely) in terms of development, and some health issues may therefore be subordinated to the development agenda.
- Making the case that health is an international security issue has not been successful to date in the UK. However the impact of health issues on domestic security has received considerable attention. But in the cases considered here, public health appears to be consulted for technical expertise and is not a decisive voice in the making of strategic policy. Care should be taken over presenting health as a security issue.
- Although the UK government is increasingly international in outlook, it appears that the national interest or enlightened self-interest remain key policy drivers. Making the case on the grounds of global engagement out of a sense of moral solidarity is possible, but less likely to succeed.
- Relations between Whitehall Departments remain crucial to the development of policy. Relations may vary from competitive to disinterested, but in all instances managing inter-departmental dynamics is likely to be crucial in developing policy successfully.
- Evidence is necessary but not sufficient to determine policy. 'Facts' do not speak for themselves, but will be used selectively, abused or even ignored. Evidence with advocacy is required.
- The potential remains for the UK to act as an international leader in this area.