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Global Responses to Chronic Diseases: What Lessons Can Political Science Offer?

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Abstract: Designing and adopting a global response to address the rise of chronic diseases in both the industrial and developing world requires policymakers to engage in global health diplomacy. In the context of the recent United Nations' High-Level Summit on Non-Communicable Diseases, the paper first reviews the rationale for collective action at the global level to address the rise of non-communicable diseases (NCDs), given the perceived limited cross-border dimensions of NCDs. Secondly, based on the social sciences literature studying policymaking at the domestic and international level, this article highlights recommendations on how to engage during the main phases of the policy process: agenda-setting, policy development and adoption.

Keywords: global health; diplomacy; non-communicable diseases; chronic diseases; policy; global collection action

1. Introduction

Until recently, chronic diseases such as cancer, diabetes and cardiovascular disorders were considered diseases of affluence and not of concern to the developing world. However, these conditions, also called non-communicable diseases (NCDs), have now been recognized as a truly global problem, further burdening the health care systems of the emerging markets and low-income countries. Four types of noncommunicable diseases—cardiovascular diseases, cancers, chronic respiratory diseases and diabetes—make the largest contribution to mortality. “These diseases are

largely preventable by means of effective interventions that tackle shared risk factors, namely: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol” [1].

Since the adoption of the Framework Convention for Tobacco Control (FCTC) in 2005, there has been a lot of interest in the public health community on how to further use global health diplomacy for chronic disease control and prevention. In addition to the Framework Convention, members of the World Health Organization (WHO) also adopted the Global Strategy on Diet, Physical Activity and Health in 2004 and an Action plan to implement this strategy in 2008. We should also highlight two resolutions adopted at the World Health Assembly (WHA), on the marketing of food to children and about the harmful use of alcohol, as other recent examples of collective action in this arena [2]. However, one of the key challenges is to bring collective action on NCDs beyond the traditional health forum. This is why the first High-Level Meeting on non-communicable diseases (NCDs) at the United Nations General Assembly in September 2011 was considered such an important step; it was the first time NCDs received such levels of attention in a forum which does not usually focus on health issues.

This article aims to draw lessons from the empirical and theoretical literature in political science and related disciplines (international relations, international law, public policy) on how best policymakers can effectively engage in an exercise of global health diplomacy related to chronic diseases. We define here global health diplomacy as the policy processes where state and non-state actors seek to design and implement global collective action to address health challenges. The article first reviews the existing debates about the incentives and rationale for collective action at the global level to address NCDs. Secondly, the article summarizes what the literature would recommend to policymakers at the various stages of the policy process.

2. Rationale for Global Collective Action

The first question policymakers have to answer before engaging in global health diplomacy, is why collective action at the global level is required? Indeed, a large number of multi-sectoral policy options available to policymakers to address non-communicable diseases are domestic policies and can be effectively implemented at the national or local level, without international collaboration.

It has been argued that the incentives for participation in global health diplomacy for chronic diseases are less powerful than for issues related to infectious diseases. “Interdependence means that two countries are mutually dependent with respect to specific activities, events, resources or problems.” [3]. With infectious diseases, “the ability of one country to protect the health of its population can directly depend on whether another country has the capacity to detect and respond to mobile, readily transmissible communicable pathogens” [3]. This perspective proposes that non-communicable diseases only involve relationships of interconnectedness among states which do not provide strong incentives for joint action, given the lack of the mutual dependence; one country may be affected by the actions of another, but the latter country may be unconcerned by what happens in the first. “For example, the export by a developed country of processed foods high in added sugars and salts may contribute to the prevalence of childhood or adult obesity in a developing country, but the health, security, and economic well-being of people in the developed country do not depend on whether the developing country controls and reduces the prevalence of obesity in its territory.” [3].

When the literature on global collective action examines global health, it also tends to focus on infectious diseases, given the perception that it poses the greatest threat. “Globalization creates an increased health interdependency worldwide that stems from enhanced transmission pathways for infectious diseases through greater mobility and transfrontier exchanges. [...] nations will not sacrifice their autonomy with respect to health policy unless the threat is especially dire or they do not have the means to address the challenge alone.” ([4], p. 99–100) We propose three main challenges to the view that incentives for global health diplomacy are not sufficient when it comes to chronic diseases.

2.1. Strengthening Public Health Authorities’ Political Position

First, there is evidence that interdependence is not the only incentive for state actors to participate in global health diplomacy. The experience with global health diplomacy around tobacco control highlights that the need to strengthen the position of national regulators and public health agencies faced with well-organized lobbying from the industry represented a different type of incentives for cross-border collaboration [5]. The FCTC differs from usual treaties because, generally, it does not address problems between countries. Rather, it addresses problems that all countries share [6]. The problem to be addressed was the ability of multinational tobacco companies to undermine the regulatory authorities of national governments. Public relations and lobbying strategies adopted by tobacco companies in industrial and developing countries contributed to prevent or limit the regulation of the industry [7]. This problem was especially acute in developing countries, given the asymmetry of resources that can be observed between large global tobacco companies and the governments of small nations.

Moreover, through global health diplomacy for tobacco control, public health authorities were seeking support to strength their domestic position to advocate and implement strong tobacco control measures. However, ministries of health are often weak players within national decision-making structures; building their capacity to obtain strong multi-sectoral collaboration from other governmental agencies or ministries, such as law enforcement or finance departments, is often part of the reason why they seek international collaboration. Global health diplomacy can be an effective strategy to strengthen their position domestically.

2.2. Transnational Negative Economic Consequences of NCDs

The second challenge to the perspective that there is little incentive for global collective action for chronic disease prevention and control relates to the nature and definition of interdependence and to transnational economic externalities. The negative impact of ill-health on economic growth can be an incentive for state actors to be involved in global health diplomacy for chronic diseases prevention [8].

Social scientists define the public good in very specific terms. Benefits from its provision are non-competitive and non-exclusive, *i.e.*, when a unit for good is consumed by one individual, it does not affect the consumption opportunities for others from the *same* unit, and it is virtually impossible to exclude individuals from benefiting from this good. Reducing air pollution is a classic example, whereas reducing greenhouse gas emissions in view of their impact on global climate would be a classic example of global public benefit. Given that it is impossible to exclude anyone from benefiting

from the public good (and impossible or very difficult to induce individuals or groups to pay for it), beneficial activities for the public good are under-produced by private provision alone.

Health status at the global level can be considered a global public benefit, given the economic externalities effects associated with it. Beyond the health status and security of their own population, the global burden of chronic diseases can have a very negative impact on the economic growth and the fiscal capacity of a country's main economic partners. Such transnational economic externalities can create incentives to seek collective solutions and participate in global diplomatic efforts to obtain that effect.

There is a large body of economics literature about the effects of ill-health on national and regional economies affected by the loss of production and income. Much is debated in that literature, but the dominant view remains that good health leads to higher economic growth; it seems to be especially the case for developing economies [9–12]. For example, it is estimated that a 10 percent increase in life expectancy is associated with an increase in economic growth of at least 0.3 percentage points per year [13].

The aggregate effect of health on economic growth is not limited to the national level. Given the economic interdependence now linking national economies (through trade in goods and services, foreign investment and financial markets), this economic impact has regional and global consequences [8]. The prosperity of one country is linked to the prosperity of its global neighbors. Investment in health improvements in other countries has positive economic externalities for its current and potential economic partners.

The economic impacts of the rise of non-communicable diseases have been documented in the research literature. For instance, the impacts of obesity in terms of medical costs and the costs associated to absenteeism from work have been reviewed by Finkelstein, Ruhm and Kosa, 2005 [14]. In its annual report on global risks, the World Economic Forum highlighted chronic diseases as one of the key risks to the global economy. “One-half of those who die from chronic diseases are in their productive years and so the social costs and economic consequences in terms of lost productivity are considerable. This fact, coupled with rising healthcare costs to employers, has made the private sector aware of the problem, in particular because many of these costs are preventable. In the US, the avoidable indirect impact of chronic disease, due for example to productivity losses, is four times as high as the direct costs of healthcare coverage. The WHO estimates that between 2005 and 2015 income loss could rise to as much as US\$ 558 billion in China, US\$ 237 billion in India, US\$ 303 billion in Russia and US\$ 33 billion in the United Kingdom. Brazil, Russia, India and China currently lose more than 20 million productive life-years annually to chronic diseases, and that number is expected to grow 65% by 2030. The losses in productivity associated with those diseases, through disability, unplanned absences and increased accidents, are as much as 400% more than the cost of treatment.” ([15], p. 25–26).

Despite the evidence as to the economic impact on the nations that are seeing a greater prevalence of chronic disease and on their economic partners, the level of global mobilization still remains relatively limited. One potential explanation could be that both the medical and non-medical costs of chronic diseases are not made sufficiently visible and explicit to policymakers; a strategy to increase the quality and visibility of information about the global economic impacts of chronic disease could be an important part of increasing incentives for cross-border collaboration.

2.3. Globalization of the Food System

The third challenge to the view that non-communicable diseases do not lend themselves to global collective action is the need for coordinated regulation in a globalized economy. When it comes to the promotion of healthy diets, one could argue that incentives for state actors to engage in cross-border collaboration are strong, given the increasingly globalized nature of the food system. For instance, 26% of the global market for packaged food products is controlled by 10 large multinational companies. In 2007, one retailer, Walmart, controlled 6% of world grocery sales [16]. If one wants to transform food systems toward healthier diets, it cannot be done effectively by focusing on local or national actions alone; one has to develop collaborative approaches in which the globalized food industry is fully engaged.

2.4. Non-State Actors

We have highlighted three types of incentives for global collective action for state actors to address non-communicable diseases. However, a key feature of contemporary global health diplomacy is the strong involvement of a diversity of non-state actors in the different phases of the process. Therefore, understanding the incentive for non-state actors, including commercial as well as not-for-profit organizations, to be engaged at the global level is crucial to have a complete portrait of the dynamics at work. Incentives are related to the costs and benefits of participation vs. non-participation and will vary greatly from one actor to another. “Resolving collective action problems requires a clear understanding of the nature, scale and timing of the costs and benefits to different countries and other parties” [17].

Understanding the structure of incentives of the private sector is especially important for global health diplomacy for chronic disease prevention and control. This is not only because of the central role played by the agri-food industry and other commercial actors in the rise of NCDs by the contribution of these actors to unhealthy food environments, but also in the role they can play in the design and implementation of effective solutions. In some cases, there may be a clear convergence between the commercial interests of some sectors and public health goals. For instance, producers and processors of fruit and vegetables will have strong incentives to participate to an effort to promote greater availability, affordability and access to fruit and vegetables, given the potential benefits to their operation, as the initiative is likely to increase their revenues.

Other factors that can create incentives for the private sector participation are: increases in consumer demand, public pressure from civil society organizations and consumers and the threat of new and potentially more onerous regulation [18]. On the last point, and in regard to firms producing for many different national markets, the reality of the globalization of many components of food value chains actually creates incentives to work towards the harmonization of standards and rules: these incentives being the reduction of costs and achieving higher economies of scale.

Understanding the structure of the industry is a key step to understanding the costs and benefits associated with the policy response. The analysis should include a mapping of the relevant industrial actors (agriculture, agri-food, transportation), of key indicators of their economic interests (revenues, market share, segmentation of their consumers) and of the key characteristics of structure of the industry and value-chain into which they are integrated (lead firm, concentration, fragmentation, geographical span). For instance, if a small number of processed and snack foods processors controls the majority of

the global market, these multinational firms will have strong incentives to realize cross-border collaboration on nutritional labeling and formulation standards, in order to reduce their costs of compliance to diverse national regulations. On the other hand, if the analysis highlights that children and adolescents constitute a large part of the consumers of these same foods, policymakers will have to take into account the much weaker incentives that these firms have in collaborating on cross-border action on the marketing of food and beverages to children. Policymakers can also, by their actions, affect the structure of incentives which will influence the participation of commercial actors. For instance, by using instruments such as subsidies or procurement policies, governments can encourage or discourage the consumption of certain food products; we have recently seen such an approach in the European Union in regard to fresh fruit and vegetables. Mapping the actors, interests and structural features of the relevant industries and value chains is essential to assess whether a collaborative or regulatory approach is most likely to be the most effective approach.

In addition to the commercial actors, there have been many non-governmental organizations involved in global health diplomacy. A large and diverse group of actors is included in this category: international federations of professional associations, health advocacy groups, humanitarian and development NGOs, philanthropic organizations. These non-state actors are capable of exerting influence at the global level; for example, the role of *Medecins sans Frontières* and *Oxfam* in the adoption of the Ministerial Declaration on Public Health at the WTO Ministerial Conference in 2001 is well documented. [19] What are the incentives for these organizations to be involved in global health diplomacy? Like commercial actors, if there is a clear convergence between the objectives of a global collective action under consideration and the objectives of the organization, the incentives for collaborating to this exercise in global health diplomacy can be very strong. For instance, health advocacy groups who have been lobbying for stricter regulations of the marketing of food may have very strong motivation to participate in consultations and negotiations about a global code of conduct as a way to strengthen their capacity to advocate stronger regulation at the national level.

Being involved in global health diplomacy also can offer a number of organizational benefits for non-state actors, beyond the achievement of their specific objectives. It can improve their institutional capacity by facilitating networking with like-minded groups and access to decision makers in governments. It can increase their visibility at the national and global level, therefore increasing their capacity to influence decision-makers, to raise funds and to increase membership. Factors which can reduce the incentives for collaboration includes the risks of losing independence from government or private sectors (or being perceived as such), of losing members, funding and credibility if involved in controversial matters where there is no consensus. The latter is especially important in chronic disease prevention, as there is very strong resistance among a number of non-state actors to collaborate with private sector actors.

3. Phases of the Policy Process

The policy process includes different phases, and in order to engage in global health diplomacy, policymakers need to have a good understanding of what phase the policy process has already reached. Each phase involves actors in a different manner and therefore, involves a different dynamic, and will mean different objectives for global health diplomacy. In this section, we examine what strategies the

literature in political sciences highlight as potentially effective in the agenda-setting phase, the policy development phase and the policy selection phase.

3.1. Agenda Setting

The first step is the agenda setting phase. Policymakers have a limited amount of time and resources to allocate to address policy problems. The policy agenda is composed of the policy problems, which receive the attention of government officials at any given moment [20]. There is a hierarchy in these problems, as some issues are deemed to be a priority; they are considered more urgent or more significant in terms of their impact at national and global levels. Political scientists have clearly shown how the agenda setting process, like the other phases of the policy process, is not simply a rational unfolding of the bureaucratic assessment of a problem and the design of a solution. Rather, it is a political process where interests, ideas and institutions meet, and where the very definition of what constitutes a problem is open to political contest [21].

If an issue is still not present or very low on the global health agenda, the objective of global collective action could be to change this state of affairs and bring policy attention to this issue. In the case of chronic diseases, this phase of problem definition has been partly achieved. The most prominent medical journals have called for global action on non-communicable diseases. Health research funders are starting to show greater interest, as witnessed by the creation of the Global Alliance on Chronic Diseases, which brings together the health research funding agencies of Canada, China, India, the United States, Australia and the UK [22,23]. Non-governmental organizations have also been active in putting chronic diseases on the global agenda. For instance, in May 2009, three global NGOs: the International Diabetes Federation, the International Union Against Cancer, and the World Heart Federation (representing more than 700 national organizations), called for the creation of a special envoy of the United Nations Secretary General for non-communicable diseases, a session of the UN general assembly to be devoted to the topic and to add action to combat chronic diseases to the list of millennium development goals [24]. These groups later joined the NCD Alliance to coordinate their action, once the members of the United Nations agreed to a special session of the General Assembly, focusing on NCDs.

Until recently, the field of global health diplomacy on chronic diseases remained strongly 'WHO-centric' [25]. Indeed, before the shift to the UN General Assembly, two prominent outcomes of diplomacy on NCD were negotiated at the WHO: the Framework Convention on Tobacco Control, and the Global Strategy on Diet, Physical Activity and Health. Moreover, a number of issues are already on the agenda of the WHO or other forums: marketing of food to children, the harmful use of alcohol and nutritional labeling. One of the key challenges was to bring NCDs beyond the traditional health forum; this is why the UN High-Level Meeting is seen as such a great opportunity.

If policymakers identify a policy problem still in the agenda-setting phase for which they want to engage in global health diplomacy, what key elements should they consider in order to be effective? One consideration is the impact of the media on the political agenda. Scholars from communications studies tend to put forward empirical evidence supporting the agenda-setting power of the mass media. However, political scientists investigating similar questions are quite divided [26]. The traditional view of the media in political science is of an accommodating conduit for elite messages, not as an actor

with its own objectives which can independently affect the policy process. In a review of twenty agenda-setting studies, mostly focusing on domestic policy issues, Walgrave and Aelst suggested that factors such as the type of media under scrutiny can explain variations in the influence of the media in agenda-setting. Indeed, elite media, in contrast to popular media, are considered to play a more active role in the shaping of the policymakers' views on foreign policy [27,28]. Moreover, the type of issues at stake is a variable to take into account. The role of the media in putting issues on the political agenda is deemed greater in foreign policy than domestic policy, given the unobtrusive nature of these issues. Given that most individuals, including policymakers, do not have direct experience with these issues in their daily lives, they would not be observable without media reporting [29].

Media reporting on chronic diseases globally has increased. This is important, given the unobtrusiveness of the economic impact of chronic diseases. Adopting a global strategy with partners to increase media coverage, especially in globally elite media (e.g. *The Economist*, *The Wall Street Journal*), about chronic diseases and potential responses, can be an effective approach to agenda setting. This may be especially important in order to set the agenda beyond the confine of traditional health forums such as the WHO.

The multiple streams model first developed by Kingdon, which has become widely used to study domestic policy processes [30], and more recently foreign policymaking, [31] stresses the importance of events such as crises, disasters, or powerful symbolic actions on agenda setting [32,33]. Dramatic events such as crises, disasters, or powerful symbolic actions have a strong impact on agenda setting [20]. Such events are recurrent in infectious diseases, with outbreak events and epidemics focusing the attention of decision makers; chronic diseases are less likely to trigger such focusing events. The role of policy champions can compensate for this.

Policy champions, also called policy entrepreneurs, can be individuals or groups located inside or outside political or administrative structures. Together, they are active in defining the nature of problems that deserve attention, as well as offering proposals to policymakers regarding the solutions for these problems. [20] In policymaking at the global level, policy entrepreneurs can be leaders of international organizations, leaders of individual countries or groupings of countries, business organizations, global civil society organizations or transnational advocacy networks that influence the process of construction and the acceptance of an issue as a problem requiring the collective action of nations [34]. It has been proposed that policy entrepreneurs are most effective in situations where incremental changes are not suited and major changes involving disruption to established ways address challenges are required. This corresponds well to the type of changes required to affect the food choice architecture faced by individuals and populations in contemporary societies.

3.2. Policy Development

The second phase of the policy process is policy development, where proposals are generated and debated. The problem is now identified and on the policy radar of authorities, but in this phase, political actors are developing and putting forward proposals to address the problem. For example, the problems related to the increasingly higher salt content of processed food and hence diets are emerging on the global health policy agenda (see for example the World Action for Salt and Health <http://www.worldactiononsalt.com/> and the PAHO/WHO Regional Expert Group on Cardiovascular

Disease Prevention through Dietary Salt Reduction). However, policy responses at the global level are still in the making.

If a policy process for global health diplomacy is in this phase, what elements should policy officials consider to be effective? An overview of the policy responses being proposed by experts and specialists is one important component. Indeed, this phase of the policy process is often influenced by global communities of specialists in a policy area (these have been called policy communities [20] and epistemic communities [35]. The policymaking process, at the national or global level, is not only explained by power, influence and pressure from interest groups. The influence of ideas in global collective action has been increasingly recognized. Experts can play an important role “in articulating the cause-and-effect relationships of complex problems, helping states identify their interests, framing the issues for collective debate, proposing specific policies, and identifying salient points for negotiation. [...] control over knowledge and information is an important dimension of power and that the diffusion of new ideas and data can lead to new patterns of behavior and prove to be an important determinant of international policy coordination.” ([35], p. 1).

Therefore, policymakers identifying an issue which has reached this phase of the policy process have to adopt a strategy of engagement with communities of experts at home and abroad who are putting forward policy proposals for national and global responses to the rise of chronic diseases. The mechanisms of engagement can include the commissioning of policy papers or review of literature, the convening of *ad hoc* consultative roundtables or permanent expert committees, the participation of officials at academic and policy conferences, *etc.* Whatever the means of engagement, the objective is to collect information in order to develop evidence-based policy proposals.

Moreover, in order to be effective in this phase of global health diplomacy, officials will have to decide what proposals they support, based not only on their assessment of the technical value, but also depending on political feasibility. Therefore, building support among international partners about the purpose and form of those global initiatives under consideration is crucial. These partners can be other national governmental agencies or non-state actors. The development of shared understanding is a key component of pre-negotiations and one important way to achieve a shared understanding comes in the form of joint fact-finding exercises [36]. “Joint fact-finding encompasses any process by which a group of stakeholders seeks agreement on a set of questions to be investigated, ways to conduct the investigation, experts and others resources, people to be involved and ways to interpret and use the results for decision making” ([36], p. 336).

Joint fact finding can take the form of expert groups, scientific advisory committee, or commissions, or more ambitiously, large long-term endeavors such as the Intergovernmental Panel on Climate Change (IPCC), which has produced reports on the health impacts of climate change. In addition to clarifying the purpose and functions of global initiatives under consideration, joint fact finding can also contribute to future successful negotiations by building trust among parties and by strengthening the capacity of partners who have less knowledge and expertise in the policy area under consideration. Looking outside chronic diseases, and as an example of such a joint fact finding exercise, we can highlight the Consultative Expert Working Group on Research and Development (CEWG), created by the WHA in 2010 to assess proposals to increase resources devoted to research on diseases that principally affect developing countries [37]. We do not know yet if these discussions will lead to the

negotiation of a new treaty on research and development, but it created the basis for more productive discussions among members with divergent views.

Creating or supporting the creation of a regional or global experts group or other type of joint fact-finding exercise can be an effective means of engagement in global health diplomacy for chronic disease, when the issue at hand has reached the second phase of the policy process. It facilitates the generation of strong and evidence-based proposals; it can facilitate consensus-building among parties by narrowing the range of options being considered. The creation of a global experts group, including scientists from the private sector, to make specific recommendations on standards on the formulation of processed food, or regarding the salt content of food products, would be an example of what forms such engagement could take.

3.3. Policy Selection

The third phase of the policy process is the policy selection phase which includes an authoritative choice among those alternatives; in diplomacy, this is the process of negotiation between parties which leads to an agreement. The discussion at the World Health Organization about a code of practice on the marketing of food to children is an example of global health diplomacy which has reached this phase. Once officials establish that the policy process has reached that point, they now have to establish their positions in the negotiations and their strategies to achieve their objective.

International negotiations are always taking place in the context of power asymmetry. Some countries or some actors have more influence over outcomes than others, given their economic power, their scientific expertise, or other assets. In the context of global health diplomacy, this situation is exacerbated by the fact that health ministries and agencies tend to be less powerful within their own governments. There are two main strategies available to officials to compensate for such power asymmetry: coalition building and preparation for negotiations [36].

One key component of preparation for international negotiations is the establishment of national positions. Scholars of diplomacy have studied international negotiations as a “two-level game.” “At the national level, domestic groups pursue their interests by pressuring the government to adopt favorable policies, and politicians seek power by constructing coalitions among those groups. At the international level, national governments seek to maximize their own ability to satisfy domestic pressures, while minimizing the adverse consequences of foreign developments” [38]. The national process of consultations inside and outside government is an integral part of diplomacy.

Within government, there will be a diversity of views as to what specific positions and strategies a country should take during international negotiations. The creation of an inter-ministerial committee to broker these different perspectives is a well-established practice in international negotiations. Such a committee plays a central role of brokering the possibly divergent views as to how better to maximize public health outcomes while protecting and promoting commercial interests. The experience with health-related trade negotiations has highlighted the importance of such institutional mechanisms for inter-sectoral collaboration [39].

The consultation process at the national level is often a crucial work of such a committee, or the agency which leads the negotiation process. Whether they take place in a formal process, or remain rather informal, such consultations will strengthen the evidence base of the policymaking process and

facilitate the brokering and balancing process necessary to establish a coherent national position. Mechanisms for consultations can include the creation of a formal advisory group with specific membership, an open call for comments on a discussion paper prepared by the government, through online or face-to-face meetings. Greater transparency tends to be associated with greater legitimacy for this phase of the policy process.

Once a clear negotiating mandate is established at the national level, global health diplomacy in its most conventional form can take place, *i.e.*, formal negotiations between parties. In international negotiations where the parties have different preferred outcomes, the process will involve the exchange of concessions. A party can concede to the preferences of another party, and in exchange, ensure its priority is reflected in the final text. For instance, a national government may be willing to accept weak language on the impact of trade agreements on trade in tobacco in the Framework convention on tobacco control in exchange for clear and explicit standards on the marketing of tobacco. In such negotiations, building coalitions with like-minded parties has often offered a useful strategy for smaller countries seeking to achieve their objectives.

4. Conclusions

After discussing three types of incentive for global collective action on NCDs, this article described several strategies that can be used to enhance the likelihood that exercises in global health diplomacy lead to successful outcome. During the agenda-setting phase, we highlighted the role of the media, policy entrepreneurs and civil society organizations. In the policy development phase, engagement with experts and the creation of joint fact-finding processes are promising strategies. During policy selection, when we move to the formal negotiations, coalition building and preparations at the domestic level are key components of a successful approach. In conclusion, we discuss which of these elements appear to have been the most determinant in the recent attempt to achieve a global response to NCDs: the NCD Summit at the United Nations.

After several months of negotiations, the UN General Assembly unanimously adopted on September 16th 2011 a political declaration that acknowledges the scope of the crisis and identifies the key components of a “whole of government and whole of society” response [40]. Most parties agree that this consensus document is only a first step in terms of mounting a global response to epidemics. Several experts analyzing the outcome of the summit found the declaration “lacking in targets, funds and action.” [41] and therefore, a missed opportunity [42].

One of the most determinant variables to explain the relatively weak outcome of this exercise in global health diplomacy is the weak presence of grass-roots advocacy and activism concerning non-communicable diseases. One of the key lessons from previous successes in global health diplomacy is the key role of civil society organizations’ mobilization in ensuring a strong collective response. This explanatory variable has certainly been identified as central in the negotiations of the Framework convention on tobacco control [43]. Grass-roots activism and global mobilization are also key factors behind the changes in financing for, and access to, treatment for HIV-AIDS patients in the developing world.

The policy process leading to the NCD High-level meeting was not devoid of civil society actors. On the contrary, we observed that the NCD alliance has been very active throughout the process:

conducting consultations internally to develop a proposed outcome document and collaboration in the production of and participation in key articles in the main scientific journals such as the *Lancet*, as well as many articles in the mass media. They also met face to face with a large number of missions in New York and participated in official meetings such as the Global Health Forum that took place in Moscow. The civil society hearings in New York attracted the participation of more than 200 Chief Scientific Officers, including members of the NCD Alliance.

However, what was lacking was extensive grass-roots activism demanding change at the local and national level in terms how governments work to prevent and treat NCDs. As noted by researchers at the Centre for Strategic and International Studies, “while the NCD Alliance is emerging as the main force of civil society engagement, in some cases national and international member societies are dominated by medical professionals and do not significantly involve people living with and affected by NCDs” [44].

Such grass-roots activism would have put pressure on political leaders, and therefore on delegations sent to New York, to be more ambitious in terms of what should be achieved at the global level. Moreover, we noted the lack of non-health NGOs in the public debate. We have not seen unions, development NGOs, faith groups or other types of organizations engaged in making demands and advocating for change at the national or global level.

Another factor to consider, in order to move beyond what was agreed at the High-Level meeting, is the need to make greater explicit economic interdependence a key rationale for global collective action on NCDs. The economic case for the need to negotiate a global response to the rise of NCDs has not been yet sufficiently made for policymakers to be strongly motivated to invest significant time and political capital. The follow-up to the High-Level Meeting, mandated by the Political Declaration, may be an opportunity to do so, and to build on the momentum created by such an event.

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