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Global Public Health as a tool and instrument of power in contemporary foreign policies. The cases of Italy and France.

Supervisor
Professor Antonio La Spina

Candidate
Grégoire Rigoulot-Michel
Student Reg. n.638952

Co-supervisors
Professor Ivan Timofeev
Professor Daniele Mascia

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The outcome of those debates in the twenty-first century will depend, as it has always done, on national histories and cultures, international developments and political will.

Dorothy Porter - *Health, Civilization and the State*

Acknowledgments

This thesis is on a subject that has been relatively under considered by contemporary international relations scholars. It is the result of more than two years of study. This thesis is the outcome of a personal work that I wished to accomplish before starting this double Master Degree at MGIMO and LUISS. However this thesis would have not came to birth without the crucial help of the following persons that I truly wish to thank.

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Contents

Acronyms

EMA - *European Medical Agency*

EU - *European Union*

FDA - *Food & Drug Administration*

G7 - *Group of 7*

G20 - *Group of 20*

GDP - *Gross Domestic Product*

IHR - *International Health Regulations*

NATO - *North Atlantic Treaty Organisation*

NHS - *National Health Service*

TRIPS - *Agreement on Trade-Related Aspects of Intellectual Property*

UNO - *United-Nations Organisation*

USA - *United States of America*

WHO - *World Health Organisation*

WTO - *World Trade Organisation*

Introduction

"I believe that this G7 has been inserted in a profound dynamic, coherent with our strategy, of a putting France back in the heart of the diplomatic game"[1]. By this sentence, pronounced before the French diplomatic corp two days after the end of the 2019 G7 Summit of Biarritz, the French President of the Republic underlines two major elements. First Emmanuel Macron recalls the French willingness and efforts to renew with diplomatic and geopolitical power. These efforts aim at making France almost impossible to overpass, to bring France back at the core of world affairs. Second, Emmanuel Macron reminds that such strategy for power is implemented and has to be unfolded through international summits and *coups de force*. President Macron's discourse took place at the opening of the annual French week of ambassadors. This annual event is increasingly used by heads of State and governments to draw and strengthen the foreign policy they intend to pursue, and above all to explain how the diplomatic corps should implement the strategy for power that is pursued. It is therefore as no surprise that Emmanuel Macron used his opening speech to underline some outcomes of the recently closed G7 summit. Indeed the G7 has been the occasion for Paris to favour multidimensional cooperation and negotiations between Member States Ministries. Above the August summit itself, the G7 saw deep longterm cooperation to assess the priority defined by Paris: inequalities and how to reduce them. In particular, the reduction of health inequalities has been at the core of the G7 negotiations[2]; which has been shown by the importance given to global health and health governance in Emmanuel Macron's speech as well as by the discourse of the French Minister of Health, Mrs Buzyn, before the diplomatic corps.

Silja Häusermann shows in his work that welfare and social spendings differences among States can be linked to the importance of politics on ones health and its power to shape society[3]. Indeed, in the words of Tabuteau, health is a major collective and political

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[1] Emmanuel Macron, *French President's speech to the diplomatic corps*, Paris, August 26th 2019

[2] Christine Berling, Paris, April 25th 2019

[3] Silja Häusermann, "Welfare State Research and Comparative Political Economy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, June 2018, p.2

challenge[4]. Such theoretical thinking has been at the core of Michel Foucault's work and concept of biopolitics. It also constitutes one of the most important assumption on which is based this thesis. Foucault allowed a scientific jump in the understanding of health and its relations with power and politics. The *Birth of the Clinic*[5] is in this regard fundamental to seize health in its full spectrum. Evidently Foucault's work knows fragilities and has to be updated for the XXIst century. Yet, as explained by Roberto Machado, Foucault's entire work has to be understood as a research on modern knowledge in relation with death[6]. Therefore the present thesis acknowledges Foucault's importance without however discharging some of its critics.

Through the concepts of biopolitics and later biopower, Foucault tried to highlight the links between health and power; limiting himself however to the national scale. Nonetheless due to the high level of globalisation known by contemporary societies, his theories can constitute the basis to a similar analysis made in the frame of international relations sciences. Globalisation processes and global actors have been critical in globalising health and introducing some similarities in local biopolitics. Christensen advanced the impact of global actors, and especially actors that *became* global, on global processes of cooperation and competition[7]. By adding expertise and financial resources, global actors have impulsed a higher degree of flexibility within health governance[8]. Indeed, such actors have been key in incorporating health in foreign policies and strengthening global health governance. Nevertheless, health remains perceived as a so-called "low-politics" even in States that are at the peak of health-related technological development, as France or Italy. The paradox of States that are looking for renewed power but also neglecting a field within which they have assets, interrogates on the role and place of global public health within States foreign policies and strategies of power.

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[4] Didier Tabuteau, "Droit de la santé et économie de la santé, *in* Bras Pierre-Louis & al., *Traité d'économie et de gestion de la santé*, Presses de Sciences Po, Paris, 2009, p.88

[5] Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, 287 pages

[6] Roberto Machado, "Foucault, Philosophy, and Literature", *Contemporary French and Francophone Studies*, Vol. 16 (2), Routledge, London, March 2012, p.230

[7] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.18

[8] Wolfgang Hein, *The New Dynamics of Global Health Governance,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.60

The primary aim of this thesis is therefore to study the impacts of global public health agendas in France and Italy's definition of foreign policy, and how it currently influences their strategy of power. Therefore the core of the present thesis is to understand how health can be understood as a source of power and why two European States, traditionally active in the field of global public health, are limitedly using their public health agendas as foreign policy tools and instruments in the framework of their strategy of power in the XXIst century. The first chapter focuses on the idea of power and its contemporary links with global public health. This chapter advances the concept of moving sources of power. The second chapter is devoted to the study of France and Italy's global strategy of power for the XXIst century with a specific focus on health dimensions of these grand strategies. The third and last chapter studies the potentials and obstacles encountered by France and Italy in dealing with global public health as foreign policy tool, discussing how to get the best outcome of it.

Consequently, this study is based on international relations realism and constructivism as well as on middle range empirical theories with a specific focus on health. In fact, being focused on States as primary actors of global affairs and on States as actors in a perpetual quest for power, it recalls realist theories. Nonetheless, the social and institutional construction of world affairs, power and health governance should not be undermined and so justifies the insight of constructivist theories. Finally, health being a scientific field by itself, empirical theories focusing on health deepen the theoretical framework of this thesis. Further justification can be found in the first chapter and more particularly within the concept of moving sources of power.

Within this theoretical framework, it appears important to recall Céline Paillette and qualify globalisation as the globalisation of pathogenic challenges under a global governance and with public health being accepted as a global public good[9]. Moreover, the theoretical framework adopted here gives a central place to the yet blurred concept of power. If Tammen, Lemke and Kugler define power as "the ability of one nation to advance policy goals by altering the policies of other nations"[10], Raymond Aron more accurately defined power as the ability of States to do, prevent other States from doing, and make other States do. However, going above such practical definitions, Foucault brilliantly theorised power as "the name that

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[9] Céline Paillette, "Diplomatie et globalisation des enjeux sanitaires", *Hypothèses*, Vol. 17, Éditions de la Sorbonne, Paris, 2014, p.130

[10] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.3

one attributes to a complex strategical situation"[11]. Furthermore recalling Nietzsche, Foucault accepted the will of knowledge as a will to power[12]. It comes therefore as no surprise that Foucault conceptualised the biopower as a consequence of the birth of the clinic and the rise of biopolitics. Didier Fassin, among other scholars, criticised Foucault's theories and more particularly the concept of biopower, underlining its ambiguity[13]. Nevertheless biopower, simply defined as the power that comes from biopolitics, Foucault's concepts remain a crucial springboard to the concepts and ideas advanced in this thesis.

Céline Paillette showed that the fight against epidemics constituted during the XXth century a *force profonde*, as theorised by Pierre Renouvin, in a way that they participated to the internationalisation of public health and its governance[14]. Indeed, public health has always been, since the United-Nations creation, of primary interest for many developed economies, and especially European States. Even before 1945, international institutions were created to strengthen cooperation and advance interests in the field of public health. Another underlying fact is the permanent willingness of the World Health Organisation (WHO) to expand its powers and fields of actions, as highlighted by the famous case on nuclear weapons legality. Currently, health remains of primary importance, France being a major actor in health institutions and on medicines' production, Italy remaining a leader in advanced surgery and medicines' production. Combining several sets of both internal and external interests, global public health remains crucial in the French and Italian foreign policy, and strategy of power for the XXIst century.

Nevertheless both France and Italy recently encountered backlashes: France having failed in securing its interests regarding the nomination of the WHO's General Director in 2017, and Italy loosing the race in hosting the new headquarters of the powerful European Medicine Agency. Furthermore, these two meaningful failures are mainly due to the French and Italian

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[11] Alan Bleakley, John Bligh, "Who Can Resist Foucault? ", *Journal of Medicine and Philosophy*, Vol. 34, Oxford University Press, Oxford, June 2009, p.379

[12] Ibid

[13] Michela Marzano, "Foucault et la santé publique", *Les Tribunes de la santé*, N° 33, Presses de Sciences Po, Paris, 2011/4, p.42

[14] Céline Paillette, "De l'Organisation d'hygiène de la SDN à l'OMS. Mondialisation et régionalisme européen dans le domaine de la santé, 1919-1954", *Bulletin de l'Institut Pierre Renouvin*, Vol. 32, IRICE, Paris, 2010, p. 194

governments lack of continuous, strategic and relevant efforts. In addition, France and Italy are facing since the 2007 economic crisis a significant economic slow down and a declining influence on both regional and international stages.

That's why, in the frame of the rising multipolar world and the renewing of both French and Italian leadership and strategies of power, studying the impacts of global public health on their strategies of power for the XXIst century, would help scholars, private actors and politicians to better understand these strategies and how it affects the global public health agenda. Furthermore, by providing an insight on the roles and impacts of global public health on the French and Italian foreign policy, it would give scholars, private actors and politicians a basis to further secure French and Italian interests in this field. In the end, because Ann Burlein highlighted the deep interlinks between biology, health, culture and politics[15], this would help understand why and how France and Italy could improve their geopolitical power and influence on the European and global stages by using their potential in public health .

The core idea of this thesis is that there are fields of international relations that can be understood, seen and studied as privileged sources of power. These fields are evolving according to megatrends, world order, and international actors. But these sources are also and above-all « country-type » specific. If everyone agrees that BRICS will, in a more or less near future, implement and assure their supremacy on the world affairs, some voices are rising saying that they are still far from the American power. But what about Europe, the European Union and European States? Always seen as threatened, weak, condemned to international insignificance, the opposite would be argued here. Precisely because of the increasing transformation of the knowledge on life[16] and the growing importance of global public health in international relations and power distribution in the XXIst century. It is found and argued in this thesis that global public health can provide to West European States, and especially to France and Italy, a room for power in the XXIst century. It can also strengthen their position in the world affairs facing the growing power of emerging and emerged countries such as India, China, Brazil or Russia.

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[15] Ann Burlein, "Knowledge is Made for Cutting: Foucault, Cognitive Science, and Intellectual Taste", *Method and Theory in the Study of Religion*, Vol. 24, Brill, Leiden, 2012, p.119

[16] Philippe Raynaud, "Michel Foucault. Philosophie, histoire, politique et littérature", *Commentaire*, N° 153, Commentaire SA, Paris, 2016/1, p.17

Part I: Global Public Health or the Primary Source of Power for the XXIst century

Recalling the pioneering work of Foucault, and more particularly his famous book *Naissance de la Clinique* as well as his lectures on biopolitics at the Collège de France, the place of health in modern societies is more important than ever before. Nevertheless, such increasing relevance of public health in the life of the State and society does not undermine the role and place of power within them. That's why this first part focuses on the relations of power and health in the XXIst century. Taking a step further, the core of this part lies on the concept of moving sources of power (Chapter I). It would then be showed and argued that such concept of power strengthen the argumentation for global public health as a power source in contemporary world affairs (Chapter II).

Chapter I: Power as a legitimising flow from moving sources

From Sun Tzu in *The Art of War*, on to the most contemporary scholars, power has been a core concept of the study of international relations; most probably because of the legitimising dimension of such force. Yet, power remains today a highly debated concept that the international relations approaches, such as realism, liberalism or constructivism, only partially explained. Relying on the constructive-realist approaches (I), it would here be developed the idea of power as a legitimising flow from moving sources (II). This understanding will moreover be enriched by its projection to the current change of world affairs (III)

I. State, a constructive-realist approach

Going back on the highly debated conceptualisation and categorisation of the concept of power would be denying the fundamental works of generations of scholars. On the contrary, the idea of power as a legitimising flow from moving sources will be here based on the constructive-realist approach of international relations. To that end, we will resort on the study of States' search for power (I.I), yet recall the non-human like entities that are States (I.II).

I.I. States and the search for power

To argument on the constructive-realist approach to the concept of power, and underline States' crucial search for power, it appears relevant, yet contestable, to start from the liberal approach of political economy and its critics. In fact the theory of social contract, as an intangible contract between a citizen and the State, leads us to, as developed by Lagasnerie, the idea that the Law shapes the citizen[17]. As such, citizenship can be defined as a submission to the public authority[18]. The consequences, in light of what has been described by Foucault in his theory of *homo oeconomicus*, for the State are dual. Firstly, the judiciary and political axis

[17] Geoffroy Lagasnerie (de), "Néolibéralisme, théorie politique et pensée critique", *Raisons politiques*, N° 52, Presses de Sciences Po, Paris, 2013/4, p.72

[18] Ibid

have as fundamental property the action towards State's legitimisation[19]. In other words, the core of political and judiciary actions, because of the social contract, aims at legitimising the State's proper existence. That's why secondly, according to Foucault the most pressuring issue of political philosophy is, before all, the issue of the sovereign[20] and sovereignty. On the global level, and because agencies have socio-political impacts beyond the State[21], the influence of such socio-political process, and the consequent search for sovereignty, have constituted the basis of realism's founding scholars such as Hobbes, Morgenthau, Aron, Waltz or Keohane. Furthermore Shapiro showed that "the agency of institutions is constricted to the space left open and essentially defined by politics"[22]. Therefore agencies, and so international relations, are "most often dominated by the power relations of raw politics (and) inscribed, for instance, in interstate relations"[23].

However relying exclusively on the realist approach to international relations would limit the understanding of power, and States' actions to cultivate it. In fact, going back to the definition of power previously drawn[24], an exclusively realist approach would undermine a revised version of power that includes new parameters such as population, productivity or political performance[25]. Going further, it would overpass the classical questioning of power redistribution in States power relations[26], or more importantly the crucial inputs of the Power Transition theory, and specifically its operational imperative of dissatisfied potential challengers' socialisation[27]. Combined to the imperative of challengers' socialisation, Robert Powell's idea that States are agents within a simple strategic setting composed of commitment

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[19] Geoffroy Lagasnerie (de), "Néolibéralisme, théorie politique et pensée critique", *Raisons politiques*, N° 52, Presses de Sciences Po, Paris, 2013/4, p.71

[20] Ibid

[21] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.2

[22] Ibid, p.15

[23] Ibid

[24] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.3

[25] Ibid, p.4

[26] Hubert Védrine, "La redistribution de la puissance", *Le Débat,* N° 160, Gallimard, Paris, 2010/3, p.24

[27] Jacek Kugler, Douglas Lemke, Ronald Tammen, Ibid, p.32

issues, informational problems, and the technology of coercion[28], justifies the resort to a theory of international relations that recognises the relevance of historically, socially and culturally constructed relations on a global level.

In this regard, constructivism helps us understood how international policies have been increasingly shaped by intermestic issues[29], and so public opinion; as for example migration, terrorism or climate change. Going a step forward, by adopting such approach power and States' inner search for power, appear strengthened by the idea developed by Foyle, of a "distinction between domestic policy and foreign policy (that) might no longer be meaningful from a theoretical perspective in the field of public opinion and foreign policy"[30]. Therefore, relying on the ideas previously developed, and in particular Foucault's idea that the States is focused on the sovereign's issue, it could be argued, in a classical realist view, that States' domestical search for power and order is reflected at the international level. Yet at the same time, it justifies the influence of domestic, cultural and historic structures and agencies on the inter-States relations.

A combined constructive-realist approach to international relations and to power leads to the idea that States are in the search for power, on both domestic and global levels, to, among other objectives, legitimise their proper existence. This is why, as an example, individual countries and organisation would use coalitions as powerful tools to amplify their influence at the global level[31], and legitimise their position. The dialogue between the two levels, necessarily shapes States foreign policy and search for power, but also the role and actions of domestic actors on the global stage. Private actors are influencing international reconfigurations, even if public administrations' policies conserve the monopoly of major decisions and their implementation[32]. Nevertheless, Haas idea that "epistemic communities are somehow the "missing link" of international policy coordination and its connections to

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[28] Randall Schweller, "The Balance of Power in World Politics", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, May 2016, p.12

[29] Douglas Foyle, "Public Opinion and Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, August 2017, p.16

[30] Ibid, p.17

[31] Diana Chigas, Nick Drager, David Fairman, Elizabeth McClintock, "Negotiating Public Health in a Globalized World. Global Health Diplomacy in Action", *Springer,* Cambridge, 2012, p.79

[32] Guy Carron de la Carrière, "Les acteurs privés dans la diplomatie", *Les cahiers Irice*, N°3, IRICE, Paris, 2009/1, p.58

national, international, and transnational levels of law and policy"[33] highlights such approach to power. This is also reinforced by Pritoni's study of national and international institutional settings influence on interest groups coalition's formation and action[34]. However, even relying on Durkheim's sociology on the crucial role of institutions as social life's organisers[35], ones cannot overpass Weber's demonstration that only individuals can have intentions[36]. In fact, going against Powell vision of State as a unitary agent[37], it appears fundamental to highlight that if States are in a constant search for power on both domestic and global levels, in what Marchesin called a "reflex of Realpolitik"[38], States are not human-like entities.

I.II. State as non-human like entity

Ian Thynne shows that executive agencies are "consciously constructed, ends-oriented means of administrative and managerial action in accordance with government policy"[39]. However executive agencies can be "referred to as "statutory" or "non-statutory," with the former being subject to legislative action along with government action, and the latter to government action without necessarily any reference to the legislature"[40]. In other words agencies, according to Thynne's study of government structure and power, have moving and different levels of ability and autonomy in respect to each others and most importantly the government and the legislature. In fact Thynne concludes his study by stating that

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[33] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.6

[34] Andrea Pritoni, "Navigating between 'friends' and 'foes': the coalition building and networking of Italian interest groups", *Rivista Italiana di Scienza Politica*, N° 49, Società Italiana di Scienza Politica, 2019, p.65

[35] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.11

[36] Ibid

[37] Randall Schweller, "The Balance of Power in World Politics", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, May 2016, p.12

[38] Philippe Marchesin, "Démocratie et développement", *Revue Tiers Monde*, N°179, Armand Colin, Paris, 2004/3,p.507

[39] Ian Thynne, "Fundamentals of Government Structure: Alignments of Organizations at and Beyond the Center of Power", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, February 2018, p.11

[40] Ibid, p.12

organisations have in their power relation to the government, various ways of serving it, from fusing to autonomously governing[41].

One of the best example is probably Robert Dahl's last great step towards democratic development: the parliamentary opposition and its institutionalisation[42]. If the institutionalisation of parliamentary opposition is recent, even in some old West European democracies, it is currently on the increase. As it, such institutionalisation, and especially its increasing role in the foreign policies of many States, highlights the non-unitary dimension of the State. In fact, as showed by Elisabetta De Giorgi, the parliamentary opposition behave in a systemic way regarding its organisational cohesion, yet tends to adapt its behaviour on the debated stakes in its relations to the government[43]. Therefore the parliamentary opposition can both support and undermine the action of the government on the global stage, and as such strengthen its role of debater and challenger. This trend is underlined by the role and behaviours of interest groups in regard to State agencies. Indeed, interest groups have been shown to behave based not only on their resources but rather on their perception of the sufficiency of those resources to counterbalance both opponents' influence and structural challenges[44].

If scholars are debating the consequences of private actors' entrance on the global stage[45], and among them Bertrand Badie whom argues that sovereignty will fade[46], they aren't debating the proper entrance of private actors within international relations. In fact, Foucault even underlined the dependance of the politic onto the economic, which protects the subject's liberties, as a result of auto-restricted liberalism[47]. This is also why Guy Carron de la Carrière

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41 Ian Thynne, "Fundamentals of Government Structure: Alignments of Organizations at and Beyond the Center of Power", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, February 2018, p.19

42 Elisabetta De Giorgi, "L'opposition parlementaire en Italie et au Royaume-Unie : une opposition systémique ou axée sur les enjeux ?", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/2, p.93

43 Ibid, p.113

44 Andrea Pritoni, "Navigating between 'friends' and 'foes': the coalition building and networking of Italian interest groups", *Rivista Italiana di Scienza Politica*, N° 49, Società Italiana di Scienza Politica, 2019, p.50

45 Guy Carron de la Carrière, "Les acteurs privés dans la diplomatie", *Les cahiers Irice*, N°3, IRICE, Paris, 2009/1, p.45

46 Ibid

47 Jean-Yves Grenier, André Orléan, "Michel Foucault, l'économie politique et le libéralisme", *Annales. Histoire, Sciences Sociales*, Editions de l'EHESS, Paris, 2007/5, p.1180

draws three levels of international activity's analysis. For him international relations are made on the first level of the links between people and States, on the second level of diplomacy as implemented by governments, and finally on the third level of foreign policies as the expression of strategic choices[48]. In that sense foreign policy and more generally States' behaviours appear more complex that what some scholars are conceptualising when they use States as unitary agents. Furthermore, as theorised by Foyle, the distinction between domestic and foreign policies in many States is increasingly blurring[49]. Which in return let more space and room for influence to the national histories and cultures regarding the debates on States behaviours[50]. In such understanding the empirical work of Graham Allison on the Cuba missiles crisis of 1962 appears fundamental to understanding the reality of both national interest multiplicity and that States must be understood as non-unitary agents[51]. On the politico-philosophical dimension, this is justified by the fusing of the agent's finitude with the infinitude of the State[52]; which allows the dual perception of State as perennial and intangible institution yet also as non-unitary short-term agency.

The constructive-realist approach of international relations helps us understand States' parallel search for power, because of its legitimising force, and non-unitary dimension. In that lens, it appears that States are focused on acquiring power, but that power is not perceived the same way within the State itself. This constitutes the theoretical basis for the main argument developed in this part, that power arises from moving and evolving sources.

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[48] Guy Carron de la Carrière, "Les acteurs privés dans la diplomatie", *Les cahiers Irice*, N°3, IRICE, Paris, 2009/1, p.47

[49] Douglas Foyle, "Public Opinion and Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, August 2017, p.3

[50] Dorothy Porter, "Health, Civilisation and the State. A history of public health from ancient to modern times", *Routledge,* London, 1999, p.319

[51] Florent Pouponneau, *Politique étrangère*, Institut Libre d'Etude des Relations Internationales, Paris, 2015

[52] Michael Dillon, "Gouvernement, économie et biopolitique", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.27

II. Power as a moving and evolving source

The idea developed here is that there are fields of international relations that can be understood, seen and studied as privileged sources of power. These fields are evolving according to megatrends, world order, and international actors. But these sources are also and above-all « country-type » specific. That's why it appears crucial to take a closer look on influence as power (II.I) to unfold the very concept of power (II.II).

II.I. Power, from basics to influence

For a long time and still nowadays, many have associated power with military apparatus, as demonstrated by some States' competition to possess the highest number of nuclear heads whereas nuclear deterrence requires only a single nuclear head to have and effect. Going over the debates of power's most effective dimension, as well as going further Joseph Nye's three categorisations of power, namely hard, soft and the later developed smart power, power would here be understood as a force in a close relationship with influence and authority. One cannot but think about Georges Lefebvre's demonstration that power and cultural influence are the two faces of the same phenomenon[53].

By answering to the question "Who is driving globalisation?"[54], Mikkel Christensen and Mikael Madsen have powerfully reminded, though focusing on the study of private actors on the international scene, that global actors' actions have impacts that one cannot undermine in the study of contemporary global power relations. Especially, power in contemporary international relations would not overpass global actors' "socio-political impact(s) in terms of exercising public authority beyond the State"[55]. As such, the contribution of global actors as contributors to the process of globalisation and global politics[56], stretches a narrow understanding of power in contemporary international relations. This is why Castells underlines the crucial links between the emergence of global actors with broader social

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[53] Fernand Braudel, "Le modèle italien", Champs Arts, *Flammarion*, Paris, August 2008, p.196

[54] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.2

[55] Ibid

[56] Ibid

processes[57]. In fact, such links between globalisation, socialisation and political influence have been brilliantly explained by Javier Santiso whom demonstrated that democratisation processes in Latin America are specific and yet used as domination tools in some States' pursuit of interest[58]. A similar idea is drafted by Hubert Védrine when he explains that within globalisation there have been globalisators and globalised actors[59]. When Ted Schrecker explains that "domestic class structures and possibilities for political action are in turn influenced by multiple elements of globalisation"[60], he shows how a foreign can influence to its own interests, yet most of the time unwillingly, the very structure of another State; maximising the power potential of further foreign policies towards this influenced State.

Consistently, the power transition theory can, to some extent be useful in assessing influence as power and power as arising from moving sources. In fact the role of the dominant nation as a nation holding substantive power within a hierarchy and managing a system of satisfied nations,[61] underlines the importance and malleability of influence, as a capacity to manage and deliver a perceived satisfaction, within the concept of power. Such understanding of the power transition theory is supported by one of the core idea of this theory, that a dominant power leads by creating satisfaction rather than fear[62]. Gilpin's introduction of public goods within the power transition theory[63] further increases the centrality of the establishment of rules that simultaneously satisfies the dominant power allies, and disproportionately favour the latter[64].

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[57] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.3

[58] Javier Santiso, « A la recherche des temporalités de la démocratisation », *Revue française de science politique*, Vol.44 (6), 1994, pp.1079-1085

[59] Hubert Védrine, "La redistribution de la puissance", *Le Débat,* N° 160, Gallimard, Paris, 2010/3, p.25

[60] Ted Schrecker, *The Power of Money: Global Financial Markets, National Politics, and Social Determinants of Health,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p.169

[61] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.2

[62] Ibid, p.11

[63] Ibid

[64] Ibid

Therefore, as it will later by further developed, the important role that domestic political interests play in shaping global interests regarding publics goods[65], and on the opposite, the use of publics goods related global policies to serve domestic political interests[66], trigger new and malleable dimensions of power. As an example, Rushton explains the fundamental importance of political and ideational rather than functional motives in the creation of UNAIDS[67]. Moreover, the perceived legitimacy of a global actor constitutes nowadays a recognition of the validity of its ideas[68] and as such an instrument of a powerful influence.

II.II. Power, or the necessity to assess and unfold

When Rushton asks himself where power lies in contemporary global health governance and how it changed[69], he intends to go beyond the fact that global health governance is dominated by the developed world[70]. Despite his focus on private actors, and his subsequent tendency to amplify their power on international relations, Rushton shows that private actors, and more specifically global partnerships and foundations are reproducing the existing inter-State geographies of power and governance[71]. In other words, power in the contemporary era is enhanced by both private and public actors on similar, yet non identical, patterns and agendas; occasionally playing each others to advance their interests. Such characteristics require therefore, as well as it shows, an active participation of an actor to unfold its power potential into an actual power. As it, the constant assessment of one's power potential appears crucial to the definition and implementation of a power strategy.

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[65] Harley Feldbaum, *Global Health in International Politics,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.136

[66] Ibid

[67] Simon Rushton, David Williams Owain, *Private Actors in Global Health Governance*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.14

[68] Ibid, p.4

[69] Ibid, p.2

[70] Ibid, p.19

[71] Ibid

In that sense, in the aftermath of the second world war and above all since the decline of the USSR, many Western State saw in the diffusion of democracy a way to influence other States and increase their regional or global power leverage through political and systemic influence. As highlighted by Philippe Marchesin, the implementation of economic conditionalities and structures has been a way for Western countries to enhance their model[72] for the rest of the world. Economic and political liberalisms and their diffusion have in that way been promoted, yet for some scholars such as Javier Santiso enforced, as political paradigm within Western States strategy of power[73]. That's why scholars such as Sarah Babb, recalling Hall's work[74], demonstrated that the Washington Consensus is a political paradigm with a strong geopolitical dimension[75]; being at the core of Western States strategies of power in the late nineties and the early XXIst century[76]. As a consequence of these geopolitical dynamics, democracy and neoliberalism became from the 1990 the dominant ideologies[77]. Concerning neoliberalism more particularly, McInnes shows the influence of neoliberalism's active, yet non-solely economic, promotion in shaping the transformation of global governance and establishing particular forms of global governance[78].

Nevertheless, recalling the influence dimension of power underlined previously, or in other words that power is highly based on the influence that a State can have on others, and going above the importance of an active promotion of power in the transformation of power potential into effective power, it appears crucial to stress the social aspect of power. Indeed, if power is a relational social resource[79] at the domestic level, the fact that some actors have the

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[72] Philippe Marchesin, "Démocratie et développement", *Revue Tiers Monde*, N°179, Armand Colin, Paris, 2004/3,p.507

[73] Mohamed El-Oifi, *Médias et Conflits*, Institut Libre d'Etude des Relations Internationales, Paris, 2016

[74] For Robert Hall, a political paradigm is a set of political ideas and principles established as a model defining the instruments to use in a specific political domain, as well as the objectives that must reach such policies.

[75] Sarah Babb, « The Washington Consensus as transnational policy paradigm: Its origins, trajectory and likely successor », *Review of International Political Economy*, Vol.20, avril 2013, pp.268-297

[76] On that subject see my Master degree thesis on the Washington Consensus challenging by Russia and Italy, for the Institut Libre d'Etude des Relations Internationales.

[77] Philippe Marchesin, "Démocratie et développement", *Revue Tiers Monde*, N°179, Armand Colin, Paris, 2004/3,p.498

[78] Colin McInnes & al., "The Transformation of Global Health Governance", *Palgrave Macmillan*, New-York, 2014, p.4

[79] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.9

right to use it in specific ways that others don't[80] also seems relevant as far as global actors are concerned. The importance to challenger's socialisation, as a process whose objective is "to persuade challengers to adopt principles embedded in the status quo"[81], given by the power transition theory highlights the necessity to adopt a fluid understanding of power and constantly assess its sources. Such position have been drawn by Kenneth Walz, when he wrote "As nature abhors a vacuum, so international politics abhors unbalanced power"[82].

In fine, it would be argued that power in contemporary politics comes from the use that States do of the power potentials it has at its disposal, themselves included in a large and malleable understanding of power. Therefore power appears to be specific to their handlers and coming from changing sources. Hence the need for global actors, and first of them all States, to assess their power potential and implement consistent and perennial strategies to unfold such potentials. Such behaviour and political position requires a power redistribution on the domestic levels; which can be exemplified by the recent redistribution of powers within the French sanitary system[83] that will later be further developed. On the global stage, and conserving the example of health, the consequences of Stefan Elbe's prediction that "in the twenty-first century our futures will not only be secured militarily but also pharmaceutically"[84] are of great importance to States searching for power; especially considering the current consolidation of spheres of influence.

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[80] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.9

[81] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.33

[82] Randall Schweller, "The Balance of Power in World Politics", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, May 2016, p.2

[83] Didier Tabuteau, "Démocratie et santé", *Les Tribunes de la santé*, N° HS 3, Presses de Sciences Po, Paris, 2014/5, p.4

[84] Stefan Elbe & al., "Medical countermeasures for national security: a new government role in the pharmaceiticalisation of society", *Social Science & Medicine*, N° 131, University of Sussex, Brighton, April 2014, p.270

III. A changing world, or the consolidation of spheres of influence

The end of the Cold War has led to a profound transformation of the world affairs and of the redistribution of power. If the question of who holds power in contemporary international politics is debated, one cannot but acknowledge the decrease of world stability (III.I), and the parallel reconstitution of spheres of influence (III.II).

III.I. An unstable world, from contestations to rebuilding

In the aftermath of the perceived Western domination of the world following the end of the Cold War, the global geopolitical order transformed. Rather than a break in the world affairs, or a new domination of the so-called BRICS[85], the current shifts appear to constitute a slow transition[86], yet unprecedented because of the globalisation of the world in the last three centuries, a *mutation*[87] of power relations. Global governances have been moulded in the aftermath of the second world war, and appear nowadays to be stretched, if not in tension with the new incoming realities of the world affairs, due to their rigidity. Such phenomenon has peculiar consequences for the different regimes of global governance. Yet generalising the exemple of global health governance, it would be argued that these tensions and the actors that are contributing to it are increasing global governance fragmentations[88]. Andrew Cooper highlights the role of the G8 in such tendency, which by bypassing the central place of existing agencies in the global health governance agenda such as the World Health Organization, increases the fragmentation of global health governance[89]. In fact such tendency is confirmed by Christine Berling whom speaking of the G7 Health, explains President

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[85] Group of States composed of Brazil, Russia, India, China and South Africa. Often presented as the new world leaders, or at least as a group of similar and powerful States, the BRICS took a growing place in the study of contemporary international relations. Yet, based on the understanding of power previously drawn, I would contest the adoption of such enthusiastic view of the BRICS countries.

[86] Immanuel Wallerstein, "Comprendre le monde. Introduction à l'analyse des systèmes-monde", *La Découverte*, Paris, April 2009, p.122

[87] Hubert Védrine, "La redistribution de la puissance", *Le Débat,* N° 160, Gallimard, Paris, 2010/3, p.23

[88] Andrew Cooper, *The G8/G20 and Global Health Governance: Extended Fragmentation or a New Hub of Coordination,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.248

[89] Ibid

Emmanuel Macron's willingness to open the G7 to other States and break the image of the G7 as a "narrow private club"[90].

Furthermore, as Shapiro demonstrated, the agency of institutions being "constricted to the space left open and essentially defined by politics"[91], institutions are most often dominated by the inter-State power relations of raw politics[92]. This increases the tensions between global governance structures and moving realities of the world affairs, as well as it favours the contestation of these very structures. Recalling Spykman's idea that political equilibrium results from the operation of political forces and the active intervention of men[93], it seems that in contemporary world politics growing States do not acquaint anymore why global governance structures, and that former hegemons do not possess a sufficient power capital to preserve world and governances stability. Moreover, if the balance of power theory wrongly focuses on military power, it remains relevant to stress that, however as it has been defined above, the most effective and reliable antidote to power is power[94]. Such attitudes and reflex of the State nurtures instability by transforming challenges into active contestations.

Nevertheless, satisfaction and dissatisfaction for global order in world politics are "two ends of a complex continuum"[95]. This why unlike in many scientific publications of international relations, it would not be argued here that the world order has changed to such a point that the West cannot exerce its perceived domination, nor that hegemons contestations are called to become open military, economic or digital wars. As clearly explained by Immanuel Wallerstein in his introduction to the world-system analysis, the period of transition from a system to another is an era of conflicts but above all of incertitudes and challenging of knowledge structures[96]. Going further, agents have to understand what the transition is and

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[90] Christine Berling, Paris, April 25th 2019

[91] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.15

[92] Ibid

[93] Randall Schweller, "The Balance of Power in World Politics", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, May 2016, p.3

[94] Ibid, p.4

[95] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.6

[96] Immanuel Wallerstein, "Comprendre le monde. Introduction à l'analyse des systèmes-monde", *La Découverte*, Paris, April 2009, p.141

adopt a strategy to shape it in its own interests[97]. To that end, Ivan Timofeev's description of the current world affairs as comparable to "an "appulse" of sorts, or to an eclipse, when trajectories of small and large celestial bodies cross in a single point"[98] seems to perfectly catch that the world order is changing but will be determined by several major factors including the development of hegemons and challengers relations[99]. More precisely, it would be argued here that it will be influenced by the development of both States understanding of power opportunities for the upcoming century, and States revendications for spheres of influence.

III.II. The XXIst century as a century for spheres of influence

Through his concept of world-system and its analysis, Immanuel Wallerstein shows that competing States, while adjusting the world order under midterm scale transformations, are attempting to profoundly change the world system[100]. They try to use its fluctuations to make it take the way that will best serve their interests[101]. This seems, at first sight, to contradict the balance of power theory, as developed by the English School, and namely the idea that balance is something of a collective good and so that the dominant power has to maintain it[102]. Moreover, Wallerstein's idea would also be at odds with Paul Schroeder's studies of States behaviours towards the dominant State, and more particularly with his conclusion that States "have bandwagoned with or hid from threats far more often than they have balanced against them"[103]. However it would be argued here that rather than being in tension, these two sets of thinking are, at least in contemporary politics, complementary.

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97 Immanuel Wallerstein, "Comprendre le monde. Introduction à l'analyse des systèmes-monde", *La Découverte*, Paris, April 2009, p.141

98 Timofeev Ivan, "An "Appulse" in International Relations and Scenarios for the Development of the World Order Dynamics", RIAC, russiancouncil.ru, consulted on March 2019

99 Ibid

100 Immanuel Wallerstein, p.138

101 Ibid

102 Randall Schweller, "The Balance of Power in World Politics", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, May 2016, p.3

103 Ibid, p.11

To reach this conclusion it appears necessary to take a closer look and differentiate the global and the regional levels of international relations. In fact if Wallerstein's theory fits perfectly if one looks at the world-system and the global stage, at a regional level, Paul Schroeder's conclusions would apply best. In this regard, Lemke's breakthrough in the power transition theory is fundamental. Through his empirical analysis, Lemke demonstrates the applicability of the power transition theory to regional hierarchies[104]. In addition, he shows that "the rules within regional hierarchies normally match those at the global level but the ability of global powers to intervene does not make this an exact parallel"[105]. Such position that regional hierarchies can differ from global hierarchies, can be enriched by Castells study, as previously recalled, that there are on the global and regional stages social processes incarnated by the power of social movements advocating cultural concerns[106]. In other words, the characteristics of contemporary politics, its inherent and increasing tensions, favour the constitution of spheres of influence around regional dominating powers, or in the words of Wallerstein, around *strong States*[107].

Strong, or powerful, States as explains the author are by definition rivals, but also have the responsibility of rival ensembles[108]. Thus, a contradiction arises: meanwhile strong States are competing with each others, it remains in their interest to preserve their control of the world system[109]. We can therefore acknowledge attempts to reach an equilibrium between complete anarchy and some coherent order[110]. In contemporary politics, strong States tend to reach such equilibrium through the creation of spheres of influence. As a consequences global governances, first among them global health governance, have seen the rising importance of

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[104] Jacek Kugler, Douglas Lemke, Ronald Tammen, "Foundations of Power Transition Theory", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2017, p.12

[105] Ibid

[106] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.3

[107] Immanuel Wallerstein, "Comprendre le monde. Introduction à l'analyse des systèmes-monde", *La Découverte*, Paris, April 2009, p.92

[108] Ibid

[109] Ibid

[110] Ibid, p.93

what Wolfgang Hein calls *nodal governance*[111]. Nodal governance can be defined as a form of coordination of different networked power and interfaces[112]. As a result, States tend to conduct what is called polylateral diplomacy[113]. In the specific domain of health governance, the best example of nodal governance and polylateral diplomacy are the annual World Health Assembly, taking place each year in May at the World Health Organization's headquarters. Despite the complexity of building multilateralism[114], such trend is particularly relevant for European States which, in the words of Christine Berling, try to build *with* each others and the European Union agencies[115]. Going back in time to the beginning of the XXth century, Céline Paillette stresses the "conquering civilisational mission" of an "imperial Europe", through the constitution of transnational health-related institutions[116]. Whereas from the first world war, Europe became only a region of the world in an international system[117]. If the world order changed over the century, the historical perceptiveness shows the relevance of world regions and can partially explains the constitution of spheres bound by a certain level of cultural and historic unity, and dominated by some of its members.

If health is one of the most ancient field for international cooperation, starting as early as 1377[118], most of the powers to govern it have been given to international institutions[119]. This favoured and allowed the development of nodal governance and polylateral diplomacy, with a regional approach of States aiming at maximising their power. According to Simon Rushton, health governance is entering a new period of flux and challenges but remains characterised

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111 Wolfgang Hein, *The New Dynamics of Global Health Governance,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.68

112 Ibid

113 Ibid, p.69

114 Christine Berling, Paris, April 25th 2019

115 Ibid

116 Céline Paillette, "L'Europe et les organisations sanitaires internationales. Enjeux régionaux et mondialisation, des années 1900 aux années 1920", *Les cahiers Irice*, N°9, IRICE, Paris, 2012/1, p.59

117 Ibid, p.60

118 Florian Kastler, "La mutation des institutions internationales en matière de santé", *Les Tribunes de la santé*, N°51, Presses de Sciences Po, Paris, 2016/2, p.65

119 Ibid, p.66

by some continuity[120]. Yet as already underlined before, "many of the major changes in global health governance over the last decade have been driven by the G8 states, which have collectively undertaken a variety of initiatives"[121]. Indeed, the G8, and G20, are composed of the States which try to develop a specific sphere of influence. Therefore, one cannot but acknowledge the increased willingnesses of powerful States to erect and protect what they see as their sphere of influence.

All in all, it has been showed here that power as a concept of international relations requires to be thought as a legitimising force arising from moving and actor-specific countries. Power, to be fully understood, necessitates a fluid and malleable conceptualisation that can be provided by a joint constructive and realist approach. Power evolves through time and especially in respect to the changes of the world order and governance structures. In this regard health will be here recognised as the new power-source for European powers in the XXIst century.

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[120] Simon Rushton, David Williams Owain, *The End of One Era and the Start of Another: Partnerships, Foundations and the Shifting Political Economy of Global Health*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.254

[121] Ibid, p.259

Chapter II: Global public health as the new power source

Based on the previous conceptualisation of power, the relevance of public health as a power source for European powers in the XXIst century blossoms. Indeed, the past decades have acknowledged a geopoliticisation of health (I) that nurtured its power-capital. Thus, in this era of health governance mutations, setting the rules of global public health is of a great potential for power (II) and could become a game changer for European States (III).

I. Global Public Health, or the geopoliticisation of Health

Health has been deeply transformed in the past decades and accrued its geopolitical relevance. This phenomenon departed from the conceptualisation of biopolitics by Foucault, quickly applied to the international level (I.I), and has been favoured by the rise of global public goods (I.II).

I.I. Biopolitics, from national to international political concept

One could not study health governance and the role of health in power relations without recalling Michel Foucault. Indeed, Foucault brilliantly developed a concept, biopolitics, or rather a set of concepts if we add biopower, that assess the interdependencies between public health, politics, economic, language and knowledge under the umbrella of power. Foucault's work, despite the critics or the crooked interpretations of the English School of governmentality studies, remains fundamental to understand contemporary power relations and public health on both the national and international level. Nevertheless, Foucault would be correctly understood only under the joint light of his famous book *Naissance de la Clinique*, and of his *Biopolitics* course at the Collège de France.

Through a historical analysis of the birth of the clinic in France during the XVIIIth century, Foucault shows that by the end of the century, there would not be a medicine of the epidemics without a police[122]. Going further, he shows that to allow the clinical experience as a

[122] Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, p.48

knowledge, steps have been undertaken: a reorganisation of the hospital, the creation of a new medical language, and the redefinition of sick people's status in the society and regarding the State assistance and knowledge[123]. In the words of the authors, the State and the Society had to envelop the sick in a collective and homogenous space where the understanding and acceptance of health has been fundamentally crucial[124]. Or in the words of Guardia, health replaced the Salvation[125]. Because for Foucault the birth of public health is a fundamental watershed and shows the political power ascendency, the clinic becomes an institution of control that has to answer the preoccupation for life[126]. Furthermore, for Foucault biopolitics is based on seeing society's members as a complex of biological constants[127]. Therefore, the population itself becomes the object of the State's biopower whereas the clinic is the cornerstone of a public health biopolitical system[128].

That's why in the words of Fassin, the development of public health policies originates from the necessity of the State to legitimise its construction[129]. Biopolitics and Foucault work on the birth of the clinic appear therefore in complete harmony with the legitimisation dimension of power as previously defined. On the national level, this has three interlinked consequences. First, as powerfully demonstrated by Macmillan within its analysis of Foucault, biopolitic came to be "the study of governmental practices rationalisation within the frame of political sovereignty's implementation"[130]. In other words, Macmillan genuinely refuses the opposition between biopolitics and discipline, but rather shows that biopolitics is a reactivation of discipline within the liberal art of governing[131]. Going further it cannot but be recognised that

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123 Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, p.270

124 Ibid

125 Ibid, p.272

126 Michela Marzano, "Foucault et la santé publique", *Les Tribunes de la santé*, N° 33, Presses de Sciences Po, Paris, 2011/4, p.40

127 Ibid, p.41

128 Ibid

129 Sébastien Guigner, "L'Union Européenne, acteur de la biopolitique contemporaine : les mécanismes d'européanisation normative et cognitive de la lutte contre le tabagisme", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.77

130 Alexandre Macmillan, "La biopolitique et le dressage des populations", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.39

131 Ibid, p.41

modern societies are before disciplinary and characterised by different ways of implementing such logic[132]. Second, public health and biopolitics always appeared, and tend to remain, apolitical. Indeed public health as such tends, on local and national levels, to remain apolitical or part of a minimal strategy of politicisation on a local level to capitalise on a peculiar expertise[133]. Such characteristic is underlined by the different view that hold the French Ministry of Health, which focuses on health as a shared good and a field for cooperation[134], whereas the Ministry of Foreign Affairs, sees the geopolitical impacts that France can have through the promotion of health[135]. Yet on a global level, and this is based on the third consequence which is biopolitics' constant evolutions, can appear, in the word of Thibault Bossy and François Briatte, "imperialist"[136]. As stressed by the two authors, biopolitics became a real and complex political enterprise[137], or as it is argued here, biopolitics became geopolitical.

Consequently, and if Foucault's notions of biopolitics and biopower are originally restricted to the national level because of their links with the rise of modern State[138], "biopolitics and health surveillance have increasingly entrenched themselves within the international political realm"[139] through biopower. In this regard, Marc Dixneuf, recalling Norbert Elias and Susan Strange, highlights the internal-international dialogue of biopolitics[140]; as Putnam did through his concept of double edged diplomacy. This dialectic nurtured the internationalisation of

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132 Alexandre Macmillan, "La biopolitique et le dressage des populations", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.53

133 Carole Clavier, "La santé publique, un enjeu politique local ? La politisation des politique publiques en France et au Danemark", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.19

134 Christine Berling, Paris, April 25th 2019

135 Taraneh Shojaei, Paris, May 24th 2019

136 Thibault Bossy, François Briatte, "Les formes contemporaines de la biopolitique", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.12

137 Ibid

138 Jeremy Youde, "Biopolitical Surveillance and Public Health in International Politics", *Palgrave Macmillan*, New-York, January 2010, p.18

139 Ibid, p.15

140 Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.303

biopolitics via a securitisation of health that influenced global governance[141]. For example, as stressed by Colin McInnes, "the securitisation of health however refers to the manner in which health security is no longer seen solely at the individual level, but at the national level: as a potential threat to the well-being of states and to international stability"[142].

Internationalised but fragmented, health had to be attached to foreign policy objectives meanwhile remaining subordinated to the national interest cluster[143]. Yet public health introduction into foreign policies had a much deeper effect, and introduced since the 61st World Health Assembly a copernican revolution[144], or paradigm shift. This is why Alcazar wrote that "it is certain that health, in the sense suggested here, instructs foreign policy to broaden its perspective"[145]. Nevertheless it would be argued that the copernican revolution also deeply affected health as such, and more than having internationalised biopolitics, it then geopoliticised it[146].

In this regard, McInnes highlights, in a heuristic posture, three transformations known by health in its formation as a global issue. The third of them, the changed institution architecture and actors[147], is to be put into perspective with neoliberalism. Indeed Adrian Kay speaks of an "imaginative transformation of health from a concept of individual and public welfare or well-being into a commodity with an economic value and the potential to be traded in markets is characteristic of the universalising logic of neoliberalism"[148]. This triad between health, economy and politics had already been developed by Foucault whom had said that the

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141 Colin McInnes, *National Security and Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p. 56

142 Ibid, p.43

143 Santiago Alcázar, *The Copernican Revolution: The Changing Nature of the Relationship Between Foreign Policy and Health,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.327

144 Ibid, p.330

145 Ibid, p.334

146 Colin McInnes, Anne Roemer-Mahler, "From security to risk: reframing global health threats", *International Affairs*, N° 93, Oxford University Press, Oxford, 2017, p.1317

147 Colin McInnes & al., "The Transformation of Global Health Governance", *Palgrave Macmillan*, New-York, 2014, p.13

148 Adrian Kay, David Williams Owain, *Introduction: The International Political Economy of Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p.6

political is dependent on the economic but that the economic would constitute a safeguard the subject's independence[149]. But the introduction of neoliberalism, because of the use of neoliberalism as a geopolitical tool within the frame of the Washington Consensus, leads to the geopoliticisation of health. In fact the knowledge/power couple is crucial in moderne biopolitics[150]. Which is why Michael Dillon shows that biopolitics articulates itself to geopolitics through a large set of mechanisms[151]. Moreover, has stressed by Dominique Kerouedan's empirical studies, health became within the international relations a source of power, influence, security, peace, commerce and a vector for geopolitical interests[152]. Such position is further acknowledged by Ha Chan on her study of China's entrance in global health governance, when she highlights that Chinese cooperation in the field of health is due to rational calculation of interests[153], going over simple domestic social issues[154].

From a national level concept of State power over its subjects to a concept of geopolitics through its links with power, knowledge and market, the concept of biopolitics highlights the transformations of health and its relevance on the global stage. Global health are partially based on geopolitical relations[155], and is used nowadays as a geopolitical tool[156]; also thanks to the rise of Global Public Goods.

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149 Jean-Yves Grenier, André Orléan, "Michel Foucault, l'économie politique et le libéralisme", *Annales. Histoire, Sciences Sociales*, Editions de l'EHESS, Paris, 2007/5, p.1180

150 Michael Dillon, "Gouvernement, économie et biopolitique", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.16

151 Ibid, p.36

152 Dominique Kerouedan, "Diplomatie de la santé mondiale", *Santé Publique,* Vol. 25, SFSP, Paris, 2013, p.253

153 Lai Ha Chan, "China Engages Global Health Governance: Responsible Stakeholder or System-Transformer?", *Palgrave Macmillan*, New-York, January 2011, p.127

154 Ibid, p.129

155 Dominique Kerouedan, "Comment la santé est devenue un enjeu géopolitique", *Le Monde Diplomatique*, July 2013, p.2

156 Hugues Tertrais, "30 ans des Relations Internationales", *Bulletin de l'Institut Pierre Renouvin1,* Vol. 37, IRICE, Paris, 2013, p.184

I.II. The rise of Public Goods as an opportunity for Health

While health, as it has been showed previously, remained for centuries an object of low politics, it gained in importance on the global stage from the 1990's. Global actors, first being multinational companies and foundations, saw an economic and political opportunity in public health. However health had to wait catastrophes, such as the SRAS epidemics in 2003 and the financial crisis of 2008 to be acknowledged as a relevant foreign policy domain. Moreover, such catastrophes showed the cruciality of a large scale cooperation between several fields of international relations, and first among them of the financial market; linking its stability to the notion of public goods[157].

Public goods refer to Paul Samuelson idea of collective consumption goods[158]. Nowadays the most of the understanding of public goods can be summarised by Jeremy Youde "these are goods and services that are essentially held in common. My use of the service or good does not diminish your ability to use it, and I cannot prevent you from using it"[159]. In addition, public goods can be divided into in subgroups such as pure public goods[160], club goods or common goods[161]. The notion of public goods has been particularly relevant to understand the development of socialisation and more recently to favour cooperation[162]. Yet the notion first emerged as a national level concept before being applied to the global level through the idea of global public goods. Which themselves can be divided, according to Kaul Inge, between natural, human created and global politics results[163]. Nonetheless, global public goods appear to involve different actors with different incentives, and so may follow different provision

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[157] Ted Schrecker, *The Power of Money: Global Financial Markets, National Politics, and Social Determinants of Health,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p.172

[158] Youde Jeremy, "Biopolitical Surveillance and Public Health in International Politics", *Palgrave Macmillan*, New-York, January 2010, p.41

[159] Ibid

[160] Ibid, p.42

[161] Ibid, p.43

[162] Hugues Tertrais, "30 ans des Relations Internationales", *Bulletin de l'Institut Pierre Renouvin1,* Vol. 37, IRICE, Paris, 2013, p.183

[163] Ibid, p.179

path[164]. Therefore global public goods can be undermined by global market failures and State failures because of the individuals preferences towards private and public goods[165].

The dual relation between health and public goods, and their absence or strengthening, pushes scholars such as Wolfgang Hein to write that there "is an urgent need for health diplomacy in other fields, which are more directly related to the role of health in the provision of global public goods"[166]. However it would argued here that such approach can be misleading in case health diplomacy is understood as a matter of aid, as did the World Health Organization through the Brundtland General Secretariat in order to make States acknowledge health as a global public good[167]. Rather health as a global public good must be acknowledged as such, but also as interlinked with other public goods, such as economic development and stability[168]. Yet health gained importance within international political and geopolitical relations through the notions of public goods, and because it has been perceived as necessarily conducted "in the spirit of a common endeavour to ensure health as a human right and a global public good"[169].

However it appears that scholars, by focusing on human rights, public goods or global justice theories, are mistakenly taking health as an object itself whereas health is more of a set of actors, perceptions, means and interests. Within this approach, health provision is perceived as aid, and as such undermines the value of health as a public good itself[170]. If health can be understood as a public good, it is in this case reduced to individuals' state of health. The study of Suerie Moon on health tools and new health product developments allows to recall the

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[164] David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.113

[165] Ibid, p.116

[166] Wolfgang Hein, *Governance and Actors in Global Health Diplomacy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.87

[167] Michael Faust, Inge Kaul, "Global public goods and health: taking the agenda forward", *Bulletin of the World Health Organisation*, Vol. 79, World Health Organization, Geneva, 2001, p.870

[168] Marc Gentilini, *Préambule. La santé sera mondiale ou ne sera pas*, in Kereoudan Dominique, "Santé Internationale", *Presses de Sciences Po,* Paris, 2011, p.14

[169] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.11

[170] Pedro Conceiçao, Inge Kaul, Katell Le Goulven, Ronald Mendoza, "Why Do Global Public Goods Matter Today?", January 2009, p.5

cruciality of medicines and health instruments on the global stage[171]. In this regard health becomes much more complex and not reducible to a simple public good that some actors can provide to everyone. If scholars are arguing that all aspects of health should be understood as global public goods, and first of all medicines[172], such step appears motivated by political understanding of public goods[173] and health, and of a global justice approach to international relations. Indeed, scholars should not forget that health introduction within global governance spheres led to a strengthened role of private actors[174] and the implementation of result-oriented policies[175] within a regional frame[176].

Far from this approach, it would here be argued that the increase influence of health in foreign policies and global governance through the idea of public goods, relies on the fact that "public goods became a key justification for the existence of a State"[177]. This is further justified by the previously underlined geopoliticisation of biopolitics and health increased relevance within the frame of the social contract. Hence the need to span the understanding of global public goods[178]. Thus, in the light of the concept of biopolitics and power, as detailed above, health appears in the XXIst century as the new power source for Western countries, if they succeed in setting the rules of health in the upcoming years.

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171 Suerie Moon, "Medicines as Global Public Goods: The Governance of Technological Innovation in the New Era of Global Health", *Global Health Governance*, Vol. II (2), Global Health Governance, Fall 2008/Spring 2009, p.13

172 Ibid, p.9

173 Hakan Altinay, "Global Norms as Global Public Goods", *Global Policy Essay*, Global Policy, Durham, April 2013, p.2

174 David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.120

175 Ibid, p.119

176 Ibid, p.118

177 Hakan Altinay, "Global Norms as Global Public Goods", *Global Policy Essay*, Global Policy, Durham, April 2013, p.1

178 Pedro Conceiçao, Inge Kaul, Katell Le Goulven, Ronald Mendoza, "Why Do Global Public Goods Matter Today?", January 2009, p.6

II. Setting the rules of Health, as a new source of power

Health increased importance on the global stage transformed this field of global governance as a multidimensional instrument of influence (II.I). Moreover, it appears essential in the redefinition of power that takes place in the XXIst century (II.II).

II.I. Health as a multidimensional instrument of influence

Going back to the notion of global public goods, because everyone can benefit from it, it appears a powerful incentive non to contribute to their provision[179]. This phenomenon is accentuated by the complexity and the technologic requirements of health. Yet it allowed the geopoliticisation of health, as it has already been showed, and the development of health as an instrument for influence. However it seems here fundamental to recall Graham Allison's theory of State as a non-human like entity. Indeed, as highlighted by Gleicher, Guo and Priyanka, whereas a Ministry of Health "may emphasize opportunities and constraints to national business interests in health-related trade. Foreign affairs interests may focus on threats to peace and security and the use of soft power"[180]. This has furthermore been confirmed by the contemporary case of France. In fact whereas Mrs Berling, from the Health Ministry, stresses the dominance of cooperation and the obscurity behind the words "strategy of influence"[181], Mrs Shojaei, from the Foreign Affairs Ministry, underlines the usefulness of health in promoting specific policy in other States, such as the abolition of female genital mutilations in African countries[182].

Nevertheless, one could not deny the influence of health in contemporary international relations of power. Foreign aid as above all been used as a foreign policy[183] and geopolitical

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179 Jeremy Youde, "Biopolitical Surveillance and Public Health in International Politics", *Palgrave Macmillan*, New-York, January 2010, p.48

180 David Gleicher, Yan Guo, Priyanka Kanth, *National Strategies for Global Health,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.287

181 Christine Berling, Paris, April 25th 2019

182 Taraneh Shojaei, Paris, May 24th 2019

183 Clair Apodaca, "Foreign Aid as Foreign Policy Tool", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, April 2017, p.1

tool[184], and because global public goods are also actors of globalisation[185], the power potential of health increased in the last three decades. In a same understanding fundings, of aid or institutions, as revealed itself to have a significant influence on global health governance[186].

Nevertheless, focusing on the State, and so on States' foreign policies, an increasing insertion of health in negotiations can be acknowledged[187]. Going further, Ilona Kickbush argues that health has become an integral part of foreign policy in many countries[188], which is often associated, recalling Joseph Nye's works, as a "smart power"[189]. This is why Harley Feldbaum wrote that knowing of the national interests[190] that drive action on global health is a critical tool for global health diplomacy[191]. The example of pharmaceiticalisation is here relevant. Indeed, as showed by Stefan Elbe "accounts of pharmaceuticalisation have mostly emphasised the pivotal role of industry, and have therefore tended to accord governments a comparatively modest role"[192]. Yet, the author shows that States through their governments are active and multidimensional actors and vectors of pharmaceuticalisation[193]; relying on a vast array of instruments, from regulatory power to political influence. In fact in its Whitepaper for 2014-2019 France officially extended its national security agendas to include

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[184] Hugues Tertrais, "30 ans des Relations Internationales", *Bulletin de l'Institut Pierre Renouvin1,* Vol. 37, IRICE, Paris, 2013, p.184

[185] Ibid, p.181

[186] Wolfgang Hein, *Governance and Actors in Global Health Diplomacy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.85

[187] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.16

[188] Ibid, p.15

[189] Ibid

[190] National interest is here a concept limited by the works of Graham Allison whom theorised the multiplicity of national interests and by extension the inexistence of a single and clear national interest.

[191] Harley Feldbaum, *Global Health in International Politics,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.143

[192] Stefan Elbe & al., "Medical countermeasures for national security: a new government role in the pharmaceiticalisation of society", *Social Science & Medicine*, N° 131, University of Sussex, Brighton, April 2014, p.269

[193] Ibid, p.263

health[194]. Therefore if States efforts have not always been complete successes[195], this trend shows the relevance and understanding of health as instrument of influence within the frame of a national-international dialectic. Such dialogue recalls Putnam's double edged theory and Susan Strange triangular diplomacy[196].

Focusing on the international stage and multinational agencies, health as instrument of influence can be seen within the TRIPS debates. Indeed, medicines appear to be a resource within the competition that nurture tensions related to what Susan Strange calls structural powers[197]. In other words, medicines are underlying as well as they increase tensions between dominant powers in the field of global public health. This why TRIPS use depends on the preservation or modification of Western States' influence[198]. Nevertheless, or maybe therefore, scholars showed that global health partnerships and foundations are entrenching the role of markets and other private actors within global health governance[199]. The impact of these actors is dual. On a first hand they fulfil a range of different functions such as advocacy, but on a second hand they also are deeply influenced. As a consequence, they tend to respond in similar ways and with similar solutions[200] than public agencies. One example is the Rockefeller Foundation's impacts on the construction of social sciences and health agencies in Europe, and how it influenced the vision that had the foundation[201].

Global health governance is complex, and probably even more when focusing on influences within it. Yet the interconnections between public and private, old and new actors are showing network of reciprocal influences; where States still have the upper hand but individuals should

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[194] Stefan Elbe & al., "Medical countermeasures for national security: a new government role in the pharmaceiticalisation of society", *Social Science & Medicine*, N° 131, University of Sussex, Brighton, April 2014,, p.265

[195] Ibid, p.270

[196] Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.281

[197] Ibid, p.292

[198] Ibid

[199] Simon Rushton, David Williams Owain, *Private Actors in Global Health Governance*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.21

[200] Ibid, p.7

[201] Ludovic Tournès, "La fondation Rockefeller et la construction d'une politique des sciences sociales en France (1918-1940)", *Annales. Histoire, Sciences Sociales*, Editions de l'EHESS, Paris, 2008, p.1402

not be undermined. Within this context States' image on the global stage appears both crucial and to be a benefits opportunity; as demonstrated by the rise of medical tourism[202]. Therefore nowadays the critical question remains "Who can and should take care of what?"[203]

II.II. Health, an open door to power for the XXIst century

Behind the question of who should take care of what, lies the crucial question of who will be responsible for setting the rules of global health governance in the XXIst century, or at least in the next decades. Céline Paillette showed that the beginning of the XXth century - from 1897 to 1920 - France and French diplomacy got a symbolic profit through the universalisation of its understandings, methods, and interests[204]. However Paris, to which could be added London, Rome and Berlin, has been quickly dominated by Washington, and both are currently contested; as it is underlined by the TRIPS debates. Helped by globalisation's acceleration, ideas and knowledge transfers have increased[205], especially in the field of health, and as it their production, or rather their legitimisation, became crucial.

Furthermore, the divisions on competition worldview and views of global health reflects, according to Kay and Williams Owain "the presence of real interests and real power in determining its future direction"[206]. Such trends appear reinforced by the transition towards a world of spheres of influence[207], as underlined previously. In the words of Ilona Kickbush,

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[202] Catherine Le Borgne, "Le tourisme médical : une nouvelle façon de se soigner", *Les Tribunes de la santé*, N° 15, Presses de Sciences Po, Paris, 2007/2, p.50

[203] Brigitte Hamm, Cornelia Ulbert, *Private Foundations as Agents of Development in Global Health: What Kind of Impact Do They Have and How to Assess It?*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.204

[204] Céline Paillette, "Diplomatie et globalisation des enjeux sanitaires", *Hypothèses*, Vol. 17, Éditions de la Sorbonne, Paris, 2014, p.135

[205] Céline Paillette, "De l'Organisation d'hygiène de la SDN à l'OMS. Mondialisation et régionalisme européen dans le domaine de la santé, 1919-1954", *Bulletin de l'Institut Pierre Renouvin*, Vol. 32, IRICE, Paris, 2010, p. 198

[206] Adrian Kay, David Williams Owain, *Introduction: The International Political Economy of Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p.4

[207] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.26

this constitutes the first of the three parallel power shifts that currently affects global health governance. The second power shift is the introduction of powerful non-State actors in this field, meanwhile the third one is the continua between national and international affairs[208]. The power shifts, or global order mutations, are affecting global health governance, and unfolds opportunities for power. This is also reinforced by the contemporary phase of health partnerships consolidation, which integrates partnerships deeper into global health governance. However Peter Hill showed that partnerships tend to align with partners' strategies[209], and so often with the State of their origin. This is why public entities, and first among them States, have a crucial role in setting the rules global health governance in the XXIst century.

Moreover, it seems here important to recall Susan Strange contribution to the study of structural power. Whereas the power of a State can be seen through its ability to shape the structure of the global order[210], or at least of a regime, Strange's structural power relies on four pillars: security, production, finance and knowledge[211]. Global health governance, because of its contemporary transformations, could provide some States with the opportunity to get structural power through the settlement of a renewed regime for health. In fact, health regime's formalisation is growing. However institutions formalisation is not a requirement nor it seizes to exist in case of violation[212]. As such, and because international regime can exist by other means than explicit treaties[213], global actors should take the opportunity of shaping the health regime. Relying on constructivism, it would be argued that norms need to be constantly reinforced through social interactions and so that actors that have a technological, knowledge and symbolic advantage on health should promote their understanding and expertise of the global health regime to grasp the power capital that it represents.

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208 Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.26

209 Peter Hill, *The Alignment Dialogue: GAVI and its Engagement with National Governments in Health Systems Strenghtening*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.80

210 Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.292

211 Ibid, p.293

212 Ibid, p.59

213 Ibid, p.60

III. Health as a power, a game changer

Acknowledging and using health as a power source for the XXIst century could reveal itself to be a game for a declining Europe. Indeed contemporary Europe balances between fears and reality regarding its global power (III.I), but health could provide it with a power to strengthen and that it currently lacks (III.II).

III.I. Europe and the world, from fears to reality

Scholars, as politicians, have since the increasing importance of health in global governance, largely focused on the level of health risks[214]; whereas focusing on the meaning of health securitisation seems more accurate to understand health as a source of power. Indeed, such approach would allow scholars to understand both the strategies and *blocages* in recognising health's power capital. Especially, since the discursive shift highlighted previously from health as a shared between States to global health politics[215]. However the emphasis on risks and threats, in other words on transnational epidemics, underlines some cultural and socio-political characteristics of some actors within the international arena. In fact, Durodie explains that risks are "socially mediated cultural product" which in Furedi's precautionary culture in modern societies leads to Beck's idea of reflexive modernity[216]. In other words, and because health is fundamental within the social contract and in State's legitimisation, health risks, despite being socio-politically constructed[217], became central to global health governance and concentrated public actors' actions towards health risks prevention. Is it therefore as no surprise that one of the first and founding object of global health governance, the International Sanitary Act, has a narrow spectrum but applies on a vast geographical space[218].

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214 Colin McInnes, Anne Roemer-Mahler, "From security to risk: reframing global health threats", *International Affairs*, N° 93, Oxford University Press, Oxford, 2017, p.1314

215 Ibid, p.1317

216 Ibid, p.1320

217 Ibid, p.1321

218 Didier Houssin, "Le règlement sanitaire international a aussi 60 ans" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.48

In addition to this first fear another, interlinked, is to be added: the dual fear that represents the increasing pharmaceuticalisation. Indeed pharmaceuticalisation of national health systems introduced a fear of pharmaceuticals shortages[219] but also the fear of public institutions to be colluded by pharmaceutical industries' interests that, among other impacts, could try to impose exogenous modes of production, distribution and consumption[220]. Such fears are further nurtured by the diversification of players, and the changing relationship they have with other actors, correlated to their structural impacts on global health governance[221]. They moreover are illustrated by the conflicts over pharmaceutical provision or intellectual property rights between States and industrials[222].

Within this contest, European initiatives have been focused on how to reduce these fears. In other words, the European Parliament has attempted to avoid conflicts of interests between the countries targeted by European medical aid, and private firms[223]. In addition the European Union has proven in the *avant-garde* by creating negotiation spaces to prevent tensions[224] and reduce fears levels. This position of the European Union in the frontline of health governance can be explained by the European expertise in this field. However this explanation alone barely seems sufficient. Indeed the EU has to face obstacles that other actors do not have to. The argument here is that the EU has the prior difficult task, because of its internal multilateralism, to identify actors both in inside and outside of its organisation to which it should talk to[225]. Nevertheless this task has to be fulfilled within the strict framework of what Mireille Delmas-Marty calls "founding forbiddens"[226], which are a set of fundamental values that impedes the subject of law to take actions undermines these values. More precisely,

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[219] Mathieu Quet, "Sécurisation pharmaceutique et économie du médicament. Controverses globales autour des politiques anti-contrefaçon", *Sciences sociales et santé*, Vol. 33, John Libbey Eurotext, London, 2015/1, p.92

[220] Ibid, p.94

[221] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.30

[222] Mathieu Quet, p.96

[223] Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.290

[224] Ibid, p.291

[225] Marie Törnquist-Chesnier, "La table ronde de la Commission Européenne sur l'accès aux médicaments anti-SIDA : un exemple original d'interaction entre ONG et instance internationale", *Relations internationales*, N°152, Presses Universitaires de France, Paris, 2012/4, p.94

[226] Ibid, p.101

among these values, can be cited: democracy, protection of human rights, liberalism, equality or transparency. This is why the European Union has sometimes found itself in a difficult position when some of its Member States, first among them France, are targeting aid to their former colonies and/or conditioning to programs promoting the diffusion of their culture[227]. In a similar way, the European Union has been attacked several times by its critics, associating its public diplomacy to propaganda because of their similar aim[228].

The dialogue between European fears and expertises has to be unfolded by a historical understanding of Europe inscription in sanitary challenges' globalisation[229]. European States have been the first to cooperate against transnational threats to health[230] and founded international health governance. However they tended to do it relying on the idea of civilised nations against wildlings[231], which currently has a part in contemporary European initiatives' carefulness. Indeed the EU currently tries to first concentrate on its internal disparities and aims at 'europeanising' health in Europe by intensifying its biopower through learning processes[232]. On this subject, Sébastien Guigner speaks of a biopolitics "europeanisation by the number"[233], and cognitive imposition. Nevertheless, and because health governance is both a legitimisation and power capital, Member States have proven to remain hostile to a European health[234]; however without overpassing the important coordination of European Health Ministries[235] and Alain Milward explanations of European construction as a strategy for national political and economic reconstruction after the second world war[236].

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[227] Clair Apodaca, "Foreign Aid as Foreign Policy Tool", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, April 2017, p.7

[228] Atsushi Tago, "Public Diplomacy and Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, July 2017, p.5

[229] Céline Paillette, "L'Europe et les organisations sanitaires internationales. Enjeux régionaux et mondialisation, des années 1900 aux années 1920", *Les cahiers Irice*, N°9, IRICE, Paris, 2012/1, p.49

[230] Ibid, p.50

[231] Ibid

[232] Sébastien Guigner, "L'Union Européenne, acteur de la biopolitique contemporaine : les mécanismes d'européanisation normative et cognitive de la lutte contre le tabagisme", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.78

[233] Ibid, p.89

[234] Alband Davesne, Sébastien Guigner, "La Communauté Européenne de la santé (1952-1954), *Politique européenne*, Vol. 41, L'Harmattan, Paris, 2013/3, p.41

[235] Christine Berling, Paris, April 25th 2019

[236] Alband Davesne, Sébastien Guigner, p.51

III.II. Health as a room for a global European Power

Europe has been dreamed[237], has been built through cooperation between States but it still lacks of effective regalia powers, especially on the global stage. Alain Milward's idea is here particularly relevant, because if Ministries of Health are building European health governance *with* the European Union[238], Ministries of Foreign Affairs seem far from such preoccupations[239]. This is further demonstrated by the fact that even if Member States are cooperating, there are highly important differences among European sanitary systems, and a lack of uniformity[240]. Nevertheless the EU effortlessly tries to fill the leadership vacuum in some international regimes such as climate change[241] or global health. Because whereas one can see global health governance as an "uncoordinated fragmentation of actors and activities"[242], others, and among them the European institutions, can see the vantage points of asserting global health governance[243]. This why Bruxelles is attempting to integrate transnational discourses on health, in order to, has described by Wolfgang Hein "transform the formerly rather thin and simply structured flows of international communication between governments and a few other actors into a dense web of exchange"[244].

This approach, such efforts put into the creation of a dense web of exchange, can be explained by the nature of the European Union, but also and above all by the efforts of EU Member States to limit its executive powers[245]. In fact white pools history showed that European

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237 Christine Berling, Paris, April 25th 2019

238 Ibid

239 One cannot but be surprised by the absence of the EU at the center of Member States foreign policies in the field of health; as demonstrated by Mrs Shojaei's interview.

240 Toth Federico, Bologna, March 20th 2019

241 Amy Below, "Climate Change in Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, July 2017, p.8

242 Wolfgang Hein, *The New Dynamics of Global Health Governance,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.63

243 Ibid

244 Ibid, p.67

245 Sébastien Guigner, "L'Union Européenne, acteur de la biopolitique contemporaine : les mécanismes d'européanisation normative et cognitive de la lutte contre le tabagisme", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.84

health integration is highly sensitive to the political and economic context[246]. Yet Bruxelles departed from harmonisation to enhance its executive capacities through already recognised coercive powers[247]. As a consequence, even if its judicial scope of actions in health governance is highly limited, the European Union acquired a non-to-be undermined biopower on European citizens. Aiming at establishing coherence in health governance and strengthening its voice in global health[248], the European Commission published its WhitePaper for health in 2007[249]. It constituted a crucial step forward in the recognition of health as a European power capital, and of Bruxelles' strengths in this field. Indeed, above the development by the European Commission of its own health security framework[250] and the reactivity demonstrated by the European Medical Agency in case of epidemic threats[251], Bruxelles has been rightfully promoting its expertise in a full spectrum of health threats; which has been proved to be crucial in the XXIst century[252].

Nonetheless this potential for power, the European Union, has to face the introduction of countries that looks for undertaking the important issue that is agenda-setting[253], and first among them China. Far from the discourse of an almighty China, it is argued here that Beijing is seeking agenda-setting and rule-making powers in global health governance[254], demonstrated by Dr Margaret Chan's two mandates as WHO's Director General, meanwhile

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246 Alband Davesne, Sébastien Guigner, "La Communauté Européenne de la santé (1952-1954), *Politique européenne*, Vol. 41, L'Harmattan, Paris, 2013/3, p.60

247 Sébastien Guigner, "L'Union Européenne, acteur de la biopolitique contemporaine : les mécanismes d'européanisation normative et cognitive de la lutte contre le tabagisme", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.80

248 Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.293

249 Ibid, p.293

250 Stefan Elbe & al., "Medical countermeasures for national security: a new government role in the pharmaceiticalisation of society", *Social Science & Medicine*, N° 131, University of Sussex, Brighton, April 2014, p.269

251 Ibid, p.268

252 Dominique Kerouedan & al., "Produire de l'expertise française en appui à la réalisation des objectifs du millénaire pour le développement du secteur de la santé", *Santé Publique*, Vol. 19, S.F.S.P., Paris, 2007, p.115

253 Sonja Bartsch, *A Critical Appraisal of Global Health Partnerships*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.39

254 Lai Ha Chan, "China Engages Global Health Governance: Responsible Stakeholder or System-Transformer?", *Palgrave Macmillan*, New-York, January 2011, p.148

remaining a status quo power[255]; and as such adopting a similar attitude to the one the European Union could pretend to. Furthermore, history has shown that the precautionary steps taken

In the XXIst century, power as to be understood as a legitimising flow from moving and State-specific sources. Indeed the adoption of a constructive-realist approach to international relations strengthen the recognition of power as a fluid and malleable phenomenon, more evenly in the current mutations of the world order and the rise of spheres of influence. In this regards, European States and the European Union have started to acknowledge health governance as a power source. Yet, they remain reluctant to fully concentrate foreign policy and intellectual efforts into the prioritisation of health governance in foreign policies. To understand such dualistic behaviour, the examples of France and Italy will be scrutinised; both countries being European and health governing dominant powers .

[255] Lai Ha Chan, "China Engages Global Health Governance: Responsible Stakeholder or System-Transformer?", *Palgrave Macmillan*, New-York, January 2011, p.141

Part II: France and Italy, or bringing the past in the present

France and Italy are two European States that, above the influence that temporarily have elected governments, are more and more challenged on the international stage. Former global powers, they currently seem unfit to the XXIst century, a century of large ensembles and spheres of influence. Yet both countries are looking for renewed powers and influences; Rome to be regional power through a European influence (Chapter III), Paris to be a global power thanks to its perceived status of European power (Chapter IV).

Chapter III: Italy, a European influence for a regional power

The Italian strategy of power for the XXIst century is first of all based on making Italy a primary power within the European Union. Despite Rome entertaining a swinging relationship with Bruxelles (I), its foreign policy is focused on the European Union (II). This is why within European health governance, Italy evolves between technicality and political influence (III)

IV. Italy in the world, and the will to mediate

One could not contest that the Italian foreign policy, either because of the consistency of the Farnesina or of the regions' foreign actions, is turned towards the European Union. Indeed Rome has developed a strategy aiming at strengthening its European influence to become a regional power (I.I) but without denying its historical role of mediator (I.II).

IV.I. The Italian strategy, from European power to leadership

The political reforms implemented by Matteo Renzi had beneficial short term positive effects on the Italian economy; putting it back on the rails of growth and reducing unemployment[256]. On the international stage but above all on the European one, it allowed Renzi to affirm himself and assume a policy of power. Because if Italy is, after the Brexit referendum and even with the last European parliamentary elections, the third most powerful and founding member of the European Union, Rome remains torn by the question of its status and its often discarded foreign policy[257]. This is why, strengthened by its national experience[258], at a time of great unpopularity for the French President Hollande, Matteo Renzi, and then Paolo Gentiloni, invited himself within the so-called "french-german motor". However as noted by

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[256] Camille Savelli, « Matteo Renzi : quel bilan pour le "rottamatore" ? », *Classe Internationale*, September 19th 2016

[257] Maxime Lefebvre Maxime, *La politique étrangère européenne*, PUF, Paris, January 2011, pp.1-128

[258] Gérard Haddad, « La "nouvelle gauche" Renzi, un modèle pour l'Europe ? », *La Revue*, Vol.61-62, March April 2016, p.53

Ettore Grecco in 2016, even if Matteo Renzi tried to cultivate a preferential relation with Angela Merkel and François Hollande, it was most probable that such relation was no bound to last over time[259]. Indeed, this strategy did not last, first because of Paolo Gentiloni's personality, second and most importantly because of the rise to power of a populist and sovereignist government. In this regard, and in the light of the last European nominations, Marta Dassù and Maurizio Massari's warning towards the Farnesina and the Chigi Palace in their report for 2020 about the lack of Italian politicians at the direction of less important, but more crucial, commissions[260] - emphasised a weakness that got stronger afterwards.

With Matteo Renzi, Rome *de facto* tried to become a leader, if not the leader, of the European Union within the difficult context of the Ukrainian crisis, of the Brexit and of a French decreasing power under the Hollande Presidency. The political *élites* in Italy tried to impose themselves and implement on the regional scale a new balance in the transnational relations, presenting themselves as an alternative to the past crooked models. Such position favoured a open contestations from Rome of the economic and foreign policies of Bruxelles. However this political strategy has been damaged by the Italian referendum of December 2016, and the parliamentary elections of 2018 that led to the nomination of a government led by the sovereignist Matteo Salvini and the populist Luigi Di Maio. Yet, up to date the current Italian government haven't succeeded in asserting its vision on European politics, nor on the Farnesina. If the Italian leadership in Europe appears affected by Italy's uncertain economic and political situation, it did not disappear ; as shown by the election of David Sassoli's election as President of the European Parliament.

IV.II. The Italian strategy, from follower to mediator

Nonetheless, it would be an error to reduce Italy's foreign policy to its European dimension. Indeed, if Rome seeks to be a European leader, it has a more developed strategy for power. Already in the previous century, Italy's adhesion to NATO and its geographic position away from the center of conflicts between East and West, allowed Rome to enhance a rational

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[259] Ettore Greco, « Italy's role in Europe under Renzi », *Istituto Affari Internazionali*, Vol.16(20), December 2016, pp1-9

[260] Marta Dassù, Maurizio Massari, *« Rapporto 2020. Le scelte di politica estera »*, Ministero degli Affari Esteri, Rome, 2008, pp. 1-104

behaviour regarding the USSR[261], and then the Russian Federation. This facilitated, and still facilitates nowadays, the development of strong relations with Moscow, and of power projects that favour the interests of both countries. It is therefore of no surprise that to have high ranked politicians that call for greater relations with Russia, such as Silvio Berlusconi that developed a publicly shown friendship with Vladimir Putin, Matteo Renzi or Matteo Salvini. This structural element of the Italian foreign policy is also supported by the Italian energetic dependency from the Russian gas and their economic relations. However every President of the Council also "has" to give positive signs towards Washington and NATO. This is why Matteo Renzi during the Ukrainian crisis neither did hide its americanism nor showed a marked anti-Russian position[262]. Yet to limit Rome's privileged relation with Moscow to exclusively economic relations[263] would have meant to restrict too much the width of Italian foreign policy. In fact, as underlined by Michele Tommasi, among other experts and diplomats, Italy is exploiting its influence within NATO in order to push the organisation to focus on what threatens it concretely, rather than on Russia[264].

Nevertheless, this straight relation between Italy and Russia remains constrained by the EU and NATO enlargements and political choices[265]. Indeed Italy entertains a with the United-States of America and NATO a strong and historical relationship, as Rome ratified the Northern Atlantic Treaty in April 1949. In this regards Italy has, and pursues such a strategy, to follow what Marta Dassù and Paolo Massari call the principle of the open door[266], or double-diplomacy, and pursues such a strategy. This geopolitical and diplomatic line has already been developed during the Cold War since Rome could, thanks to its political, economic, social and territorial submission to Washington, get close to USSR[267]. Nowadays, and especially since the creation of the Eurasian Economic Union by Russia in 2014 as an

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261 Nadezhda Arbatova, « Italy, Russia's voice in Europe ? », *Ifri Russia/NIS Center*, n°62, septembre 2011, p.18

262 Elisabetta Brighi, Lilia Giugni, « Foreign Policy and the Ideology of Post-ideology: The Case of Matteo Renzi's Partito Democratico », *The International Spectator*, Vol.51(1), April 27th 2016, pp.13-27

263 Ibid

264 Michele Tommasi, *Dibattito sulle relazioni tra l'Italia e la Russia*, Italian Embassy in Moscow, Moscow, May 12th 2017

265 Marta Dassù, Maurizio Massari, *« Rapporto 2020. Le scelte di politica estera »*, Ministero degli Affari Esteri, Rome, 2008, pp. 1-104

266 Ibid

267 Manlio Graziano, *The failure of Italian nationhood: the geopolitic of a troubled identity*, Palgrave Macmillan, New-York, September 2010, pp.120-203

economic and normative system which is supposed to be antagonist to the EU[268], the partial reactivation of this geopolitical principle can be seen as a geopolitical willingness. Within this framework, and going over contextual uncertainties, Rome is willing to revive its role of mediator. Indeed, strengthened by its diplomatic tradition, during the Ukrainian crisis Italy tried to keep political relations distinct from economic ones, in order to appear as a mediator between Russia, the USA and the EU, aiming to reduce the tensions that would harm its interests[269].

In other words, Italy has a foreign policy and a strategy for power that, even if it remains linked to national political uncertainties, favours a position of mediator within and out of the European Union. Yet, the EU remains the main focus of the Farnesina, despite the swinging relationships with Bruxelles.

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[268] Jacques Rupnik, *Géopolitique de la démocratisation. L'Europe et ses voisinages*, Presses de Sciences Po, Paris, 2014, pp.13-75

[269] Ibid

V. Italy and the EU, a swinging relationship

Italy demonstrated over the past decades to have a swinging relationship with the European Union, that prevented it from acquiring all of its benefits. Such behaviour can be explained, going over the contextual impacts of governments, by two opposing forces: on the one hand, Italy's position as founding member (I.I) ; on the other, the unfitness of the EU with regard to the Italian interests (I.II).

V.I. Italy, a founder and promotor of the EU

The idea of permanent demolition, of profound transformations has been a constant of Matteo Renzi's political project since the beginning of its campaign for the socialist party's premiership[270]. Regarding foreign policy, this translated into a more offensive affirmation of Rome's interests, as perceived by the government. In this regard one can think of the nomination in 2014 of Federica Mogherini as High Representative for the EU and Vice-President of the European Commission. This has been a success for Italy[271], confirmed in 2018 by the election of Antonio Tajani as President of the Europarliament. This constituted the starting point of a renewed foreign policy towards Europe, with open criticisms uttered by Matteo Renzi agains the European Commission, typical of a newly elected Italian government facing a difficult internal situation.

Rome's swinging relationship with Bruxelles is highlighted by the fact that despite being a founding member, and since the United-Kingdom referendum of 2016 the third most important Member State, Italy remains obsessed with the question of its status within the European Union[272]. It therefore balances between recognising the benefits of the Union and contesting the structures of it. Furthermore with the rise to power of a government composed of the Five Stars Movement and the Northern League after some centre-left governments, such behaviour is accentuated. Moreover, meanwhile the EU remains one of the major field of

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[270] Camille Savelli, « Matteo Renzi : quel bilan pour le "rottamatore" ? », *Classe Internationale*, September 19th 2016

[271] Elisabetta Brighi, Lilia Giugni, « Foreign Policy and the Ideology of Post-ideology: The Case of Matteo Renzi's Partito Democratico », *The International Spectator*, Vol.51(1), April 27th 2016, p.20

[272] Maxime Lefebvre, *La politique étrangère européenne*, PUF, Paris, January 2011, pp.1-128

action if the Italian foreign policy[273], in 2008 Marta Dassù and Maurizio Massari alerted the Chigi Palace and the Farnesina on the absence of Italian politicians at the head of medium European directions[274]. This analysis appear even more accurate after the 2019 European elections. As a result, the Italian foreign policy towards the European Union can lack coherence, especially since the rise the so-called "European neo-sovereign wave"[275]. Furthermore it tended and tends to marginalise Italy within the Union[276], or in a lesser way, to reduce its influence.

Nevertheless, as it has already been demonstrated, and especially within the EU, one cannot reduce foreign policies to government's actions. In this regard, even the Italian Ministry of Foreign Affairs demonstrated itself to be particularly constant in its actions. In addition, Muller showed the progressive construction of a European space for public policies with multiplying forms of representations and the emergence of a European political agenda[277]. Within this framework, regions have been increasingly influential and compete to access European policies[278]; an attitude developed by Italian northern regions. In other words, Italy is both attracted and repulsed by the EU without therefore having been able to relying on its status and inner strengths. This can be explained, among other factors such as the Italian structural weaknesses, by the unfitness of the EU in regard to the Italian interests.

V.II. Italy in an "unfitting" EU

The European Union has proven to be unable to satisfy each of its Member States' interests because of its nature, the need for consensus, and of the high differences among them. Moreover, the EU has become an arena for power itself and a way for some European powers

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[273] Marta Dassù, Maurizio Massari, *« Rapporto 2020. Le scelte di politica estera »*, Ministero degli Affari Esteri, Rome, 2008, pp. 1-104

[274] Ibid

[275] Stefano Silvestri, "Italia e Francia: la debolezza fa la forza", ISPI, www.ispionline.it, consulted on March 2019

[276] Ibid

[277] Ural Ayberk, François-Pierre Schenker, "Des lobbies européens entre pluralisme et clientélisme", *Revue française de science politique*, Vol. 48 (6), Presses de la Fondation nationale des sciences politiques, Paris, December 1998, p.733

[278] Ibid, p.752

to spread their models and enhance their interests. In this regards Germany became an incontestable leader, promoting Bonn and then Berlin's vision of political economy and geopolitics. The key role of Germany in European geopolitical processes is highlighted by Stefano Silvestri whom stresses both the current and contextual *affaiblissement* of Germany[279], and the lack of cooperation in Berlin's attitude towards Rome[280].

Indeed Italy's continued and motivated willingness to both redefine EU's foreign policy, with a focus on the Balkans and the Mediterranean, and push for the end of austerity in the economic field has crystallised the German and European Commission position. In fact, despite the enormous benefits stemming from the EU for its Member States, Joseph Stiglitz showed that the European Union's political projects are weakening the Italian economy[281]. While Bruxelles endorsed a neo-liberal orthodox-like economic project, as well as an expansion towards the East, Rome would rather benefit more of a catholic-like economic project, and a focus on the Mediterranean. Such EU's unfitness in the perspective of Italian interests led to the rise of tensions between the Chigi Palace and the European Commission, even if Italy was contributing to the restart of the European project[282], and favoured a popular resentment that eventually contributed to the rise to power of a populist and sovereignist government.

In other words, Italy is trying, more or less actively depending on the Council's Presidency, to spread its regional influence in the Balkans and on the Mediterranean problematics. But above all, Rome would try to diffuse its cultural tradition, its latin vision, going against a German hegemony which embraces a rigourist understanding of economic and political issues. In turns, such a dynamics favours the Italian swinging relationships with the European Union, despite the fact that Italian foreign policy is being oriented towards Bruxelles.

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279 Stefano Silvestri, "Italia e Francia: la debolezza fa la forza", ISPI, www.ispionline.it, consulted on March 2019

280 Ibid

281 Pascal Allizard, Jean Bizet, René Danesi, André Gattolin, Gisèle Jourda, Simon Autour, *« Rapport d'information n° 292 »*, Sénat de la République française, Paris, 12 janvier 2017, pp.1-47

282 Ibid

VI. Italy and European health, between technicality and political influence

Italy has been highly influential within some European regimes and particularly in health governance. Indeed the Italian *savoir faire* in the health and sanitary fields is recognised (III.I) and constitutes a leverage for Roman political influence (III.II).

VI.I. A recognised Italian *savoir faire*

In its Health Care Efficiency for the year 2018, Bloomberg ranked Italy as fourth in the whole world, winning two positions from 2017, whereas France, famous for its sanitary system, has been ranked 13th[283]. In 2000, the WHO established a then widely spread ranking of health care systems efficiency. This ranking overpassed the national disparities and assessed two main variables, the sanitary spendings *per capita*, and people's health expectancy[284]. The WHO ranked France as the most efficient system, and at the second place Italy[285]. Talking about avoidable deaths, Italy was also second, right after France[286]. Nonetheless the small evolutions over the years and the methodological differences, two main conclusions can be drawn from these two classifications. First that Italy has a highly efficient sanitary system, and recognised as such. Second, that the Italian *savoir faire* in this field is acknowledged and accepted on the international level[287].

The Italian system has been reformed and transformed several times since the establishment of the Republic in 1946, and especially during the European wave of sanitary reforms in 1992-1993[288]. Nevertheless it can be argued that the current system is inspired by the Beveridgean reform of the British sanitary national system of 1947[289]. It is therefore based on

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[283] L.F, "Classifica Bloomberg 2018: sanità italiana al 4° posto nel mondo per efficienza. Secondi in Europa dopo la Spagna. Ultimi, Usa e Bulgaria", *Quotidiano Sanità*, September 20th 2018

[284] Federico Toth, "La sanità in Italia", *Il Mulino*, Bologna, 2014, p.142

[285] Ibid, p.141

[286] Ibid, p.147

[287] Modesta Visca, Rome, July 24th 2019

[288] Federico Toth, Bologna, March 20th 2019

[289] Amalia Diurni, "Les systèmes de santé en Italie et en Espagne", *Les Tribunes de la Santé*, Vol 51, Presses de Sciences Po, Paris, 2016, p.23

three main principles that are equality, globality and universality[290]. Yet Federico Toth recalls that nowadays one cannot use only one model to describe any national system, but rather that national systems are broken up into subsystems[291]. In the specific case of Italy, the successive reforms created a system that could be qualified as a sort of "federation" of about twenty different regional systems[292]. In this regard, most of the Italian regions have adopted integrated systems to the exception of Lombardy that adopted a separated model. Some regions are in between those two models[293]. But above the different models adopted, regions have shown to have high differences with regard to performance and provision of health services[294].

Therefore scholars argued that these principles are progressively marginalised by the decentralisation[295] of the system that accentuated the North-South gap. Indeed the gap between the Italian North and South is "not limited to healthcare, but these gaps are congruent with disparities in healthcare"[296], and linked to out-of-pocket costs[297]. However, despite the Italian sanitary system weaknesses, such issues should not overshadow the real quality of this system[298], and its recognised expertise. Their cruciality in negotiating within global health governance has been stressed by international relations scholars[299].

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[290] Amalia Diurni, "Les systèmes de santé en Italie et en Espagne", *Les Tribunes de la Santé*, Vol 51, Presses de Sciences Po, Paris, 2016, p.23

[291] Federico Toth, "Classification of healthcare systems: Can we go further?", *Health Policy*, Elsevier, Shannon, March 2016, p.6

[292] Federico Toth, "La sanità in Italia", *Il Mulino*, Bologna, 2014, p.63

[293] Ibid, p.69

[294] Ibid, p.64

[295] Ibid, p.36

[296] Federico Toth, "The Italian NHS, the Public/Private Sector. Mix and the Disparities in Access to Healthcare", *Glob Soc Welf*, N° 3, Springer International Publishing, New-York City, July 2016, p.175

[297] Ibid

[298] Federico Toth, "La sanità in Italia", *Il Mulino*, Bologna, 2014, p.146

[299] Kelley Lee, *Key Factors in Negotiations for Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.257

VI.II. A potential for political influence

At the occasion of a meeting between the President of the French Republic and the Italian President of the Council in Lyon in September 2017, both countries stressed their willingness to cooperate and straighten their cooperation for scientific research[300]. Moreover, the choice of Lyon as the host city moreover shows the focus on the health research since Lyon is an internationally recognised biopole with a P5 laboratory. We can also consider the current negotiation with the WHO directorate to host the WHO's Health Academy[301]. More than adopting a European view, both States acknowledged their respective strengths and the (geo)political benefits from an accrued cooperation. Indeed, meanwhile some scholars seem obnubilated by the human rights and ethical dimension of global health, and as previously explained, health within foreign policy unfolds diversified political and geopolitical interests that one should not neglect. Furthermore as demonstrated by Colin McInnes, "in published statements by foreign ministries there is considerable consistency in prioritising the national interest when discussing health security issues"[302]. However such promotion of self-interest is tempered by globalisation processes and normative elements that unfold the notion of self interests[303].

Moreover, global health governance is deeply interlinked with other global regimes, and factors that can be recognised as determinants of health; the economic and social ones being the last ones to have been fully recognised. As a result, it can be argued that a nexus of health and foreign policy issues and interests exists around global health and its governance[304]. Within this context, and in the particular environment of the United Nations, international law scholars conceptualised soft and hard law to differentiate binding international norms from non binding ones. Yet, and at least as far as global health governance is concerned, such

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[300] Anonymous, *« Sommet Franco-Italien »*, Présidence de la République française, Lyon, September 27th 2017, p.25

[301] Taraneh Shojaei, Paris, May 24th 2019

[302] Colin McInnes, *National Security and Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p. 45

[303] Ibid

[304] Luvuyo Ndimeni, *Global Health and Foreign Policy at the UN,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.215

distinction is blurring the impacts and influence that carry non-binding international norms[305]. An example would be Italy's ability to enhance within the WHO the crucial role of economic determinants of health, which helped it move forward in the protection of its economic and political interests.

As far as Italy, within the European sphere, is concerned, some stress that Italian tend to expect from European initiatives rather than presenting themselves as a leader[306]. This could be true for the climate change regime. Italy's activism in this regard is different within the European health regime. The most accurate and recent example is the Lorenzin bill of 2017, increasing the vaccines coverage. Its transformation into a proper statute and its implementation were indeed complicated by the change of government in 2018. Nevertheless the Italian initiative led to a European focus on the need for a better vaccines coverage, it was transformed into proper initiatives in France, and was held as a model within the WHO[307]. Such political phenomenon of mutual inspiration[308] could reveal itself to be an important power capital, especially for countries that have a recognised *expertise* in health governance, as Italy does. In other words, health could constitute a multidimensional power capital. However this would require an accrued coherence across government agencies[309], and a national strategy[310]. Which, as the EMA case shows[311], Italy currently lacks.

One cannot but agree that despite its weaknesses, that will be further be unfolded below, Italy remains a European power which foreign policy is primarily focused on the European Union. Going above contextual dynamics, Italy seeks to strengthen its European influence to

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[305] Steven Solomon, *Instruments of Global Health Governance at the World Health Organization,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.195

[306] Xavier Lallemand, Arnaud Leconte, "Italie - Une analyse du discours sur le développement durable", *L'Europe en Formation*, N° 352, Centre international de formation européenne, Nice, 2009/2, p.85

[307] Federico Toth, Bologna, March 20th 2019

[308] Christine Berling, Paris, April 25th 2019

[309] Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.281

[310] Ibid, p.282

[311] Nicla Panciera, "Beppe Sala: "Per Ema, riconsiderare Milano"", *La Stampa*, May 16th 2018

shape the EU and better enhance its interests. It is here argued that health governance is and could even more be a way for Rome to develop its political influence. With another approach, it appears that France is pursuing global influence through its status of European power.

Chapter IV: France, a European power for a global influence

Paris is developing a rather different approach than Rome, focusing on using its status and strengths as European power to unfold, or revive, its global power status. Indeed, France appears to be stuck between its past as world power and its uncertain future (I). However, and because its status of European leader is criticised (II), health could constitute a bridge from power to effective influence (III).

I. France in the world, between past and future

Studying the French foreign policy, even by taking a peculiar focus on health, means to acknowledge a highly present past and the French souvenir of historic power relations (I.I). Nonetheless, it also means to recognise a present future, as well as a Parisian desire to build new power tools (I.II).

I.I. A present past, from souvenir to the perpetuation of historic links

Through his study of the French sanitary system transformations, Frédéric Pierru stresses the contemporary importance given to comparisons, imports and exports of instruments developed in other States[312]. However national peculiarities remain influential[313], and especially in France. Indeed in Pierru's words, the French sanitary system, the Sécurité Sociale, is seen as the expression of a national *génie*, as the best system in world despite poor knowledge of other systems[314]. This element is crucial in order to understand France's look towards the past and how it influences its vision of itself. Recalling Norbert Elias, it could be argued that French people are a good example of a population that sees itself as it used to be rather than how it currently is. France remains a powerful State, and its sanitary system one of the best of the world, yet it lacks a proper and objective vision of its potential and weaknesses.

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[312] Frédéric Pierru, "Les recompositions paradoxales de l'état sanitaire français", *Education et sociétés*, N° 30, De Boeck Supérieur, Paris, 2012/2, p.107

[313] Ibid, p.108

[314] Ibid, p.109

Foucault himself, when considering *Naissance de la Clinique* as an object of the history of ideas[315], highlighted the cruciality of understanding history and perceptions to evaluate State policies and health system mutations. Therefore it is of no surprise that France actively promotes the implementation of a universal sanitary system[316], or is among the seven founding members of the so-called Oslo Group and ratified in 2006 the Oslo Ministerial Declaration on Foreign Policy and Global Health[317]. This is also why France main strategic lines[318] - prevention and promotion, security and quality, risk management - are all exportable and exported on the international stage.

Moreover, in addition to France's perception of itself in global health governance, the influence of history can be seen through the perpetuation of strong bilateral links and a foreign policy focus on former colonies. As recognised by Taraneh Shojaei, if the Ministry of Health is acting worldwide, the Ministry of Foreign Affairs is focusing on development aid in Africa[319]. If critics speak about neocolonial behaviours, or scholars are interrogating the qualifications of actions as part of humanitarian or of development aid[320], reasons for such approach and prioritisation are far more complicated and also rely on systems structure or States expectations[321]. This also recognised by Kerouedan, whom stresses some States needs and expectations held by some States towards the French *expertise*[322] on the short, medium and long terms[323]. In this regard Paris strengthened from the beginning of the seventies the

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315 Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, p.269

316 Taraneh Shojaei, Paris, May 24th 2019

317 Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.291

318 Anne-Claire Amprou, Benoit Vallet, "60 ans : un projet stratégique pour la Direction générale de la santé" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, pp. 4

319 Taraneh Shojaei, Paris, May 24th 2019

320 Laëticia Atlani-Duault, Jean-Pierre Dozon, "Colonisation, développement, aide humanitaire. Pour une anthropologie de l'aide internationale", *Ethnologie française*, Vol. 41, Presses Universitaires de France, Paris, 2011/3, p.400

321 Taraneh Shojaei, Paris, May 24th 2019

322 Dominique Kerouedan & al., "Produire de l'expertise française en appui à la réalisation des objectifs du millénaire pour le développement du secteur de la santé", *Santé Publique*, Vol. 19, S.F.S.P., Paris, 2007, p.112

323 Ibid, p.114

exportation of its *expertise* through both public and private initiatives and actors, such as the "*expertise* packages"[324] or the creation of Médecins Sans Frontière and Médecins du Monde by Bernard Kouchner[325].

I.II. A present future, from desire to the construction of new tools

Nevertheless, one should not reduce France initiatives to their historical influences. Indeed France has proven to be active in the creation of new tools regarding global health governance. One of the most important among these tool would probably be, as already explained, the creation of the Oslo Group[326]. Indeed recognising - and influencing others in recognising it, the importance of health in foreign policies constitutes the basis for the edification of new tools. Furthermore this appear to be correlated to France's activism in promoting universal sanitary coverage and access to health, as well as to its willingness to do even more, resorting on multilateralism[327].

Regarding specific actions for the future, and even if the Ministry of Foreign Affairs is rightfully reluctant to diffuse too many information at this early stage[328], Paris is currently discussing with the World Health Organization to help it establish its Academy in Lyon[329]. In a similar understanding the French President François Hollande publicly expressed his willingness to strengthen the International Health Regulations and transform Lyon into a center for global health crisis preparation[330]. This activism resulted in an increased

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[324] Christine Berling, Paris, April 25th 2019

[325] Dominique Kerouedan & al., "Produire de l'expertise française en appui à la réalisation des objectifs du millénaire pour le développement du secteur de la santé", *Santé Publique*, Vol. 19, S.F.S.P., Paris, 2007, p.107

[326] Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.291

[327] Emmanuel Macron, *French President's New Year greetings to the diplomatic corps*, Paris, January 4th 2018

[328] Taraneh Shojaei, Paris, May 24th 2019

[329] Direction Générale de la Santé, "*Rapport d'activité 2016"*, Ministère des Solidarités et de la Santé, Paris, November 2017, p.2

[330] Ibid

influence[331] that helps France in establishing a global legitimacy in constructing new tools for health governance. In the words of Jérôme Salomon, Health General Director, "it is important to show that in France we have the capacities to innovation in the field of health"[332].

In addition to political initiatives, and to show its strengths, France is slowly opening its legislative apparatus to favour its attractiveness in the field health and industrial pharmacy. Indeed, July 2018 legislative processes have started to facilitate clinical procedures[333]. This comes as a new step in the power retribution within the French sanitary system[334], that saw a progressive affirmation of the State[335]. A consequence that can be acknowledge on the French political strategy towards global health governance is the importance taken by promotion and prevention[336] whereas France was characterised by a domination of a curative medicine model[337]. Moreover, the French sanitary system and overall situation is not exempted of problems and weaknesses. These have been identified by scholars[338] and certain laws have been thought as "necessary solutions"[339].

France's foreign policy, especially regarding global health governance, is turned both towards the past and the future. Paris is seeing itself as an important player, and often tends to think itself as a power on a global stage, tacking for granted its status of European dominant power.

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331 Direction Générale de la Santé, "*Rapport d'activité 2017*", Ministère des Solidarités et de la Santé, Paris, November 2018, p.3

332 Jérôme Salomon, *Rencontres de Santé publique France*, Paris, May 29th 2018

333 AFP Agence, "Le gouvernement dévoile des mesures pour doper l'attractivité de la France en santé", *Le Point*, July 10th 2018

334 Didier Tabuteau, "Démocratie et santé", *Les Tribunes de la santé*, N° HS 3, Presses de Sciences Po, Paris, 2014/5, p.4

335 Ibid

336 Christine Berling, Paris, April 25th 2019

337 Henri Bergeron, Constance Nathanson Constance, "Faire une loi, pour faire la loi. La loi de santé publique d'août 2004", *Sciences sociales et santé*, Vol. 32, John Libbey Eurotext, London, 2014/4, p.9

338 Ibid

339 Ibid, p.8

II. France in the EU, a discussed leader

France tends to see itself as a European leader, a power without which decisions could not, or should not, be taken. It testifies of a strong willingness to lead the European Union (II.I), which appears to be challenged by other European powers (II.II).

II.I. The EU and the French willingness to lead

It is commonly accepted, correctly or not, that France is one of the heads of the European Union dual leadership. Since the end of the second world war, with the political, social and cultural influence of the De Gaulle era that shaped France's image of itself and impulsed a renewed willingness for *grandeur*, France developed a strategy for national power but also acknowledged its need for multilateralism[340] and European construction. Indeed it seems that France understood, sometimes better than others, that in the XXIst century the idea of *grandeur* is an idea that would suit a united European Union rather than France as a nation-State[341]. This is why Paris developed and continues to develop and strong European ambition[342] that reveals itself through an enhanced European activism. It is also worth noting that even when right-wing governments - usually less keen on European integration - are elected, they pursue an active European policy. The example of Nicolas Sarkozy's presidency in fact shows that even if contesting European policies regarding migration or members integration, rightwing governments car strongly favour the EU[343].

Keith Middlemas wrote that the "French system works on the hypothesis that European affairs are fully integrated to national politics and has therefore to be at image of Paris' pursued interests"[344]. As Evgueni Kojokine explains, limits have to be settled regarding Middlemas

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340 Emmanuel Macron, *French President's New Year greetings to the diplomatic corps*, Paris, January 4th 2018

341 Fernand Braudel, "Le modèle italien", Champs Arts, *Flammarion*, Paris, August 2008, p.9

342 Anonymous, *« Sommet Franco-Italien »*, Présidence de la République française, Lyon, September 27th 2017, p.2

343 It is here a reference to Nicolas Sarkozy's active role, as President of the European Council rather than President of the French Republic, in the settlement of the war between Russia and Georgia in August 2008.

344 Evegueni Kojokine, "La politique étrangère française est-elle soluble dans une Europe unie ?", *Revue internationale et stratégique*, N° 45, Armand Colin, Paris, 2002/1, p.106

affirmation and France's attitude towards the European Union is more complex than what wrote Middlemas wrote in 2002. Indeed, it appears that when Paris can achieve its objectives without the European structures, or can act faster, it conducts policies that overpass the Union; conducting itself as a traditional nation-State[345]. However Middlemas is right when asserting the importance of the EU for France, and above all when he stresses Paris activism in shaping European affairs to the French objectives.

Furthermore it explains, correlated to the previous points made on the French thinking regarding past and future, France's willingness to lead the European Union, shaping it according to its identified interests. Nevertheless, with the EU enlargements and above all because of the EU structural and political developments, especially in the last decade, France's strategy for the European Union is not fully efficient. Indeed nowadays, despite a ambitious European politics pursued by Emmanuel Macron's government, and despite the overall support of the European institutions, France lacked support, and first among them the German one, in promoting and implementing new political and institutional European developments[346]. This can be linked to the fact that even if France remains one of the most powerful European Member States, and has a strong willingness to lead the Union, this desire is challenged.

II.II. France in the EU, a challenged desire

Even if Kojokine's writings have to be tempered and his understanding of European dynamics appear too reductive, his idea that the European Union is based on the assumption that Europe will be united or won't be[347], can be useful in understanding contemporary European relations. Above the fact that such thinking had disastrous consequences for the European Union itself, leading to inconsiderate enlargements and a cult for consensus, it reduced for a long time alternative models to rise. In its turn this phenomenon lead after the financial crisis of 2008 to the cristallisation of two kinds of European thinking: pro-EU

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345 Evegueni Kojokine, "La politique étrangère française est-elle soluble dans une Europe unie ?", *Revue internationale et stratégique*, N° 45, Armand Colin, Paris, 2002/1, p.109

346 Stefano Silvestri, "Italia e Francia: la debolezza fa la forza", ISPI, www.ispionline.it, consulted on March 2019

347 Kojokine, Ibid, p.108

liberals and anti-EU sovereignists. Aspiring to a European leadership France always, both under right and left wing governments, France always championed the idea of more European Union. Therefore, currently trying to renew the European growth and cooperation, France is confronted with some Member States tendencies to neo-sovereignism and euroskepticism, especially from the Visegrad group[348]. In addition, France willingness to lead the EU is confronted with other Member States interests, such as Germany, or refusal to be under the domination of a single State.

Moreover, a European lobbying system have been growing[349] in influence within the European Union, and with it a new source of challenges for Member States. Indeed, as explained by Ayberk and Schenker, the relation between the EU and interest groups is close to the corporatist model[350]. In other words, "interests articulations can by made both on a national and European level whereas their aggregation is in the hands of the European institutions"[351]. In this regards, Member States can be confronted to the influence of lobbies and interest groups that can act for the interests of another Member States, as well as for their own interests. Furthermore a plurality of actors are actually emerging on the European political scene, such as regions or associations, that constitute interest groups; sometimes even against the willingness of some States[352]. Therefore the French desire to lead the European Union is often in contrast with other political agendas, and appears to some extents to be challenged. Paris is a contested leader, yet because of its assets, it could resort on public health as a bridge between influence and power.

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[348] Stefano Silvestri, "Italia e Francia: la debolezza fa la forza", ISPI, www.ispionline.it, consulted on March 2019

[349] Ural Ayberk, François-Pierre Schenker, "Des lobbies européens entre pluralisme et clientélisme", *Revue française de science politique*, Vol. 48 (6), Presses de la Fondation nationale des sciences politiques, Paris, December 1998, p.753

[350] Ibid, p.725

[351] Ibid

[352] Ibid

III. Public Health as a French bridge from power to influence

France has many assets regarding public health. Being a contested European leader, it could therefore resort on the health sector as a tool for regional power (III.I) and use health diplomacy as an instrument of influence (III.II).

III.I. The health sector as a tool for regional power

Alcázar and Buss explained that the growing challenges to the legitimacy and representativeness of international organisations lead to an order of change that entrenched health into foreign policies[353]. In other words, because most international institutions are increasingly seen as representing great powers and the world of 1945, and even more illegitimate because of their alleged poor efficiency, health and its protection have been integrated into States foreign policies. In this regards, a global and regional public good approach can be highlighting. Indeed, as recalled by Gleicher and Kaul, most global public goods "follow a summation process, meaning that several or all countries need to take national-level measures in order to correct the under-provision of a global public goods" by international actors[354]. Furthermore the world remains, in the words of both scholars, divided between policy-setting and policy taking States[355], between States that are able to set or at least shape the international agenda in a specific field, and States dominated by this agenda. Thus States, and especially great powers, are retaining powers and influence, increasing international institutions lack of credited legitimacy by undermining their actions; providing global and regional public goods and as it advancing their interests. This is also why global public goods focused actions, such as most actions undertaken in the framework of global health governance, are targeted and results oriented on a short or medium term[356].

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353 Santiago Alcázar, Paulo Buss, *Health is an Integral Part of Foreign Policy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.153

354 David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.115

355 Ibid, p.117

356 Ibid, p.119

Within this context and because, as seen previously, France has already incorporated health in its foreign policy, with the aim of shaping international agendas to favour its interests. In fact it appears[357] that France effortlessly tries to negotiate the regional and global health agendas, adopting a strategy close to Kelley Lee's key factors[358] in negotiations for health[359]. Furthermore, focusing on France and its use of health for regional power, the context on the global and European stage regarding health governance are, to some extent, quite similar. Indeed both the United-Nations and the European Union know some form of legitimacy deficit regarding global health protection. In addition, in both arenas, if Member States have to depart from the status quo with regard to health governance, they will favour non legally binding recommendations[360]; even if recommendations can develop a form of bindingness[361]. It is therefore of no surprise that both scholars and States' decision-makers are pushing France to strengthen its capacities to enhance its expertise and experts[362]. Within European health governance, and in the EU arena, France's activism and assets are used[363], among other factors and elements, to secure its interests and increase its influence on the European stage. Yet such strategy is even stronger and more visible at the international level.

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357 A reference is here made to the interviews of Mrs Berling, from the French Ministry of Health, and Mrs Shojaei, from the French Ministry of Foreign Affairs.

358 According to Kelley Lee, "(k)nowing what you want from the negotiations is also essential. The question of what you ideally want may seem relatively straightforward, but effective negotiation is about "give and take," and it is likely that some "giving" will be needed for an agreement to be reached (…) Equally important is arriving at an understanding of what other interested parties or your counterparts are likely to want from the negotiations".

359 Kelly Lee, *Key Factors in Negotiations for Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.259

360 Steven Solomon, *Instruments of Global Health Governance at the World Health Organization,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.194

361 Ibid, p.195

362 Dominique Kerouedan & al., "Produire de l'expertise française en appui à la réalisation des objectifs du millénaire pour le développement du secteur de la santé", *Santé Publique*, Vol. 19, S.F.S.P., Paris, 2007, p.115

363 Christine Berling, Paris, April 25th 2019

III.II. The health diplomacy as an instrument of influence

The provision of regional public goods, and more specifically health-related goods, is thus a source of power on a regional level, used by Paris in the European Union. Nevertheless, as explained by Inge Kaul and David Gleicher, the definition and cooperation around regional public goods are growing factors for building blocks around global public goods[364]. This is why, related to the always increasing globalisation and incorporation of health in foreign policies, there is in the XXIst century new forms of cooperations regarding health[365], which in turns lead to new directions in the conduct of international relations[366]. It has already been underlined how the global public goods approach shaped the conception and implementation of public health diplomacy, and how such approach can be in tensions with health integration into States' strategies for power. Yet the assertion of the global public goods concept has also favoured, at least within public health governance, new forms of cooperations, focused on regional arenas and regional public goods. Therefore nowadays health diplomacy appears to be built for both the global North and South[367].

As a consequence, and health governance is particularly affected by such dynamics - because it remains seen as low politics, States or in the case of the European Union regional institutions, favour a regional bloc approach to international negotiations with leading parties conducting negotiations on behalf of a collective[368]. States approach to the World Trade Organization TRIPS Agreements demonstrates these phenomena with a clear division between developed States, which stresses the necessity of strict agreements regarding medicines property rights, as opposed to developing States, which favours light agreements to have access to medicines from the global North at lesser costs and above all protect their

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364 David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.118

365 Santiago Alcázar, Paulo Buss, *Health is an Integral Part of Foreign Policy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.161

366 Ibid

367 Ibid

368 Kelley Lee, *Key Factors in Negotiations for Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.261

industries copying protected medicines[369]. However if this dynamics favoured regional block approaches to global health governance, it also favours the rise of influence of some States that tends to lead the regional blocks. Furthermore, the securitisation of health - which as previously explained allowed the addition of health in the international agenda - because it focuses on regulatory and policy capacities detained by States allowed the dominance of the State over other agents and institutions of global health governance[370]. Thus some States, such as France, have been able to strengthen their influence on global health governance agendas and political dynamics.

Nonetheless, implementing such strategies is complex and benefiting from them is limited; as demonstrated by France. In fact it first of all requires a high level of policy coherence between organs of the State through inter-institutions negotiations, coordination and cooperation[371]. In this regard, France developed, since the end of the Valls premiership, and increasingly under the Philippe's premiership, a strategy for health governance negotiated between several States agencies and strengthened national institutions coordination and cooperation[372]. This political and institutional effort helps France increasing its global influence in the field of health. Yet, Paris' main assets and source of political influence are related to its colonial past. Indeed, as described by Mrs Shojaei or by scholars such as Atlani-Duault and Dozon[373], health in the French foreign policy is a source of power and influence especially with regards to African and french-speaking countries[374].

Thus, health can reveal itself to be a source of influence for France and Italy, especially within the European health governance framework. Enhancing a strategy that would give importance

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369 Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.277

370 Colin McInnes, *National Security and Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p. 56

371 Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.292

372 Christine Berling, Paris, April 25th 2019

373 Laëticia Atlani-Duault, Jean-Pierre Dozon, "Colonisation, développement, aide humanitaire. Pour une anthropologie de l'aide internationale", *Ethnologie française*, Vol. 41, Presses Universitaires de France, Paris, 2011/3, p.394

374 Taraneh Shojaei, Paris, May 24th 2019

to these phenomena, could moreover, in a process similar to the American and the Rockefeller Foundation influences over European social sciences construction at the beginning of the XXth century[375], initiate a first collective institutionalisation, at the European level, of health as instrument of power in the XXIst century. However both France and Italy are weakened by contextual and structural issues that prevent them from upholding their high potentials and capacities in transforming global public health policy into a power source; and among these weaknesses, especially the lack of a constant and strong political strategy.

[375] Ludovic Tournès, "La fondation Rockefeller et la construction d'une politique des sciences sociales en France (1918-1940)", *Annales. Histoire, Sciences Sociales*, Editions de l'EHESS, Paris, 2008, p.1373

Part III: France and Italy, from high potentials to lack of constant political strategy

If a reconceptualisation of power, in order to assess its fluid and actor-specific origin, and an understanding of the geopolitical dimension of public health are undertaken, one can see that public health is, or can be, a new power source for France and Italy in the XXIst century. Indeed, both countries possess unexploited leadership and market potentials regarding health governance (Chapter V). The unexploitation of such potentials for power in a highly competitive world can however be explained by an unstable political involvement toward a global health strategy (Chapter VI).

Chapter V: National leadership and European market as unexploited potentials

It has been shown that public health integration into foreign policies has had geopolitical consequences and introduced new dynamics in both European and global health governance. Moreover it appears that health could constitute a power capital for France and Italy (I), especially since the empowerment of global public health within the European arena (II), and because health constantly swings between apoliticisation and high-politicisation (III).

I. Health in France and Italy, as a power capital

France and Italy ambitious countries that have to face difficulties in finding their status and renew with power in the XXIst century. It would be argued here that public health could provide both countries because of their assets, or in other words their public expertise (I.I) and the strength of their private sector (I.II).

I.I. France and Italy, a public expertise

The Italian and French sanitary systems are highly different yet, as it has been showed, both are particularly efficient. Most European countries including France have an obligatory sanitary system, meaning that citizens are constrained to have a health insurance either private or paid through contributions on salaries[376]. On the contrary, the Italian system is a sanitary national[377] system inspired by the famous Beveridge plan of 1942. The Italian system is therefore and moreover protected by the Constitution and relies, at least in its formulation, on a strong universality[378]. An interesting insight into these two systems and their efficiency is to look on the basket of basic services they offer. Indeed, the definition of a basket of sanitary services is not always explained by willingness to reduce costs but, as in Italy, often to reduce

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[376] Amalia Diurni, "Les systèmes de santé en Italie et en Espagne", *Les Tribunes de la Santé*, Vol 51, Presses de Sciences Po, Paris, 2016, p.24

[377] Ibid, p.23

[378] Modesta Visca, Rome, July 24th 2019

inequalities[379]. In fact Italy is the only European country to have set an official catalogue of longterm healthcare services divided in four categories and according to which public institution is responsible for their provision[380]. If such complete catalogue doesn't seem to exist in France, a similar one has been defined[381]. In other the difference between the two basic sanitary services baskets, is a difference of logic. If the Italian catalogue defines the obligations and duties of public sanitary services, the French one defines the rights of the patient[382]. Thus the Italian and French sanitary systems are highly different but the basic sanitary services baskets show that these differences are on the structural logic rather than on the efficiency or the quality. This is why both countries are recognised for their expertise.

Evidently both systems currently know difficulties and are facing rising inequalities in healthcare provision, and especially the Italian one in certain regions[383] due to the federalisation of the system[384]. However current reforms undertaken in France and Italy aim at a better integration[385], a transversality among health sectors[386], through the assessment of social determinants of health[387]. On the international stage this has been translated into, on the first hand, a political activism within global health governance arenas for the recognition of social determinants of health. On the second hand, it has been translated into an increase in local micro projects to repair case by case inequalities[388]. In addition, on both the international and national scenes, the French and Italian expertise can be seen through the strength of their private sector, and the low penetration of generic medicines.

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379 Marcial Velasco-Garrido & al., "Description des paniers de soins dans neuf pays de l'Union Européenne", *Revue française des affaires sociales*, La Documentation française, Paris, 2006/2, p.88

380 Ibid, p.76

381 Ibid

382 Ibid, p.67

383 Federico Toth, "The Italian NHS, the Public/Private Sector. Mix and the Disparities in Access to Healthcare", *Glob Soc Welf*, N° 3, Springer International Publishing, New-York City, July 2016, p.177

384 Modesta Visca, Rome, July 24th 2019

385 Ibid

386 Jean-Yves Grall, "DGS et ARS : des liens nouveaux pour la déclinaison de la politique de santé publique" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.5

387 Christine Berling, Paris, April 25th 2019

388 Laëticia Atlani-Duault, Jean-Pierre Dozon, "Colonisation, développement, aide humanitaire. Pour une anthropologie de l'aide internationale", *Ethnologie française*, Vol. 41, Presses Universitaires de France, Paris, 2011/3, p.400

I.II. France, Italy, and the strength of the private sector

Federico Toth explains the complexity and various ways of classifying healthcare systems. In an interesting essay on this argument, he suggests to take into consideration the integration of insurers and providers[389]; resulting in a distinction between integrated and separated systems. The present paper is not focusing on healthcare and sanitary systems structures and analysis, yet understanding the role of private actors in the French and Italian national health governance can be of a powerful insight. In this regards, and as previously introduced, France and Italy's low penetration of generic medicines is highlighting the strengths of the private sector in the health systems of both countries. Indeed, it has been shown that generic medicines represents 12% of the market share in France and 4% in Italy, whereas they represent 41,1% in Germany and 49,3% in the United-Kingdom[390]. Similarly, the penetration in volume of generic medicine molecules represents 58% in France whereas it reaches 88% in the United-Kingdom[391]. These datas alone cannot be considered as proof of an active and strong influence of national pharmaceutical industries on the healthcare policies of a country. However they're underlying the cultural background within which healthcare policies and strategies are established.

In this regards, it is interesting to acknowledge that the ways of health systems reforms in West Europe, and particularly in France and Italy, since the 1990s aim at "fostering efficiency competition among the various components of the healthcare system (which has been encouraged by) the recognition of the rights of patients to a greater freedom of choice"[392]. Nonetheless, if France always favoured the intervention of both public and private insurances[393], the State recently increased its dominance over other actors and secured the

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389 Federico Toth, "Classification of healthcare systems: Can we go further?", *Health Policy*, Elsevier, Shannon, March 2016, p.5

390 Blandine Juillard-Condat, Willy Thao Khamsing, "Comparaison des ventes de médicaments antihypertenseurs dans cinq pays européens en 2009", *Revue française des affaires sociales*, La Documentation française, Paris, 2013/3, p.101

391 Ibid

392 Federico Toth, "Healthcare policies over the last 20 years: Reforms and counter-reforms", *Health Policy*, N° 95, Elsevier, Shannon, 2010, p.83

393 Rémi Pellet, "La place du secteur privé dans les systèmes de santé", *Les Tribunes de la santé*, N° 51, Presses de Sciences Po, Paris, 2016/2, p.54

protection of public hospitals from private clinics concurrence[394]. In Italy, the health sector has a first place role in the economy, representing indeed about 11% of the GDP[395]. Both countries know therefore a private health sector at the crossroads of commercial, political and professional interests[396], topped by multinational industrial champions such as Sanofi in France or Angelini in Italy. It is therefore as no surprise that such actors have been able to influence, by their acceptation or opposition, national and European healthcare policies. In fact, the opposition of French pharmaceutical industries such as Rhône-Poulenc, to the creation of a common European market for medicines has been one of the main reasons to the failures of Ribeyre's Europe of health project in the early 1950s[397].

Furthermore private actors, both pharmaceutical industries and foundations, are increasing drivers of cooperation[398] and elements of the geopolitics of health. Such actors are replacing States authorities that find themselves unable to fulfil their mission of providing their population in basic healthcare as well as they sometimes replace bilateral relations in these fields[399]; influencing, if not shaping, global or regional health governances. Going back to the tensions surrounding the TRIPS agreement regarding medicines, and the fight against counterfeits, it appears that these two phenomena are mutually unfolding themselves[400]. They are indeed commonly actively participating in their prioritisation within the discourse of developed countries. Above all and in other words, we cannot but agree when Mathieu Quit explains that these two phenomena are inserted in the larger domain that is a political economy[401], and established in a health security discourse from which both France and Italy can find a power capital.

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394 Rémi Pellet, "La place du secteur privé dans les systèmes de santé", *Les Tribunes de la santé*, N° 51, Presses de Sciences Po, Paris, 2016/2, p.54

395 Federico Toth, "La sanità in Italia", *Il Mulino*, Bologna, 2014, p.7

396 Ibid

397 Alban Davesne, Sébastien Guigner, "La Communauté Européenne de la santé (1952-1954), *Politique européenne*, Vol. 41, L'Harmattan, Paris, 2013/3, p.57

398 Brigitte Hamm, Cornelia Ulbert, *Private Foundations as Agents of Development in Global Health: What Kind of Impact Do They Have and How to Assess It?*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.184

399 Ibid

400 Mathieu Quet, "Sécurisation pharmaceutique et économie du médicament. Controverses globales autour des politiques anti-contrefaçon", *Sciences sociales et santé*, Vol. 33, John Libbey Eurotext, London, 2015/1, p.102

401 Ibid, p.111

II. France, Italy and the EU, and the empowerment of Global Public Health

Mostly because both Paris and Rome are definitely turned towards Bruxelles, the European Union cannot be dismissed. It played and plays a crucial role within the Italian and French strategies regarding health governance, either as a geopolitical springboard (II.I), either as an power potential for the EU itself (II.II).

II.I. Economic and political integration as a geopolitical springboard

Following the insight previously given on the French and Italian policies in confront to the European Union, and more particularly the ambitions and scopes of unfoldment of these two States regarding the EU, it can be said that both Paris and Rome are adapting their behaviour towards Bruxelles according to their interests. If this affirmation has to be increasingly nuanced, with Bruxelles gaining powers and legitimacy, the European health governance remains subjected to States *a la carte* behaviour. In their study of the Europe of health, Davesne and Guigner show that the European Community of Health drawn by the French politician Ribeyre in the 1950s has been thought as a springboard for France's sanitary revival and modernisation[402], assessing the fields where the French Ministry of Health lacked resources[403]. More importantly however, the authors recall that using the EU has also been a way for States' administrations to increase their resources, legitimacy and foster their actions within the frame of their competition with other national administrations[404]. Such historic perspective is important to understand remaining current dynamics[405] within European health governance and is supported by the differences in the priorities, strategies and methods highlighted by Mrs Berling[406], from the French Ministry of Health, and Mrs Shojaei[407], from the French Ministry of Foreign Affairs.

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[402] Alban Davesne, Sébastien Guigner, "La Communauté Européenne de la santé (1952-1954), *Politique européenne*, Vol. 41, L'Harmattan, Paris, 2013/3, p.51

[403] Ibid, p.52

[404] Ibid

[405] Ibid, p.61

[406] Christine Berling, Paris, April 25th 2019

[407] Taraneh Shojaei, Paris, May 24th 2019

Nonetheless considering the European Union as a national administrations competition prize is undermining the increasing influence and power that the EU itself has within the frame of the European and global health governance. In this regards, Radaelli identified to europeanisation[408] mechanisms: vertical and horizontal[409]. Vertical europeanisation refers to the implementation of EU policies by or mimetism among Member States; which as it has already been written remains limited in the field of health. However horizontal europeanisation is based on the fact that the EU can create preconditions to the diffusion of common standards, practices and policies. It's for example the case of States participations to a European sanitary cooperation, which leads according to Sébastien Guigner to a public health rationalisation[410]. The European Parliament and European Union Council bill N° 282/2014, defining the EU strategies for 2014-2020 regarding health is a good example in such a way that it strengthens the importance of spreading good practices through the Union[411]. Such dynamic is also reinforced by the increasing influence of lobbies, as analysed by Ayberk and Schenker[412], which tend to use but also be used by the European Union institutions to either influence Member States or increase its own influence.

As already explained the rise of regional public goods and their substitution to some global public goods[413], as can be health in Europe, also favours the geopoliticisation of health. Regarding the European Union, it appears that it also incentives States to strengthen their influence on global health governance through the EU[414], and strengthen the influence of the EU itself. Indeed, the European Union has proven to have a threefold advantage by being able

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[408] Europeanisation is here understood as a phenomenon, a process leading to some sort of uniformisation of practices, understandings, policies and behaviours within the European Union.

[409] Sébastien Guigner, "L'influence de l'Union Européenne sur les pratiques et politiques de santé publique : européanisation verticale et horizontale", *Sciences sociales et santé*, Vol. 29 (1), John Libbey Eurotext, London, March 2011, p.83

[410] Ibid, p.94

[411] European Union, "*Règlement (UE) N° 282/2014 du Parlement Européen et du Conseil du 11 mars 2014 portant établissement d'un troisième programme d'action de l'Union dans le domaine de la santé (2014-2020) et abrogeant la décision n° 1350/2007/CE"*, European Union, Bruxelles, March 11th 2014

[412] Ural Ayberk, François-Pierre Schenker, "Des lobbies européens entre pluralisme et clientélisme", *Revue française de science politique*, Vol. 48 (6), Presses de la Fondation nationale des sciences politiques, Paris, December 1998, p.726

[413] David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.118

[414] Sébastien Guigner, Ibid, p.103

to push Member States for effective coordination, give voice to smaller States and being considered as a stable and reliable partner[415]. Furthermore, the Union has a competitive advantage regarding global health governance based on its regulatory experience and, according to Emmerling and Heydemann, a rights-based approach[416] that allows it to gain some trust within multilateral arenas. This last point, has however to be nuanced, as it is showed here the importance of a coherent and geopolitical approach to health governance. Nonetheless, such approach enables to understand to role and opportunity for the European Union of global public goods.

II.II. Global Public Goods and their opportunity for Europe's global influence

If States are using the European Union as a geopolitical springboard, and especially within the frame of global health governance, they can constitutes resistant obstacles to the unfoldment of the Union global influence or even regional role. Nonetheless, scholars have demonstrated that the tensions created by Member States and their opposition to European initiatives are mostly contextual[417]. In fact and more particularly regarding health governance, governments refusal to concede powers to Bruxelles depends on a specific contexts. Therefore States contemporary reluctances towards a European health can be compared to the white pools that failed in the 1950s due to changing regional and national contexts. This is why European States opposition to the Union "should be questioned and not established"[418]. On the contrary, it appears crucial to stress the dialogue between the EU level and the States level which led, thanks to the EU institutions efforts to create a European health, to a public health's revalorisation[419].

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415 Thea Emmerling, Julia Heydemann, *The EU as an Actor in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.237

416 Ibid, p.238

417 Alban Davesne, Sébastien Guigner, "La Communauté Européenne de la santé (1952-1954), *Politique européenne*, Vol. 41, L'Harmattan, Paris, 2013/3, p.60

418 Ibid

419 Sébastien Guigner, "L'influence de l'Union Européenne sur les pratiques et politiques de santé publique : européanisation verticale et horizontale", *Sciences sociales et santé*, Vol. 29 (1), John Libbey Eurotext, London, March 2011, p.82

Indeed, EU institutions have proven to be crucial to the rise of a European health through the global public goods approach and a more indirect approach via health-related fields. As explained by Emmerling and Heydemann the European Commission and Parliament have been among the most important actors in strengthening EU health actions as well as the European Court of Justice which strengthened EU prerogatives through cases law[420]. In addition, and above all, relying on a global public good approach, the EU favoured projects to improve scientific research with the Research Framework Program, tackle neglected tropical diseases and assess health security issues thanks to the Global Health Security Initiative[421]. To that end, and in order to enforce their efficiency and legitimacy to act, EU institutions draw a strategy for 2014-2020 which focuses on health equalities and improvements[422].

Thus, basing its ability and legitimacy to act on global and regional public goods and a rights-based approach, the European Union unfolded its influence and the one of its Member States. As a consequence, going back to Gleicher and Kaul's idea that the world is divided into "policy-setting" and "policy-taking" nations[423], it can be argued that the EU has become a policy-setting agent of global health governance. By signing treating and unfolding its normative instruments the European Union, as the WHO has been able to do within global health governance through its Constitution[424], has been able to increase its influence within both European and global health governances. The impact for States and especially for Italy and France has been an increasing influence on both spheres, even if Rome and above all Paris tend to uphold their national influence in these transnational spheres. In other words, public health constitutes a geopolitical springboard for France and Italy, but also for the European Union itself. Such phenomenon can be largely but exclusively explained by public health status, between apoliticisation and high-politicisation.

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420 Thea Emmerling, Julia Heydemann, *The EU as an Actor in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.225

421 Ibid, p.236

422 European Union, "*Règlement (UE) N° 282/2014 du Parlement Européen et du Conseil du 11 mars 2014 portant établissement d'un troisième programme d'action de l'Union dans le domaine de la santé (2014-2020) et abrogeant la décision n° 1350/2007/CE"*, European Union, Bruxelles, March 11th 2014

423 David Gleicher, Inge Kaul, *New Diplomacy for Health: A Global Public Goods Perspective,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.117

424 Steven Solomon, *Instruments of Global Health Governance at the World Health Organization,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.188

III. Public health, between apoliticisation and high-politicisation

As explained by Taraneh Shojaei, but also by a historic perspective of public health in foreign policies, this field of international relations retain a special status. More than a low-politic element, public health has proven to be contemporarily apoliticised (III.I) and hyper politicised (III.II)

III.I. Apoliticisation, from obstacle to opportunity

In a conference at LUISS University on March 2019 Giuseppe Conte, Italy's President of the Council, declared that the issues known by the Italian sanitary system can be explained by the preemption of politics on managerial forces in this field[425]. Regarding France, Tabuteau explains that the relations between health and politics always had and still have a significant backwardness mainly due to an historic opposition between doctors and the State[426]. This two example show that health has always been and remains seen as a technical field where politics should interfere. In fact both of the case studies have historically failed in building a real public health culture, letting health professional corps organising it rather than public authorities[427]. Such apoliticisation led to lack of policy coherence, accrued by the multiplication of health-related international fora, and a lack of national policy coordination[428]. In this regards, Foucault wrote about a State autolimitation to the benefit of the political economy rather that the law[429]. Going further, at the occasion of its lectures *Naissance de la biopolitique* at the *Collège de France*, Foucault recalls Hayek's thesis and states that the State doesn't have the cognitive means to efficiently intervene on the market economy[430] related to biopolitics.

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[425] Giuseppe Conte, Rome, March 20th 2019

[426] Didier Tabuteau, "Santé et politique en France", *Recherche en soins infirmiers,* Vol. 109, ARSI, Paris, 2012,p. 6

[427] Ibid, p.8

[428] Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.281

[429] Jean-Yves Grenier, André Orléan, "Michel Foucault, l'économie politique et le libéralisme", *Annales. Histoire, Sciences Sociales*, Editions de l'EHESS, Paris, 2007/5, p.1158

[430] Ibid, p.1169

In other words, health's apoliticisation has therefore constituted an obstacle to the State intervention and unfoldment of health governance, and to health's recognition as a potential power source. In addition, as it has already been underlined, the right-based approach to health[431] and the so called "growing consciousness of a global responsibility for global health"[432], have undermined States' intervention in health governance and reduced health to low politics. Nonetheless health apoliticisation allowed, yet has been reduced by, a securitisation approach[433]. Yet if such approach brought the State within health governance, security concerns and framing being political[434], it has done so without unfolding health's power potential.

However, with the rising importance of health in global governance, and because health rose through securitisation, its appearing apoliticisation allowed the unfoldment of national interests and so political agendas[435]. Indeed as explained by Harley Feldbaum, "nations filter global health through the lens of their own interests, a process that creates both synergies and conflicts between global health and states' interests"[436]. In fact securitisation, prioritisation and framing have shaped States interests on global health[437] to the unfoldment of more powerful States interest. Stopping on frames, it appears that framing favoured global collective action[438] because of their apparent apoliticisation. Four main frames have been used, the biomedical frame, the rights frame, the economic frame and the security frame[439], and are all characterised by an apparent apoliticisation but constituted an opportunity for health to be recognised as power source. The example given by Mrs Shojaei, when France

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431 Wolfgang Hein, *Governance and Actors in Global Health Diplomacy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.73

432 Ibid, p.72

433 Colin McInnes, *National Security and Global Health Governance,* in Kay Adrian, Williams Owain David, "Global Health Governance. Crisis, Institutions and Political Economy", *Palgrave Macmillan*, London, 2009, p. 44

434 Ibid, p.53

435 Harley Feldbaum, *Global Health in International Politics,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.132

436 Ibid

437 Ibid, p.136

438 Colin McInnes, Roemer-Mahler Anne, "From security to risk: reframing global health threats", *International Affairs*, N° 93, Oxford University Press, Oxford, 2017, p.1327

439 Ibid, p.1330

tries to improve the rights of young girls in Africa through the development of sanitary programs regarding sexual health[440], shows that health apoliticisation through biomedical frame can be used as an instrument for influence.

Thus health apoliticisation constitutes both an obstacle and an opportunity, but more importantly, it can be explained by the socio-political role of health and biopolitics. Indeed, as demonstrated by Foucault and its french-speaking disciples, the emergence of biopolitics is the emergence of the mercantilist model and contemporary governmental rationality[441]. Within this dynamic, the policy will increasingly establish the link between citizens life, and State power[442], biopolitics constituting the extension of disciplinary methods in the liberal art of government[443]. Therefore health through biopolitics constitutes a powerful factor for State legitimacy placing it however above politics[444].

III.II. High politicisation, from opportunity to obstacle

Despite such apparent apoliticisation; health became, especially since the 1990s, more politically relevant in both domestic and foreign policies[445]. This dynamic also introduced a change in the relationship between health and diplomacy[446], which has been a catharsis to the advancement of perceived national interests in global health governance. Nonetheless the political *bagage* of health, because health constitutes a source of State legitimacy, can be traced at least to the beginning of the modern era and the rise of the modern State[447]. Indeed

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[440] Taraneh Shojaei, Paris, May 24th 2019

[441] Alexandre Macmillan, "La biopolitique et le dressage des populations", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.48

[442] Ibid, p.47

[443] Ibid, p.53

[444] Carole Clavier, "La santé publique, un enjeu politique local ? La politisation des politique publiques en France et au Danemark", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/4, p.13

[445] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.12

[446] Ibid

[447] It is here made reference to the Westphalian treaties of 1648, the English and the French civil wars.

Foucault explained that after the French revolution, the first task of the medical corps is the war against bad governments, governments that prevent peoples from being free, and so is fundamentally political[448]. Institutionalisation and publication of health within the frame of the modern State resulted in health politicisation and socialisation[449]. Going farther by recalling both Foucault and Illich, Bleakley and Bligh show that these phenomena led to the idea that "disease(s) must not only be mapped but also conquered, where the birth of the clinic aligns with the "medicalization of industrial society" to bring "its imperialistic character to ultimate fruition""[450].

Thus within this frame that shaped public health institutionalisation and construction, or in other words biopolitics, health has been a powerful instrument of State legitimacy and national control in a first time, and colonisation justification in a second time. Health politicisation indeed played a key role in colonisation processes[451] and constituted of an opportunity for imperialist States. Nowadays these dynamics drastically reduced in importance, yet health politicisation remained. This has consequences on aid receiving States even when the aid giving agent is not actively developing such strategy; agents giving aid and funds influencing above their will the way in which receiving agents are structured to receive such aid[452]. On a national scale, health high politicisation has regularly been seen by politicians and State institutions as a way to foster other interests, such as governments legitimacy or enhance a particular image. It is for example as no surprise that French President Emmanuel Macron, elected in 2017 with a political project based on France profound reforms and renewed dynamics, intended in 2018 to reform the French health system and enforce new turning points[453].

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448 Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, p.59

449 Ibid, p.55

450 Alan Bleakley, John Bligh, "Who Can Resist Foucault? ", *Journal of Medicine and Philosophy*, Vol. 34, Oxford University Press, Oxford, June 2009, p.372

451 Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.277

452 Christine Berling, Paris, April 25th 2019

453 AFP Agence, "Numerus clausus, assistants médicaux… Ce qu'il faut retenir du plan santé d'Emmanuel Macron", *Le Figaro,* September 18th 2018

However, health high politicisation also constituted a powerful obstacle to health's recognition as a power source. Indeed, as explained by Tabuteau, because science can track the cause and solution of sanitary risks, the State has the responsibility of treating such risks before they happen[454]. This led in France and Italy to the multiplication of sanitary reforms and health institutionalisation failures or at best partially realised[455]. Above the complexity of such reforms, and the necessary dissatisfaction of either the population or health workers corporations, their failures can be explained by external and national factors. Indeed, Rose and Robertson have shown that political factors are deeply affecting the way in which public policies are borrowed from other countries[456]. But more importantly, Federico Toth explains that "the ideological leaning of the governments in power may play an important role in affecting the content of healthcare reforms"[457]. This is why for example, the two parties forming the current Italian government being ideologically very distant, it is most probable that few will be done regarding health under Giuseppe Conte's government[458]. On the international stage, health high politicisation led to divergent interests with regard to global health issues, best showed by the tensions on intellectual property regarding pharmaceuticals[459]. Health inequalities and divergent interests have therefore created heated tensions between international agents that reduced agents' ability and willingness to unfold health governance's power capital. Moreover these dynamics and inequalities combined to the difficulty of protecting peoples health through the management of transnational and national sanitary risks, allowed the rise of contestations[460].

Thus public health, swinging between apoliticisation and high-politicisation, and so between opportunities and obstacles, remains an unexploited potential for French, Italian and European power. Health requires a certain degree of politicisation, but in this case constitute a high

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454 Didier Tabuteau, "Santé et politique en France", *Recherche en soins infirmiers,* Vol.109, ARSI, Paris, 2012, p. 13

455 Ibid

456 Federico Toth, "Healthcare policies over the last 20 years: Reforms and counter-reforms", *Health Policy*, N° 95, Elsevier, Shannon, 2010, p.87

457 Ibid

458 Federico Toth, Bologna, March 20th 2019

459 Harley Feldbaum, *Global Health in International Politics,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.140

460 Colin McInnes, Roemer-Mahler Anne, "From security to risk: reframing global health threats", *International Affairs*, N° 93, Oxford University Press, Oxford, 2017, p.1335

potential for regional and global powers; yet unexploited because of unstable political involvement towards an ambitious global health strategy.

Chapter VI: The unstable political involvement toward global health strategy as the main obstacle

Indeed, no States have by far developed an ambitious and constant power strategy regarding regional and global health governance. France and Italy have neglected this political capital (I), going back and forth in this field (II) due to high uncertainties regarding a European biogeopolitics (III).

I. France and Italy, or the negligence of a political capital

Both Paris and Rome never truly looked at health governance as a power potential and therefore developed a consistent strategy. Rome's attitude can be explained by the Italian structural instability (I.I), meanwhile Paris behaviour can be explained by a perennial undervaluation (I.II).

I.I. Structural instability as an Italian weakness

After campaigning against vaccines and children's vaccination, Paola Taverna, the current Italian Senate Vice-President, announced in September 2018 that she vaccinated her son after having been properly informed on the subject. She also stated leaving the no-vax movement and trusting the Health Minister on the matter[461]. Furthermore, Mrs Taverna explained that the position of her party, the Five Stars Movement, is not against vaccination but against its obligation[462]. In fact, Europe is acknowledging for about a decade an outbreak of measles[463] directly due to the reduction of vaccination coverage and the growing mistrust against vaccines. In terms of total cases per million of inhabitants between July 2017 and August 2018, Italy was the third most impacted country with about a rate of 55,1, behind Romania

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461 Anonymous, "Vaccini, Paola Taverna (M5S) fa retromarcia: "Non ne parlerò più, ho immunizzato mio figlio"", *Il Corriere della Sera* , September 15th 2018

462 Ibid

463 European Center for Disease Prevention and Control, *« Monthly measles and rubella monitoring report »*, European Center for Disease Prevention and Control, Stockholm, August 2018, p.1

(68,9) and Greece (296,5), and before France (40,9)[464]. Within this context, the Renzi government, under the leadership of the Health Minister Lorenzin, introduced a bill to constrain Italian citizens to vaccinate themselves. However Conte's government Health Minister, Giulia Grillo, proposed a bill to reform the Lorenzin decree, making vaccination mandatory in territories, regions and cities where the vaccine coverage is lower or where there is an epidemic[465]. On this matter, the Five Stars Movement argues that by constraining citizens, the Lorenzin decree does not assess the roots of the lack of vaccinations, and so is undermining WHO's recommendations on the subject[466].

Focusing on this example and on the current Italian situation, is to underline the main obstacle to the assessment of health as a power capital, and as it is specially the case in Italy: a lack of coherence due to a structural political instability. Indeed, this instability resorts to a longterm crisis of the Italian democracy[467], and has only been tempered either by charismatic leaders or experts government. Mario Monti's government is as such an example of a technical government seen as a government independent from parties, a government of numbers and objectivity[468] that nevertheless failed in keeping itself into power. The current challenge faced by global and regional health governances is States' lack of coherence in policy, actions and financial sustainability[469]. This dynamic is unfortunately combined in Italy to a political instability, despite a cohabitation between systemic and thematic related parliamentary oppositions[470], and makes this challenge even more acute.

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[464] European Center for Disease Prevention and Control, *« Monthly measles and rubella monitoring report »*, European Center for Disease Prevention and Control, Stockholm, August 2018, p.3

[465] Anonymous, "Il ministro Grillo tira dritto sui vaccini: "Depositata proposta di legge per obbligo flessibile"", *Huffington Post Italia*, August 9th 2018

[466] Monica Guerzoni, "Vaccini, la ministra Grillo: «L'obbligo rimane per tutti ma la coercizione non può essere l'unico strumento»", *Il Corriere della Sera*, August 7th 2018

[467] Ortoleva Peppino, "Qu'est-ce qu'un gouvernement d'experts ? Le cas italien", *Hermès, La Revue*, N° 64, C.N.R.S. Editions, Paris, 2012/3, p.143

[468] Ibid, p.138

[469] Ilona Kickbush, *21st Century Health Diplomacy: A New Relationship Between Foreign Policy and Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.30

[470] Elisabetta De Giorgi, "L'opposition parlementaire en Italie et au Royaume-Unie : une opposition systémique ou axée sur les enjeux ?", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/2, p.113

Nonetheless, the Italian structural instability towards health governance should not be reduced to the political arena, but also has to be linked to the sanitary system itself. With the economic crisis of 1992, and the Tangentopoli scandal, one of the first sector to see its budget reduced was the sanitary one[471]. More, due to this peculiar context[472], the Italian sanitary system has been drastically reformed with the aim of depoliticising it. In 1993 and by decrees, the sanitary system has been reformed on three main objectives that were privatisation, separation between suppliers and consumers and regionalisation[473]. These reforms led to a moderately integrated model[474], characterised for example by tendencies to affiliate insurers and providers with the same organisation, concentrating primary and secondary care and a limited patient's freedom of choice[475]. Amongst these dynamics, the regionalisation is the one that has had the most consequences. Indeed, even if such shift of jurisdiction from the centre to the regions is a European movement[476], Italy has been particularly concerned by it since the 1990s, to the point of speaking nowadays about a federalisation of the Italian sanitary system[477]. Yet this dynamics increased the gaps between northern and southern Italy[478], and created important inequalities towards health. In fact, four factors have been identified by Toth to explain such increase and the subsequent rise in out-of-pocket costs: categories of services are not or partially financed by the NHS, co-pay fees are charged to patients, the waiting time in public facilities and the possibility to choose practitioners without a special agreement of the NHS[479]. Such phenomenon created resentments and instabilities on a national level weakening the implementation of a constituent and ambitious power strategy towards health governance.

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471 Federico Toth, "La sanità in Italia", *Il Mulino*, Bologna, 2014, p.26

472 Ibid, p.25

473 Ibid, p.27

474 Federico Toth, "Integration vs separation in the provision of health care: 24 OECD countries compared", *Health Economics, Policy and Law*, Cambridge University Press, Cambridge, September 2018, p.10

475 Ibid, p.9

476 Federico Toth, "How health care regionalisation in Italy is widening the North–South gap", *Health Economics, Policy and Law*, Vol. 9 (3), Cambridge University Press, Cambridge, July 2014, p.231

477 Modesta Visca, Rome, July 24th 2019

478 Ibid, p.247

479 Federico Toth, "The Italian NHS, the Public/Private Sector. Mix and the Disparities in Access to Healthcare", *Glob Soc Welf*, N° 3, Springer International Publishing, New-York City, July 2016, p.175

I.II. Perennial undervaluation as a French weakness

Italy is therefore characterised by a structural instability as far as its political system is concerned. The French situation is different, the Vth Republic being characterised by a strong executive power and so greater stability. Yet France is not exempted of weaknesses and especially regarding health governance. The French view, if not excessive pride, of its sanitary system has already been explained, but it is important to recall that France can be described as a highly separated model[480]. On the opposite of the Italian one, the French sanitary system is based on the separation between insurers and providers, as well as between primary and secondary care providers, gatekeeping are mechanisms are of low and therefore the patient's freedom of choice is almost unlimited[481]. Moreover, and most probably because the sanitary system is paradoxically both an object of pride and seen as an economic burden, each government is tempted to reform it. The current government is not overpassing such tradition, President Emmanuel Macron calling in September 2018 for new turning points and deep reforms[482]. However, and this is typical of the French situation and its weakness, suggested reforms axis are more symbolic and politically ambitious than structurally impacting; the best example of such measures being the cancellation of the *numerus clausus* to access medicine studies[483]. Adopting a larger look, it appears that the Juppé Plan of 1996, implemented by the Jospin socialist government, has been the most ambitious reform attempt of the last decades[484]. This shows that despite its potential, France remains unable to reform its sanitary system through the implementation of a new ambitious and structurally reforming strategy.

In other words, France appears to undervalue both and paradoxically the need to structurally reform its sanitary system and unfold its power potential regarding regional and global health governance. This attitude can be explained by a strong sanctuarisation of the sanitary system itself[485], which led to first a separation between public health policies and sanitary insurance

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480 Federico Toth, "Integration vs separation in the provision of health care: 24 OECD countries compared", *Health Economics, Policy and Law*, Cambridge University Press, Cambridge, September 2018, p.10

481 Ibid, p.9

482 AFP Agence, "Numerus clausus, assistants médicaux… Ce qu'il faut retenir du plan santé d'Emmanuel Macron", *Le Figaro,* September 18th 2018

483 Ibid

484 Federico Toth, "Healthcare policies over the last 20 years: Reforms and counter-reforms", *Health Policy*, N° 95, Elsevier, Shannon, 2010, p.88

485 Didier Tabuteau, "Santé et politique en France", *Recherche en soins infirmiers,*Vol.109, ARSI, Paris, 2012,p.9

policies, and second to the erection of professional walls by doctors corporations[486]. These phenomena, even if their influence has been reduced in the last decade, contribute to the lack of coherence among multilevel health actors, which has been identified as crucial by Silberschmidt and Zeltner with regard to global health governance[487].

In other words, it appears that if France tries to develop required and effective tools to assess health governance, it then never includes them in a major, longterm and ambitious strategy of power through health. The example of the newly created Biomedicine Agency underlines this trend, as it will have, in the words of the Ministry of Health itself, a more modest role than other agencies[488]. In a similar understanding, the annual reports of the General Direction for Health for 2016[489] and 2017[490] lay their emphasis, as far as international relations are concerned, almost exclusively on the prevention, and the International Health Regulations implementation. Such tendency also led to the multiplication of microprojects by public and private institutions[491] as well as the inability of the Ministry of Health to answer queries and calls for cooperation from other States[492] that would help France to strengthen its image and unfold its influence. It is therefore as no surprise that agents inside and outside the Ministry of Health and other health-related institutions are calling for greater economic and political investments regarding health governance[493]. Indeed and in a sentence, France is undervaluing health as a potential for power, and remains reluctant to make (geo)political investments.

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[486] Didier Tabuteau, "Santé et politique en France", *Recherche en soins infirmiers,*Vol.109, ARSI,Paris,2012,p.10

[487] Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.293

[488] Anne Courrèges Anne, "L'Agence de la biomedicine et de la sécurité sanitaire" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.47

[489] Direction Générale de la Santé, "*Rapport d'activité 2016"*, Ministère des Solidarités et de la Santé, Paris, November 2017, p.3

[490] Direction Générale de la Santé, "*Rapport d'activité 2017"*, Ministère des Solidarités et de la Santé, Paris, November 2018, p.3

[491] Laëticia Atlani-Duault, Jean-Pierre Dozon, "Colonisation, développement, aide humanitaire. Pour une anthropologie de l'aide internationale", *Ethnologie française*, Vol. 41, Presses Universitaires de France, Paris, 2011/3, p.400

[492] Christine Berling, Paris, April 25th 2019

[493] Laurence Caté, Périnne Ramé-Mathieu, "Investir dans la promotion de la santé et la prévention" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.12

II. France, Italy and the EU, between back and forth

Therefore both France and Italy are neglecting a power capital either because of a structural instability of undervaluation. As a consequence, Paris, Rome and so Bruxelles are going back and forth to recognise health power potential; swinging between the recognition of global public health importance (II.I), and its consideration as a margin for adjustments (II.II).

II.I. France, Italy, the EU and recognition of Global Public Health importance

Despite their weaknesses in unfolding health governance power capital, France, Italy and so the European Union have assessed the importance of health governance. On the national scales, France developed ambitious plans regarding its sanitary system. President Emmanuel Macron wished to make health one of the main pillars of the welfare State for the decades to come[494]. Paris also wants its sanitary expansion, Prof. Salomon speaking of showing that France has the capacities to innovate in this field[495]. Similarly, Rome is also developing tools and strategies regarding health governance, to better and systematically monitor the diseases[496] and reduce inequalities[497]. Thirdly and as it has already been underlined, the EU itself recognised health governance importance through the publication by the European Commission of White Papers on health since 2007[498]. The European Union position on health governance and especially its enhancement of global health governance cruciality is of importance as it pushes Member States to act accordingly. Indeed, scholars showed that the European Strategy for Sustainable Development adopted in June 2006 directly influenced the

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494 AFP Agence, "Numerus clausus, assistants médicaux… Ce qu'il faut retenir du plan santé d'Emmanuel Macron", *Le Figaro,* September 18th 2018

495 Jérôme Salomon, *Rencontres de Santé publique France*, Paris, May 29th 2018

496 Monica Guerzoni, "Vaccini, la ministra Grillo: «L'obbligo rimane per tutti ma la coercizione non può essere l'unico strumento»", *Il Corriere della Sera*, August 7th 2018

497 Modesta Visca, Rome, July 24th 2019

498 Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.289

economic plan 2007-2011 of the Prodi government, which has been based on sustainable development and public health challenges[499].

Furthermore, if health "with its ethical basis in social justice and human rights, has actually been perceived as a barrier to rather than as a basis for the making of foreign policy"[500], France, Italy and the European Commission recognised the potential of influence given by public health in foreign policies. This is therefore of no surprise that diplomats have been seconded by technical experts[501] within health governance negotiations, and especially within the European health governance framework[502] where experts have the ascendence on diplomats. Evidently such dynamic in the European sphere has also been strengthened by the rising influence of lobbies[503], either public or private, within the European institutions. Yet public agents in Europe have been prompt to assess the importance of health governance and the power capital that lies beyond public health in foreign policies. The European Union recognition process of global public health importance is to that end highlighting. Indeed, EU institutions tried to progressively act on health governance through indirect legislations such as food safety or animal health from 1999[504]. In this regards and gradually, Bruxelles strengthened global health diplomacy to enhance its powers on European public health[505].

As a consequence, France, Italy and the European Union itself have been particularly active with regard to the TRIPS agreements[506] and the protection of pharmaceutical industries

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499 Xavier Lallemand, Arnaud Leconte, "Italie - Une analyse du discours sur le développement durable", *L'Europe en Formation*, N° 352, Centre international de formation européenne, Nice, 2009/2, p.88

500 Santiago Alcázar, Paulo Buss, *Health is an Integral Part of Foreign Policy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.155

501 Kelley Lee, *Key Factors in Negotiations for Health,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.257

502 Christin Berling, Paris, April 25th 2019

503 Ural Ayberk, François-Pierre Schenker, "Des lobbies européens entre pluralisme et clientélisme", *Revue française de science politique*, Vol. 48 (6), Presses de la Fondation nationale des sciences politiques, Paris, December 1998, p.725

504 Thea Emmerling, Julia Heydemann, *The EU as an Actor in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.232

505 Ibid, p.234

506 Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.277

against generic medicines on both the global and the national stages[507]. Furthermore, it appears that such phenomenon, the gradual recognition of health governance importance and public health power capital, is to be linked with the increasing influence and role that has biopolitics and above biopower in contemporary societies; understood as the development of a larger governmental problematic[508] referring to the biological properties of the individuals as member of a more and more global society. Nevertheless, and precisely because biopower is part of a larger governmental problematic, public health appears often to be a governmental margin for adjustments.

II.II. Public Health as a margin for adjustments

Speaking at LUISS University in March 2019, the Italian Prime Minister Giuseppe Conte condemned the intervention of politics on health systems and affirmed that if the current government has not planned major reforms it at least has not reduced health budgets[509]. Despite the political view ones can have on such affirmations, they show that governments in recent years and not only in Italy have been reducing frequently budgets for health related politics and systems. In fact, while political, economic, social and geopolitical developments and dynamics "reflect what health experts have advocated as "health in all policies," they also reflect a growing need for policy coherence across government agencies"[510]. Moreover, and furthermore, the lack of internal coherence and the subsequent defence within international fora by different institutions of a same State[511] show that health has been considered as at best an interesting field of low politics, and at worst a simple margin for budget and political adjustments.

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[507] Blandine Juillard-Condat, Willy Thao Khamsing, "Comparaison des ventes de médicaments antihypertenseurs dans cinq pays européens en 2009", *Revue française des affaires sociales*, La Documentation française, Paris, 2013/3, p.101

[508] Michael Dillon, "Gouvernement, économie et biopolitique", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.37

[509] Giuseppe Conte, Rome, March 20th 2019

[510] Gaudenz Silberschmidt, Thomas Zeltner, *Global Health Begins at Home: Policy Coherence,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.281

[511] Ibid

It came therefore as no surprise that the Italian government decentralised the sanitary system with the primary objective of reducing health spendings[512]. A similar trend can also be identified in France. In addition, both scholars and political agents themselves have declared that the cost-effectiveness factors is determinant in the choice made on including or not a health-related service in the national catalogue of reimbursed sanitary services[513]. Both of these trends underline the remaining vision of as a margin for budgetary or political adjustments. Moreover, this consideration leads to the denial of health and its governance as a power capital; explaining the back and forth behaviour of some States such as France and Italy. Indeed, Toth brilliantly noted that without denying the path dependence theory it is key to acknowledge that policy processes regarding health are not linear[514]. Rather, that they "evolve through reforms and counter-reforms"[515].

In other words, it appears that the introduction of the economy in health has allowed the control of the State on it, but contemporarily reduced the vision of health as a potential for power. Foucault theorised that the main issue of the modern government is the introduction of the economy in the political practice[516] and art of governing. In Foucault's words, biopolitics therefore has been a mean to unfold the governing and economic arts of the modern States[517]. As a consequence of such dynamic during the formation of the modern State itself, biopolitics appears fundamentally linked to the economy's introduction into the liberal art of governing. This in turns can partially explain the remaining view of health governance as a margin of adjustments, but also a crucial opportunity for States such as France and Italy. Nonetheless, the unstable political involvement toward global health governance, has also to be explained by the uncertainties surrounding European biogeopolitics.

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512 Amalia Diurni, "Les systèmes de santé en Italie et en Espagne", *Les Tribunes de la Santé*, Vol 51, Presses de Sciences Po, Paris, 2016, p.35

513 Marcial Velasco-Garrido & al., "Description des paniers de soins dans neuf pays de l'Union Européenne", *Revue française des affaires sociales*, La Documentation française, Paris, 2006/2, p.87

514 Federico Toth, "Healthcare policies over the last 20 years: Reforms and counter-reforms", *Health Policy*, N° 95, Elsevier, Shannon, 2010, p.88

515 Ibid

516 Michael Dillon, "Gouvernement, économie et biopolitique", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.30

517 Ibid, p.33

III. The late 2010's, as a decade of uncertainties for a European biogeopolitics

The last decade shows that combined to the negligence of health power capital and the back and forth attitude developed by France and Italy regarding health governance, European biogeopolitics are characterised by high uncertainties; going from initiatives to either actions (III.I) or electoral uncertainties (III.II).

III.I. The late 2010's, from initiatives to actions

The problematic increase in the number of mandatory vaccines in Italy in 2017 has already been recalled to show that Rome is often going back and forth regarding health initiatives. Yet it is important to note that despite the modifications of the Lorenzin Bill by Conte's government, the mandatory vaccines remained in place[518]. As small as such policy can appear, they in reality tend to constitute the basis for the unfoldment of both national and regional health governance. Indeed, Federico Toth[519] and Christine Berling[520], talking about mandatory vaccines policies in Europe, stress the cruciality of the Lorenzin Bill, as others, in the multiplication of similar laws' implementation in Europe, and in the increase of the European Commission interest. In fact European States, and first of all France and Italy, have been key in developing national, regional and global actions to strengthen public health and favour health governance.

Both States are simultaneously adopting national and international strategies to implement actions that would favour their control or legitimacy on a national scale as well as their influence within international fora. In this regard, the Italian Ministry of Health defined health services catalogues to ensure the equity among its regions[521] and implemented a strong cooperation on health between the State and the regions through the State-regions

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[518] Monica Guerzoni, "Vaccini, la ministra Grillo: «L'obbligo rimane per tutti ma la coercizione non può essere l'unico strumento»", *Il Corriere della Sera*, August 7th 2018

[519] Federico Toth, Bologna, March 20th 2019

[520] Christine Berling, Paris, April 25th 2019

[521] Marcial Velasco-Garrido & al., "Description des paniers de soins dans neuf pays de l'Union Européenne", *Revue française des affaires sociales*, La Documentation française, Paris, 2006/2, p.88

conference[522]. A similar willingness, of reducing inequities toward health, can be seen in the French strategy[523]. Moreover, while Italy is focusing on its decentralisation, France is rebuilding the State importance in public health by progressively implementing what scholars called the "New public health" through legislative innovations such as the law on public health of 2004[524]. Thus both Rome and Paris appear to have a willingness of fostering their attractiveness to foreign investments in health-related fields[525]. It is therefore no surprise that Paris is actively promoting the mutation of the WHO office in Lyon into the WHO Academy[526] as it would greatly enhance Lyon as a European and global biopole, and favour the French and European influence in global health governance. To that end is also to be understand the increased multilateral cooperation regarding health governance[527].

On the international stage, France and Italy have also, either through the European Union or their own channels, been proactive to strengthen public health and health governance. The Paris Declaration referring to the issues inherent to global health governance[528] is an example of such actions that would simultaneously foster signatories' legitimacy in health governance and advances signatories' interests in global health. Another example of Paris, Rome and Bruxelles activisms in international arenas is their role in the TRIPS negotiations on pharmaceuticals[529]; which also revealed themselves to be a powerful mean of developing States resources control[530]. Moreover France and Italy's role in the creation and enhancement of health-related international institutions such as the GAVI or UNAIDS[531] shows that States

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[522] Modesta Visca, Rome, July 24th 2019

[523] Christine Berling, Paris, April 25th 2019

[524] Henri Bergeron, Constance Nathanson, "Faire une loi, pour faire la loi. La loi de santé publique d'août 2004", *Sciences sociales et santé*, Vol. 32, John Libbey Eurotext, London, 2014/4, p.26

[525] AFP Agence, "Le gouvernement dévoile des mesures pour doper l'attractivité de la France en santé", *Le Point*, July 10th 2018

[526] Taraneh Shojaei, Paris, May 24th 2019

[527] Anonymous, *« Sommet Franco-Italien »*, Présidence de la République française, Lyon, September 27th 2017, p.25

[528] Wolfgang Hein, *Governance and Actors in Global Health Diplomacy,* in Kickbush Ilona, Novotny Thomas, Told Michaela, "21st Century Global Health Diplomacy", *World Scientific,* Singapore, 2013, p.86

[529] Marc Dixneuf, "Au-delà de la santé publique : les médicaments génériques entre perturbation et contrôle de la politique mondiale", *Revue française de science politique*, Vol. 53, Presses de Sciences Po, Paris, 2003/2, p.302

[530] Ibid

[531] Marc Gentilini, *Préambule. La santé sera mondiale ou ne sera pas*, in Kereoudan Dominique, "Santé Internationale", *Presses de Sciences Po,* Paris, 2011, p.13

actions can, if integrated in a strategy for power, lead to the transformation of public health as a power potential into a power capital. Furthermore such institutions became influential agents on the international stage. The influence of the G8 and G20 are in this regard key on global health governance either to mobilise collective responses[532] and foster States agendas[533]. However if some initiatives led to concrete actions, many of them have been undermined by electoral uncertainties and the lack of longterm political power.

III.II. The late 2010's, from initiatives to electoral uncertainties

Despite the undertaken initiatives and implemented actions, one should not assume that health governance, and its power potential, has been properly assessed by France and Italy. Indeed, the best example being the dramatic and from another time measles outbreak[534], both countries have suffered from a lack of political involvement in an ambitious, transnational and longterm strategy toward health and its governance. Moreover, as far as European sanitary systems are concerned, the slight strategies that had already been enhanced have been greatly undermined by the increase in health spendings; which led to growing contradictions between the sanitary system objectives and the willingness to reduce sanitary costs[535]. In this regards and even more for health governance, electoral outcomes, because they led to the implementation or the reform if implemented strategies, have been crucial in the development of national and global actions regarding global public health[536]. A recent example is the nomination of an almost entirely new *Consiglio Superiore della Sanità* by the Italian Health Minister shortly after her own nomination[537]. Indeed such political move is typical from spoil

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[532] Andrew Cooper, *The G8/G20 and Global Health Governance: Extended Fragmentation or a New Hub of Coordination,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.249

[533] Christine Berling, Paris, April 25th 2019

[534] European Center for Disease Prevention and Control, *« Monthly measles and rubella monitoring report »*, European Center for Disease Prevention and Control, Stockholm, August 2018, p.1

[535] Marcial Velasco-Garrido & al., "Description des paniers de soins dans neuf pays de l'Union Européenne", *Revue française des affaires sociales*, La Documentation française, Paris, 2006/2, p.63

[536] David Gleicher, Yan Guo, Priyanka Kanth, *National Strategies for Global Health,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.302

[537] Redazione Ansa, "Grillo nomina il nuovo Consiglio Superiore di Sanità, due conferme e meno donne", *ANSA*, February 5th 2019

system behaviours[538] and usefully undermine strategies that, as it has already been underlined, require stability.

In addition political and more specifically parliamentary oppositions and *alternance* have also proven to be factors of health governance strategies destabilisations. If an opposition based on stakes and a systemic opposition are coexisting in Italy[539], political oppositions have prevented in both Italy and France the implementation of efficient strategies and actions to assess global health governance. This has been seen through both direct, preventing the departure from the status quo, and indirect, by requiring too much political investments to depart from the status quo, roles undertaken by the oppositions. As a consequence since the 2000's sanitary reforms in France and Italy can be attributed to a combination of three main factors: the need to reduce sanitary costs, the citizen dissatisfaction and the increasing pressure of challenges[540]. The law of 2004 to reform the French sanitary reforms has, in this regard, been the object of a systemic competition between to vision of public health and State's role in public health governance[541]. Therefore, the rise of new political forces in both France and Italy and their influence on their national and international policies[542]

Furthermore, international politics being increasingly influenced[543] by intermestic issues such has global health[544] increased, with globalisation processes, the influence that public opinion

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538 Federico Toth, Bologna, March 20th 2019

539 Elisabetta De Giorgi, "L'opposition parlementaire en Italie et au Royaume-Unie : une opposition systémique ou axée sur les enjeux ?", *Revue internationale de politique comparée*, Vol. 18, De Boeck Supérieur, Paris, 2011/2, p.113

540 Federico Toth, "Healthcare policies over the last 20 years: Reforms and counter-reforms", *Health Policy*, N° 95, Elsevier, Shannon, 2010, p.87

541 Henri Bergeron, Constance Nathanson, "Faire une loi, pour faire la loi. La loi de santé publique d'août 2004", *Sciences sociales et santé*, Vol. 32, John Libbey Eurotext, London, 2014/4, p.21

542 Stefano Silvestri, "Italia e Francia: la debolezza fa la forza", ISPI, www.ispionline.it, consulted on March 2019

543 The term influenced is here preferred to the term driven as such analysis appears as an overstatement considering the current state of international affairs.

544 Douglas Foyle, "Public Opinion and Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, August 2017, p.16

can have on global affairs[545]. In that sense, the WHO's politicisation[546] has contributed to the reduction of effectiveness of some of its actions in public health governance. On the national level, this phenomenon is demonstrated by the evolution of experts government appreciation rates[547]. Thus the recent two last decades have seen the drawing of interesting strategies to assess the power capital of regional and global health governance in both France and Italy. Yet electoral instabilities and uncertainties reduced the impacts and overall efficiency of such initiatives; contributing to the back and forth attitude of Rome and Paris regarding global health governance, itself englobed in the French and Italian longterm negligence of health as a power capital.

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[545] Douglas Foyle, "Public Opinion and Foreign Policy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, August 2017, p.17

[546] Florian Kastler, "La mutation des institutions internationales en matière de santé", *Les Tribunes de la santé*, N° 51, Presses de Sciences Po, Paris, 2016/2, p.67

[547] Ortoleva Peppino, "Qu'est-ce qu'un gouvernement d'experts ? Le cas italien", *Hermès, La Revue*, N° 64, C.N.R.S. Editions, Paris, 2012/3, p.142

Conclusion

Health, public health, global health governance, health in foreign policies, these concepts rose in the last decades and especially since the 1990's as various forms of biopolitics' crystallisation. Health in social studies and more acutely health in international relations has yet been largely labelled and viewed as low politics. Even more, it would be argued that health in social sciences and international relations but also, and probably above all, in national and international politics, has been stringed to human rights and global justice theories. Such tendency, despite its brief fading during the era of health security prioritisation, importantly undermined the full assessment of public health and its governance realities. If the dominance of global justice and human rights scholars on international health affairs allowed the necessary improvement of global health determinants and favoured the growing importance of health in contemporary societies, it also on the short and long term damaged the unfoldment and understanding of health governance.

"Determinants of global health include a complex mix of biological, social, economic, political, environmental and security issues many of which, as Lee, describes are driven by aspects of globalisation"[548]. Indeed, global health as a fragmented definition and unfolds in a myriad of ways that are driven and drivers of globalisation. As such, global health appears to have, when distancing ourselves from the social studies and global justice approaches, a fundamental interplay with power and its unfoldment in the XXIst century. Foucault showed the growing importance of biopolitics in modern and contemporary societies. It has been demonstrated here that, taking a step forward from Foucault, contemporary global affairs are characterised by the rise of power sources which requires a moving and fluid understanding of power and its implementations. In this regards, public health can constitute a source of power for the most technologically advanced States such as the European ones, and more particularly France and Italy. The two sister countries are looking for renewed powers and influences on both the European and global stages. If Rome concentrates on being a regional power through a European influence, Paris seeks to be a global power through its perceived

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[548] Graham Lister, Michaela Told, *Current and Future Issues in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.28

status of European power. Yet if, as already said, one makes the effort of reconceptualising its understanding of power to asses its fluid and actor-specific origin, and an understanding of the geopolitical dimension of public health are undertaken, one can see that public health is, or can be, a new power source for France and Italy in the XXIst century; within the possibilities and limits drawn here.

In fine the core question of international relations' studies based on realism and constructivism is the question of power. Power as handled by the State because power precludes, conditions and legitimises the basic existence of the State itself. This thesis is fundamentally impregnated in realism and constructivism precisely because it lies on the idea of power ; studying it as many before have studied it, and as many after will study it. This thesis studies the State's desire, understanding and use of power in a highly competitive and power-creating domain of international relations; in this case, global public health. That's why, even if acknowledging the crucial role of institutions and non-State actors on global public health and international relations, it cannot be detached from a realist and constructivist's understanding of the world and international relations. It cannot be stretched-out from an understanding of the world and international relations with the State as the keystone of it, a keystone for which power is the mainly (if not only) object of attention and efforts; precisely because power is the only justification and resource for its existence.

Although power has been understood mainly through security/military dimension by realists and constructivists this thesis remains deeply rooted in these theories by opening up a new horizon to the study of power and security by realists and constructivists. A horizon lying on a reality: global public health is far more than people's wellbeing. But it has to be studied in international relations as a source of power in all its dimensions and an arena for competitiveness in broader agendas for both States and institutions but also megatrends. Understanding this, scholars and States would open up their understanding of international relations and the current world affairs and order. More specifically, for States, this would be a way to develop better strategies that would secure interests, and so provide power which sustains their proper existence.

Nonetheless, focusing too much on power itself would obscure the specificities of health governance. In this regards the adopted constructivist approach recalls that health issues are

perceived as global because of the material conditions interplayed with social construction phenomena[549]. Moreover, and according to McInnes, the social construction of health as global, and so shared, rose along and contemporarily nurtured material and non material conditions such as the interpretation by a global actor or group of actors of health issues as global and promoted as such[550]. Giving in this regards more room for power and biogeopolitics.

It may appear to the reader that this paper is focusing exclusively on power and reject any right or cooperation approach to health governance. Indeed, it is here argued that health governance and global public health can be new sources of geopolitical power and influence in the XXIst century for France and Italy. Moreover, it is also argued that the over-studied right based approach and above all global justice approach to health have been crooking the understanding of global health and appear at best preventing the assessment of health governance as a source of power, at worst dangerous to the improvement of people's health. Yet it is important to recall that health being and public good and requiring cooperation, Paris and Rome wouldn't succeed in transforming health power capital into effective influence without cooperating. It would even be argued that cooperation is one mandatory side of such process.

Within this context, many scholars suggested health governance forecasts. In this regards, Owain and Rushton drawn two main forecasts. The first theorises that because of geopolitical changes and financial crisis solving, health governance priorities, flux and challenges will be restructured[551]. The second forecast is that global health governance will be marked by elements of continuity[552]. Both of these forecasts are general and therefore could not be highly criticised. Indeed it appears highly probable that in the XXIst century global health governance will be characterised by elements of continuity but will also be affected by the moving power relations. It also appears that, unfortunately, neither France or Italy will, for the reasons previously detailed, fully and efficiently take health governance as a power

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549 Colin McInnes & al., "The Transformation of Global Health Governance", *Palgrave Macmillan*, New-York, 2014, p.97

550 Ibid, p.99

551 Simon Rushton, David Williams Owain, *The End of One Era and the Start of Another: Partnerships, Foundations and the Shifting Political Economy of Global Health*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.254

552 Ibid

opportunity. Yet, Owain and Rushton wrote that as priorities wax and wane, "the bigger surprise should be that (health governance) 'golden age' even came at all"[553]. Indeed, and it has largely been commented, health governance importance rose in the 1990's along with the dual basis that constituted human rights based philanthropism and biosecuritisation. However it would be argued here that the power potential of health governance and the search for power from France and Italy, once acknowledged and fully embraced by the two studied States, could impulse a new so-called "golden age". More, it would be argued here that above the fragile prediction of a past, present or future golden age, health governance *should* have a golden age in XXIst century.

Furthermore, if one relies on Castel's description of post-disciplinary societies[554], the consequent increase management of the population's health by the State rather than the clinic[555] should give increased opportunities for the State to handle health governance power capital. Such phenomenon had already been theorised by Foucault himself whom wrote about a progressive increase in individual bodies political control and populations' global management[556]. In addition, this trend known by health governance on national, regional and international levels, has been favoured by the copernican revolution - or profound change in the conceptual framework[557] - it has been engaged into since the 1970's.

Meanwhile many scholars are tempted to reduce health governance importance in contemporary politics, it appears important to acknowledge the longterm processes it embraces. It would be of a great mistake to break the link of global health governance, biogeopolitics and Foucault's biopolitics. This why, one could not but agree with Lister and

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553 Simon Rushton, David Williams Owain, *The End of One Era and the Start of Another: Partnerships, Foundations and the Shifting Political Economy of Global Health*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.267

554 Paul Rabinow, "L'artifice et les lumières : de la sociobiologie à la biosocialité", *Politix*, N° 90, De Boeck Supérieur, Paris, 2010/2, p.30

555 Ibid

556 Alexandre Macmillan, "La biopolitique et le dressage des populations", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.44

557 Santiago Alcázar, *The Copernican Revolution: The Changing Nature of the Relationship Between Foreign Policy and Health,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.324

Told that "global health diplomacy herald a major reform of global health governance"[558] to "provide multiple pathways through which the many different actors can exercise legitimate influence to achieve agreement on action for the common good"[559]. Regional and global health governance requires important reforms from States that can drawn and implement them, such as France and Italy could be with consistent and ambitious strategies that would not undermine health governance power potential. Evidently such reform calls for investments, but as stated by Perinne Ramé-Mathieu and Laurence Caté, these multidimensional investments are indispensable and demanding but are above all a collective stake[560].

In a sentence, quoting Dorothy Porter, the outcomes of the current health governance debates will depend on national and regional histories and cultures, international developments and political will[561]. France and Italy therefore have a great opportunity and responsibility in assessing health governance's power potential and drawing a subsequent foreign policy strategy, that Paris and Rome should recognise and blossom.

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[558] Graham Lister, Michaela Told, *Current and Future Issues in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.34

[559] Graham Lister, Michaela Told, *Current and Future Issues in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.34

[560] Laurence Caté, Perinne Ramé-Mathieu, "Investir dans la promotion de la santé et la prévention" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.12

[561] Dorothy Porter, "Health, Civilisation and the State. A history of public health from ancient to modern times", *Routledge,* London, 1999, p.319

Appendix

Appendix 1: Interview with Prof. Federico Toth

FEDERICO TOTH

Università di Bologna - Bologna - 20/03/2019 - 12PM-1PM

- *Brevemente, per iniziare con una domanda molto ampia, come potremmo definire l'ambito sanitario, e della salute, in Italia?*

È un settore molto rilevante dal punto di vista economico e sociale. Dal punto di vista economico, corrisponde al 15% della spesa pubblica. Uno studio di qualche anno fa diceva che è la quarta filiera produttiva più importante. Quindi è un settore molto rilevante dal punto di vista economico, visto gli interessi che esposta. È importante dal punto di vista politico perché è, e di gran lunga, il principale settore di intervento regionale. Più del 80% del budget delle regioni a statuto ordinario è investito in sanità. Le regioni, come principale materia di intervento hanno la sanità. Quindi è anche rilevante a livello politico-sociale. A me sembra però, questa è una mia opinione, che dal punto di vista mediatico, dal dibattito pubblico, sia un po' trascurato. Non è un soggetto di cui si parla spesso sui giornali, nei talk-show in televisione, mentre altri temi come le politiche di lavoro o delle pensioni sono continuamente esposte nel dibattito pubblico. Invece la sanità è trascurata, sebbene invece tocchi appunto tutti i cittadini, e per cui tutti hanno esperienze o insoddisfazioni magari in confronto di certi servizi. Però se ne parla poco nel dibattito pubblico. E questo non so come mai. Non so perché ci sia questo poco interesse mediatico, se sia anche dietro un qualche interesse da parte di qualcuno di non farlo diventare un argomento di discussione pubblica per cui anche grandi trasformazioni che stanno avvenendo, come per esempio la crescita della così detta sanità integrativa, sui giornali ha trovato fino a ora poco spazio. Anche se questo è un argomento che si presterebbe bene ad un dibattito, anche di principio. Tutte cose che sono d'interesse per i cittadini. Però, quello che è la mia percezione, è che non è un argomento particolarmente caldo e dibattuto al livello pubblico e giornalistico.

- *Quindi secondo lei gli attori più importanti sarebbero le regioni?*

Allora, no, per quello che riguarda gli attori pubblici, ci sono importanti competenze che ha il livello centrale, in particolare il Ministero della Salute. E quindi i grandi attori sono il Ministero della Salute al livello centrale, e poi invece le singole regioni. L'idea è che le regioni sono molto autonome nel poter organizzare in maniera diversa i servizi sanitari sul proprio territorio. Quindi ci sono anche molti modelli e sistemi diversi da una regione all'altra, scelte strategiche diverse sul come organizzare i servizi sanitari. Però invece il livello centrale è molto importante perché fissa le regole generali e soprattutto controlla il budget. Cioè il finanziamento viene ancora da Roma. Quindi questo è una leva molto importante che il Ministero della salute controlla. Perché in teoria il governo centrale dovrebbe garantire l'uniformità nelle diverse regioni, i diversi modelli che dovrebbero in qualche modo garantire un'erogazione uniforma delle cure. Non è cosi assolutamente, per cui ci sono delle regioni molto migliori delle altre, e il governo ha mantenuto alcuni poteri regolatori e soprattutto del budget.

- *Lei ha scritto molti articoli e libri in cui fa il paragone tra l'Italia e altri paesi europei. E quindi, oggi com'è l'Italia se facciamo questo paragone nell'ambito sanitario?*

Dal punto di vista del modello scelto, l'Italia è, in compagnia di alcuni paesi dell'Europa meridionale - Spagna, Portogallo - e del nord Europa, quindi regno unito, Irlanda, Norvegia, Danimarca, Svezia… fa parte dei paesi che hanno un servizio sanitario nazionale. Un servizio quindi universale, pubblico, finanziato dallo Stato, in cui la maggior parte delle cure è fornita dallo Stato. Quindi un servizio pubblico sia per quello che riguarda il finanziamento sia per quello che riguarda la fornitura. Invece i paesi dell'Europa centrale, che sono la Francia, la Germania, l'Austria, il Belgio, i Paesi Bassi, hanno un modello sanitario differente; proprio come intervento dello Stato. Questo è dal punto di vista dei modelli. L'Italia fa parte dei paesi con un servizio nazionale al contrario invece di altri paesi come la Svizzera anche che hanno un servizio di assicurazioni diverse, divise in più pilastri. Per quello che riguarda le *performance*, le prestazioni, su alcuni elementi di efficacia, che sono per esempio un indicatore secondo me molto utile è quello della mortalità evitabile, l'Italia non è il primo paese in Europa ma è a buone performance. Anche su altri indicatori di questo genere, l'Italia non va a fatto male. Il problema dell'Italia è che il sistema sanitario è sotto-finanziato, cioè gli investimenti in sanità in percentuale del PIL (*prodotto interno lordo*) è meno di quanto

facciano altri paesi. Secondo me il fatto che su una serie di limiti in Italia ci sia in termini di qualità dei servizi, delle strutture, degli ospedali… dipende dal fatto che investiamo meno in sanità in termini di percentuale del PIL da quanto facciano altri paesi, tra cui appunto la Francia… quasi tutti tranne Spagna, Portogallo e Grecia, investono più di noi. Questo in fine di termine di qualità di servizio, si paga, si sente.

- *Il sistema sanitario italiano è caratterizzato da una forte regionalizzazione. Come possiamo spiegare lo sviluppo di tale sistema?*

In realtà è diventato regionalizzato con la grande riforma del 1992-1993. L'idea è che si era insoddisfatti delle cure, soprattutto in alcune parti dell'Italia, e quindi si pensò di cambiare il sistema, cercando di creare maggiore competizione nel sistema, maggiore competizione all'interno del servizio pubblico. Da un lato, viene creato un sistema di finanziamento per cui gli ospedali venivano pagati in base a quanto producevano. Quindi di fatto gli ospedali venivano messi in competizione l'uno con l'altro e se erano bravi attiravano molti pazienti e ricevano molti finanziamenti. Se no invece ricevano meno finanziamenti. La competizione si è creata fra i diversi ospedali. E poi, insieme nello stesso pacchetto di riforma del 1992-1993, si decise anche in qualche modo di lasciare più libere le regioni affinché anche tra le regioni ci fosse un po' di competizione. La speranza era che questi meccanismi competitivi avrebbero portato le regioni, che allora erano più indietro, a colmare il divario perché stimolate da questa competizione con le regioni migliori. Invece purtroppo non si è verificato. Le regioni, soprattutto quelle del centro-sud hanno storicamente delle capacità amministrative inferiori e quindi, pur avendo avuto in questi ultimi 25 anni le stesse risorse pro capite ne hanno fatto un uso peggiore. Il gap è rimasto e su alcuni aspetti è aumentato. Per cui adesso c'è una forte spaccatura e, sono convinto di questo, ma lo dicono anche i dati, fra Nord e Sud. Forse è il principale problema del sistema sanitario italiano, che è molto diverso da com'è organizzato al Nord di Roma in rispetto a come è organizzato al Sud di Roma. E purtroppo lo dimostrano tutti gli indicatori. Tanto per intenderci, anche l'aspettativa di vita, che è un indicatore scivoloso perché tiene conto di molti fattori, un tempo le popolazioni del meridione, del Sud d'Italia vivevano più lungo in rispetto al Nord Italia per tante questioni anche climatiche, di dieta… Invece gli ultimi dati dicono che tra uno che nasce a Trento, uno che nasce in Campagna, ci sono tre anni di aspettativa di vita in meno. Quindi oltre la qualità dei servizi inizia adesso a essere peggio la salute della popolazione delle regioni del Mezzogiorno. E ci sono molti cittadini che, potendo scegliere, nel senso che in Italia uno può andare a farsi

assicurare dove vuole, ci sono moltissimi, decine di migliaia di pazienti che lasciano le regioni del meridione per farsi assicurare invece nelle regioni del Nord. Nessuno fa il percorso contrario. Tutti lo sanno ed è un problema grosso. Quindi questa autonomia regionale non ha portato quell'effetto di emulazione che invece si sperava 25 anni fa. Infatti, alcuni dicono, che forse bisognerebbe tornare ad un asseto più centralizzato in modo da garantire una maggiore uniformità visto che alcune regioni hanno dimostrato di non essere in grado di gestire bene le risorse, di non saper bene organizzare le cure sanitarie.

- *Che influenza ha questo sistema, fatto di sistemi diversi, sulle politiche di sanità pubblica nazionali?*

È una bella domanda a cui faccio un po' fatica a rispondere nel senso che la sanità è sempre poco strategica. Per cui anche quando pensiamo appunto al nuovo governo e alle elezioni precedenti dell'anno scorso, e anche le promesse e grandi progetti che vengono dibattuti in campagna elettorale, non riguardano la sanità; riguardano le pensioni, il lavoro, le tasse… Sono altri ambiti magari anche del *welfare*, ma non la sanità. Alla fine, non avendo fatto promesse, non essendo un tema caldo, sulla sanità non vengono anche fatti grandi investimenti e diventa uno dei settori dove si prova a tagliare. La dinamica è sempre tipica, ma da 20 anni, in cui c'è il Ministro della Salute che dice "io voglio che si trovano nuove risorse per la sanità perché il nostro sistema pubblico deve essere maggiormente finanziato". Poi invece all'interno del governo ci sono tanti altri che dicono di no, le risorse vanno messe su altre voci che sono più strategiche o che portano più consenso e quindi negli ultimi 10 anni la spesa sanitaria pubblica è cresciuta ad un ritmo lentissimo; a meno di 1% all'anno. Invece la sanità sarebbe una materia in cui bisognerebbe sempre investire nuove risorse perché la tecnologia va avanti, le cure sono più costose, e soprattutto la popolazione italiana invecchia quindi ha bisogna di più cure. Il fatto di aver mantenuto più o meno stabile la spesa pubblica vuol dire che di fatto il sistema è stato finanziato ancora di meno. Abbiamo quindi un problema di sotto-finanziamento che deriva dal fatto, secondo me, che non è politicamente strategico. Non è una priorità dei governi. Anche se ci sono degli extra budget, o delle risorse da investire, si investono in altri settori.

- *Quindi abbiamo parlato degli attori pubblici, ma se parliamo un po' degli attori privati?*

Appunto, parliamo di un settore in cui ci sono degli enormi interessi privati. Molto più che tanti altri settori. Forse per questo anche, in effetti, di alcuni temi non si discute apertamente, anche sui giornali alcuni problemi non vengono sollevati, perché, il dubbio che viene, in questa situazione qua di scarso investimento pubblico, ci sia invece un interesse da parte della sanità privata. Sanità privata vuol dire diverse cose. Da un lato ci sono le industrie farmaceutiche, la filiera del farmaco, che ha naturalmente una bella fetta anche del fondo sanitario nazionale, e che ha anche in Italia diversi progetti. Poi, e forse ancora di più, ci sono gli ospedali privati. Ci sono in Italia alcune grandi catene di ospedali privati. Alcuni hanno anche intrecci con i giornali. I proprietari di queste grandi catene di ospedali privati hanno per esempio l'Espresso, la Repubblica… C'è anche un collegamento con il settore finanziario con i mass media, con i giornali così e quindi ci sono questi grandi gruppi imprenditoriali che gestiscono gli ospedali privati che hanno interesse nel settore. Poi sta crescendo negli ultimi 10 anni la sanità integrativa, le assicurazioni volontarie che vengono incentivate fiscalmente e sono in grande crescita. Per cui 10 anni fa erano pochi milioni, adesso sono diventati 13 milioni di italiani, 1 su 4, che hanno una copertura integrativa. Lì ci sono dei gruppi assicurativi importanti come l'Unipol, RBM, l'Intesa San Paolo… sono dei grandi attori bancari, assicurativi etc. Hanno naturalmente un grande interesse in questo settore che è in espansione, perché avendo compresso la spesa pubblica, è necessario aumentare la spesa privata; quindi sta aumentando sia il consumo diretto, sia si sente naturalmente la necessità di sottoscrivere una polizza assicurativa privata. Ci sono fortissimi interessi anche privati. Ma in tutto in Italia c'è anche molta ricerca farmaceutica, ma anche dei biomedicali, quindi è un settore molto importante, anche da un punto di vista economico con forti interessi. Poi anzitutto c'è anche una partita che è quella delle professioni, anche li un po' continuamente in conflitto. Perché alcune sono tradizionalmente subordinate. Ci sono quindi dinamiche anche lì legate ai diversi professionisti della sanità, che possono essere interessanti per capire qual è il gioco.

- *Oggi quali sono le priorità e strategie nell'ambito sanitario in Italia?*

La priorità degli ultimi 10-20 anni è stata di tagliare i costi, soprattutto nelle regioni che avevano i deficit economici, finanziari pesanti, che erano concentrate nel Sud d'Italia. Questo

è stato fatto tramite i così detti piani di rientro. I piani di rientro sono di fatto dei piani concordati fra la singola regione e il Ministero dell'Economia e il Ministero della Salute per azzerare il deficit della spesa sanitaria. Sono stati dei programmi per sostanzialmente ridurre le spese, dei programmi di *austerity* sanitarie e di *spending review*. Questo purtroppo è stata la priorità. Tutte le riforme hanno teso a questo, ridurre le spese, ridurre li sprechi… Poi invece i problemi sul tavolo che però non vengono in qualche modo risolti sono quelli del divario Nord-Sud per cui anche diversi ministri della salute lo hanno ammesso, lo dicono, tutti sono consapevoli di questa disparità però fino a ora non è stato messo in campo nessun strumento per correggere il problema. L'altro problema che tutti i ministri della salute dicono e che tutti coloro che sono coinvolti nella sanità fanno notare, è che ci sono troppe poche risorse pubbliche per i servizi sanitari nazionali ma anche qui non è stato pensato in realtà a nessuna soluzione. Non è stato invertito il *trend*. È un problema che tutti dicono di essere grave ma che in realtà non è stato affrontato.

Poi al livello regionale, credo che ci siano alcune dinamiche che stanno infatti rispondendo al fatto che sta invecchiando la popolazione, sta cambiando un po' la medicina. Quindi che si debbano spostare le risorse dall'ospedale ai servizi sul territorio. Non in tutte le regioni, ma nelle regioni più avanzate, l'Emilia-Romagna, la Toscana, la Lombardia, anche in parte il Veneto, il Friuli, quello che si sta provando a fare è di trovare dei modelli che rispondano ai bisogni degli anziani e dei malati cronici: che non hanno bisogno di *recovery* in ospedale, di essere trattati in ospedali con tempi di ricovero, ma che hanno bisogno di servizi continuativi tutti giorni, di ambulatori… Quelle sono probabilmente le innovazioni più interessanti che adesso vengono intraprese nelle diverse regioni. Perché sta cambiando un po' il quadro e le regioni che sono un po' più all'avanguardia stanno sperimentando opzioni diverse che però hanno in qualche modo l'obiettivo di migliorare le cure sul territorio, di migliorare l'assistenza dei malati cronici.

- *Oggi l'UE ha un'influenza molto importante sulle politiche nazionali. Però la sanità ritiene una dimensione politica forte legata al contratto sociale tra lo Stato e la sua popolazione. Come possiamo valutare l'influenza dell'Europa sulle politiche di sanità pubblica italiane?*

Questa è una bellissima domanda, e io devo dire la verità, è un argomento che anche io ho in testa e non ho mai approfondito, e le ripropongo di andare più affondo nella problematica. La

mia idea, in generale, sarebbe questa, cioè che l'Europa in verità incide molto poco sulla sanità come è organizzata nei singoli paesi. Tant'è che in Europa abbiamo dei sistemi sanitari molto diversi da paese a paese, e anche a secondo del paese in cui abiti, hai dei diritti o dei benefici sanitari molto differenti. In un articolo, non ancora pubblicato, riporto un dato che è che nell'Unione Europea dei 28 paesi attualmente membri, ci sono 7 milioni di non assicurati. È un problema di cui non si parla. Si dice che gli assicurati sono solo negli Stati Uniti e in altri paesi, ma in alcuni paesi dell'Unione Europea possono esistere persone che non hanno nessun tipo di assicurazione sanitaria. Quindi ogni tanto parliamo dell'Europa, pensiamo che tutti paesi dell'Europa garantiscano come *welfare* alcuni diritti minimi, ma questo non è vero per quanto riguarda la sanità. In Europa non c'è questa uniformità per quello che riguarda le cure sanitarie.

L'Europa ha inciso in due modi. Uno, nel senso che sull'Italia ad un certo punto ha detto "dovete risparmiare, non potete andare avanti con i vostri deficit ecc". Non ha detto di intervenire sulla sanità perché già la sanità spendeva poco in rispetto agli altri paesi, quindi non è stato un'indicazione da parte delle istituzioni internazionali. Però ha detto "tagliate, mettete apposta delle riforme, tagliate il budget", e quindi poi a livello nazionale, si è tagliato il budget anche in sanità. Anche se era un settore che spendeva poco rispetto ad altri paesi, in verità, la spesa è stata quasi bloccata negli ultimi 15 anni. Quindi le ripercussioni ci sono state, anche se le indicazioni non erano di intervenire sulla sanità. Poi invece il livello europeo decide di intervenire sul alcune singole precise questioni che arrivano, diciamo, come dei vincoli di carattere europeo e che poi invece hanno un effetto sul livello nazionale. Sui vaccini, in realtà l'abbiamo scelto noi dal 2017 di cambiare la tematica dei vaccini, però erano arrivati dei forti *alert* da parte invece dell'Organizzazione Mondiale della Sanità, in particolare dalla sezione Europea, perché avevamo dei problemi di copertura vaccinale molto bassa, soprattutto un problema come il morbillo, che abbiamo ancora, però formalmente abbiamo istituito una vaccinazione volontaria, quindi dovremmo in futuro migliorare.

Invece una cosa che secondo me ha avuto poco effetto, è una direttiva di qualche anno fa sulla circolazione dei pazienti. In teoria doveva favorire la circolazione dei pazienti da un paese a l'altro. Ho guardato i rapporti annuali sulla circolazione dei pazienti e sono pochissimi i pazienti che vanno a farsi assicurare in un altro paese dell'Unione Europea. Doveva essere in teoria una sorte di mercato unico dei pazienti e delle cure, e invece i dati dicono che a parte la Polonia - ci sono molti polacchi che vanno ad assicurarsi in altri paesi vicini - in generale negli altri paesi dell'Unione Europea questa opportunità non è stata sfruttata. I pazienti non

vanno all'estero più di prima per curarsi. Forse l'idea era di creare una situazione in cui c'è questo mercato unico e criteri standard anche di qualità simili tra un paese e l'altro con la circolazione dei pazienti. Ma è una direttiva che ha avuto uno scarso effetto. Anche sulla circolazione dei medici, ci sono tanti, per dire, anche medici italiani che vanno a lavorare all'estero, e ci sono in Italia, non tanto i medici ma molti infermiere che vengono da fuori. Però non solo dall'Unione Europea, vengono da altri paesi perché intanto nel loro paese c'è bisogno di alcune figure professionali quindi c'è un po' di travaso. L'Unione Europea ha un po' favorito questa transazione dei professionisti sanitari. Sono le cose che io ho in mente, in cui l'Unione Europea ha ricaduto su l'organizzazione dei sistemi. Però rimane il fatto che i diversi paesi dell'Unione hanno modelli diversi fra di loro che dipendono da come il modello si è sviluppato nel tempo. La sanità non è affatto uniformata fra i paesi dell'Unione Europea.

- *Se appunto parliamo un po' dei vaccini, abbiamo visto che dopo l'adozione in Italia dell'obbligo vaccinale con il decreto Lorenzin, c'è stato un movimento, sia nell'Europarlamento, sia nei singoli paesi, tendendo verso l'aumento dell'obbligo vaccinale. Quindi potremmo parlare al contrario di un'influenza nell'ambito sanitario dell'Italia sull'Europa e/o sugli altri paesi?*

Può essere. Però appunto lo vedrà in questo tema qua. Ho studiato bene questo decreto vaccini del 2017 e la sua conversione in legge, quindi so bene qual è la storia in Italia. Ho intervistato l'allora Ministro Lorenzin, che mi ha detto "guarda poi la Francia ha fatto una misura simile e anche l'Organizzazione Mondiale della Sanità ci ha preso a modello". In effetti, ho guardato i dati qualche settimana fa, e dimostrano che nelle regioni stanno aumentando le coperture vaccinali. Però solo in questo settore, non so se in altri elementi l'Italia, in qualche modo, condiziona gli altri paesi. Può essere, in generale, che la dinamica sia mentre forse in altri settori c'è un'influenza più *top-down* dell'Europa - che da delle direttive, delle limitazioni più precise che poi vengono attuate al livello nazionale - può darsi che in ambito sanitario a parte alcune tematiche, invece, l'influenza in Europa sia più una contaminazione da paese a paese. I singoli paesi diventano dei modelli e copiati dagli altri, in un fenomeno che potremmo chiamare *policy transfer*. Un trasferimento di certe riforme, di certe politiche, però in qualche modo alla pari. Negli anni 1990 questo è stato abbastanza evidente. Ci sono state alcune ondate di riforme in cui appunto c'era qualche paese influente che partiva e altri hanno esplicitamente ripreso le riforme; per esempio la riforma Thatcher di questi mercati poi è stata copiata da tanti altri paesi. Di recente forse non c'è un singolo paese

che fa da *benchmark*, ma può darsi che su singoli temi, qualche paese si muove per primo poi in qualche modo gli altri lo seguono. Per dire, anche nei diritti dei pazienti, nella tutela dei diritti del paziente, credo che i paesi che si sono mossi per primi sono i Paesi Bassi e il Regno Unito, poi gli altri paesi hanno in qualche modo introdotto anche loro delle leggi che tutelino determinati diritti del paziente, di privacy. Quindi senza esserci una direttiva formalizzata al livello europeo, l'appartenenza a l'UE porta a contaminarci o a emulare strategie che vengono prese da altri paesi. Può essere.

- *E quindi, secondo lei le prossime elezioni europee non dovrebbero influenzare molto queste dinamiche?*

Io credo di no. Dal punto di vista italiano, direi certamente di no. Abbiamo guardato, dobbiamo scrivere un paper su questo, forse lo scriveremo, sulle ultime elezioni invece in Italia. Abbiamo guardato tutte le liste che si sono presentate alle elezioni cosa dicevano per la parte sanità. Abbiamo visto che dedicano pochissimo spazio alla sanità, che spesso più che suggerire delle proposte concrete, si limitano a dire che c'è un problema. Appunto abbiamo visto che i temi caldi erano pochi, e le proposte concrete, radicali, per riformare il sistema non è nei programmi dei partiti, un tema particolarmente sviluppato. Mi immagino che al livello europeo, della campagna elettorale in Italia, non credo che la sanità sarà un tema toccato. Credo anche, nella mia previsione, che a livello europeo non sarà un tema caldo perché fino a ora l'Europa si è interessata poco di sanità, quindi mi immagino che i temi di dibattito saranno altri.

- *Però Lei ha scritto che la base ideologica d'un governo ha un ruolo importante sul contenuto delle riforme sanitarie. Il ministro Grillo essendo del M5S, come l'ideologia del M5S influenza le riforme attuale del sistema italiano?*

L'idea è che, nel corso della storia, è più probabile che dei sistemi pubblici governati dallo Stato, come il sistema sanitario nazionale, siano implementati da governi di sinistra. Mentre invece dei sistemi diversi in cui è previsto una maggior competizione, un sistema basato sulle case mutue o sulla competizione fra le assicurazioni, sia invece approvato da un governo di centrodestra, liberale; perché apprezzano di meno l'intervento dello Stato ma credono di più

nella libertà di scelta dei pazienti, dei cittadini, e nella competizione. È un tema interessante che c'è anche in Italia. La Lega, che viene da l'alleanza del centrodestra e che aveva una base lombarda, secondo me tende a, diciamo cosi, vedere più favorevolmente il coinvolgimento della sanità privata, la competizione fra pubblico e privato, che sono appunto temi cari al centrodestra e alla regione Lombardia. Mentre invece, il M5S, anche leggendo il programma di governo non solo sulla sanità ma anche sul *welfare*, secondo me, è adesso il partito più a sinistra che abbiamo in Italia. È il partito, non si direbbe dai *talk-show* ma se si guarda il programma e le loro proposte nel tema *welfare*, sono molto Stato, molto uguaglianza, e tipicamente delle ricette di sinistra. È molto più a sinistra dal Partito Democratico come visioni e ricette per quello che riguarda il *welfare*; anche l'idea del redito di cittadinanza, un'idea, secondo me, tipicamente di sinistra. L'idea è che hanno delle idee diverse, anche in sanità, Lega e M5S. Quella dei vaccini è una situazione un po' più scivolosa perché forse come ideologia il M5S sarebbe per l'intervento dello Stato però li è tutto una questione perché il M5S è vicino di alcuni movimenti anti-vaccinazione, quindi ha un po' di ambiguità sul tema. Ma sulle altre questioni, non mi sorprenderei se ad esempio il M5S chiedesse un maggior intervento pubblico, una maggiore regolazione pubblica, o la riduzione delle attività libero-professionale dei medici etc. Secondo me c'è una base del M5S molto statalista, molto anche egalitaria. Però il fatto che non la pensino nello stesso modo M5S e Lega, probabilmente farà si che in sanità non ci saranno dei grossi cambiamenti.

- *Appunto, con questo governo, ci sono stati sia dei cambiamenti, il Ministro Grillo ha dimesso il Consiglio Superiore della Sanità, ma una certa continuità; per esempio la legge Lorenzin non è stata ancora toccata.*

L'hanno dichiarato. Da quello che so io, adesso c'è una discussione in parlamento su alcune modifiche della legge Lorenzin però al momento in tutta continuità con il governo precedente. Quello che invece si è creato, ma forse fa parte d'un normale *spoil system,* è che alcuni vertici dell'Istituto Superiore di Sanità e del Consiglio Superiore della Sanità erano apertamente vicini al governo precedente. E non hanno apprezzato alcune uscite da parte di Salvini ma anche da parte di alcuni esponenti del M5S, secondo loro non scientifici sui vaccini ma anche su altri temi e quindi ad un certo punto il presidente dell'Istituto Superiore della Sanità, Walter Ricciardi, ha dato le dimissioni prima di Natale. Quello è stato una mossa sua, come dire, in polemica contro il Ministro, contro il governo per esprimere il suo non riconoscimento nelle posizioni non scientifiche. Mentre il Consiglio Superiore della Sanità invece è stato sciolto e

rinnovato con una diversa composizione ed è stato una mossa tipica di *spoil system*. Però ho visto la composizione del nuovo Consiglio, è fatto da persone molto famose e competenti. Non uno scandalo insomma.

- *Continuiamo con una domanda forse meno legata a quello che ha scritto Lei. Secondo Lei, l'Italia potrebbe usare l'ambito sanitario, le sue forze in questo ambito, nella sua politica estera?*

Dipende cosa intendiamo, me lo può dire Lei, nel senso che sono molto curioso da questo intreccio. Credo di si. Credo che in Italia ci siano delle eccellenze, anche delle conoscenze del nostro sistema che possono essere utilizzate in tante relazioni, tanti scambi internazionali. Mi verrebbe da dire, forse più in paesi extra-UE piuttosto che negli altri paesi dell'UE. Per cui si, l'Italia potrebbe farsi promotrice di scambi, conoscenze, formazioni, di aprire delle proprie strutture in altri paesi… Potrebbe in qualche modo sfruttare questo. E potrebbe, in termini di mobilità dei pazienti attrarre pazienti dall'estero perché ci sono delle strutture di eccellenza, soprattutto nel centro-Nord. Quindi si potrebbe anche in qualche modo sfruttare questo, che è anche un business in affari di attrazione dei medici. Potrebbe diventare una risorsa, un settore in cui tanti servizi che non esportiamo, e ci potrebbe essere anche essere questo. Per dire ci sono state spesso molte richieste dall'estero richieste per delle attività, dei master in formazione di medicina, in affari sanitari. Perché le nostre facoltà di medicina sono buone quindi molte persone chiedono di venire qua o di aprire dei master, accordi con delle altre università in tutto il mondo che ci chiedono in qualche modo di portare loro delle conoscenze in medicina. Anche la mobilità dei pazienti, i numeri sono ancora bassi però in futuro potrebbe infatti - anche se ci sono molti italiani che si fanno curare all'estero, per esempio in Croazia, in Romania perché i prezzi sono più bassi - va in qualche modo regolamentato. Qui c'è appunto un problema di strozzatura, nel senso che noi abbiamo pochi medici e abbiamo poche scuole di specializzazione. Quindi esportiamo dei medici paradossalmente perché non riescono ad avere posti nelle specializzazioni. C'è anche tutto un dibattito sul numero chiuso in medicina, anche quello uno lo potrebbero fare rientrare negli accordi con altri paesi. In realtà ci sarebbero tante tematiche, senza pensare alle epidemie, ai vaccini che devono essere concordati. Credo che da tanti punti di vista la sanità potrebbe rientrare in dinamiche di politica estera, negli accordi dello Stato a vari livelli; in termini commerciali, di sanità pubblica, di emergenza sanitaria, di scambio di conoscenze, di personale… Sicuramente la politica estera potrebbe essere un veicolo per esportare conoscenze, servizi, cure. È molto

affascinante, io non ci ho mai pensato bene, ma secondo me il tema è molto interessante. Mi dica Lei cosa ha in testa.

- *A me piacerebbe, però con le mie ricerche mi rendo anche conto che l'Italia, come la Francia in realtà, non usano troppo la sanità. Ieri c'è stato un bel esempio. Il Presidente del Consiglio, Giuseppe Conte, ha fatto una conferenza alla LUISS, e su una domanda sulla sanità, ha risposto che non ci saranno altre risorse date dal governo per la sanità, ma soprattutto, ha molto criticato la politicizzazione della sanità dagli altri governi. Questo mi fa chiedere se c'è una vera voglia da parte dei governi di veramente prendere l'ambito sanitario e trasformarlo in uno strumento di politica estera.*

Si credo anch'io. Però invece le potenzialità potrebbero essere molteplici. In molti scambi con altri paesi ci potrebbero essere dei punti di comune interesse riguardando la sanità, il personale, la ricerca… Infatti è un tema molto affascinante, molto importante da studiare.

- *Sì, forse sarebbero gli attori privati a portare più avanti questo, piuttosto che gli attori pubblici e politici.*

Può darsi, che forse la spinta fosse loro e appunto poi gli attori pubblici seguono le pressioni degli attori privati.

- *In questo caso, che gli attori privati hanno sempre più potere e influenza, potremmo dire che in un prossimo futuro questi attori avrebbero un ruolo più importante sulla definizione delle politiche di sanità pubblica?*

Secondo me è già cosi. Nessuno lo studia perché ci sono pochissimi studi sui gruppi d'interesse, sul *lobbying*, ma in generale. In Italia si studia poco il *lobbying,* e sono pochissimi gli studi sul *lobbying* sanitario. Da quello che so io, dalla percezione che ho io, è che già adesso i gruppi privati, ma anche le regioni, gli ordini professionali si muovono, senza andare sui giornali, per fare proposte, per suggerire al ministro delle determinate soluzioni, per influenzare le politiche. Quindi in molti ambiti, senza che questa cosa divenga oggetto di

dibattito pubblico, i gruppi chiedono delle misure per loro favorevoli. È normale, questo continuo *lobbying*. Nelle interviste che ho fatto in questi ultimi mesi ho parlato con il segretario personale del ministro della salute e lui mi ha detto che è in continuo. Cioè nel senso che quello che fa continuamente il ministro è incontrare diversi gruppi, apertamente, e gruppi hanno richieste, domande, suggerimenti, e quindi fanno pressione.

Immagino che alla fine le scelte sono molto più influenzate da questi gruppi che non invece dal dibattito pubblico, che non c'è, o magari anche dei partiti che spesso non si interessano alle problematiche di sanità pubblica. Per cui ci sono tante cose che in realtà stanno cambiando e che sono appunto i singoli gruppi che chiedono e ottengono dal governo nazionale o da quelli regionali. C'è già secondo me questa forte influenza, solo che magari è su piccole misure locali, settoriali, che non sono oggetto di grande dibattito. Se ne è poco la percezione ma credo che invece già adesso i gruppi riescono ad influenzare o fare capire chiaramente cosa vorrebbero dai *policy maker*. Perché alcuni di questi gruppi sono forti, sono le compagnie farmaceutiche, gli ospedali privati, i gruppi assicurativi, sono soggetti forti, molto influenti, con delle risorse. Ma anche i professionisti della sanità sanno farsi ascoltare, senza farlo apertamente, ma credo che abbiano sempre un canale aperto con il ministero e le singole regioni. Però è stato poco studiato, quindi se ne sa poco. Ci sono alcuni libri di denuncia, ma sono libri giornalistici, ma libri con un punto di vista più scientifico con dei dati più approfonditi c'è poco. Ma chi lavora nel settore dice che va cosi. Ci sono queste normali attività di *lobbying* da parte dai gruppi privati impegnati nella sanità.

- *Per finire, volevo parlare un po' dell'AIFA (Agenzia Italiana del Farmaco), e sapere un po' di più del suo ruolo. Soprattutto, se il suo ruolo sta crescendo in importanza. Penso al fatto che negli ultimi anni, abbiamo visto la FDA (Food & Drug Association) usata dagli Stati Uniti per le loro politiche estere. Per esempio la FDA quando controlla le aziende europee è molto più dura e attenta che per le aziende statunitense. La FDA è spesso usata per proteggere gli attori statunitensi nel settore sanitario e soprattutto farmaceutico. So che in Francia non si fa ancora, ma in Italia?*

Non lo so bene. Quello che so è che l'AIFA è questa agenzia nominata e finanziata dal Ministero della Salute, quindi sotto controllo dal ministero, che si deve occupare di tutta la filiera, di tutto il processo produttivo dei farmaci; quindi la loro autorizzazione, è l'AIFA che stabilisce il prezzo, che stabilisce se verrà rimborsato il farmaco, e che dovrebbe controllare

anche le aziende che producono farmaci in Italia. Tutti processi che riguardano i prodotti farmaceutici dovrebbero essere controllati dall'AIFA. L'AIFA, da quello che so io, è all'interno d'un gioco bellissimo, che io conosco poco ma che ho capito essere, anche dal punto di vista scientifico molto affascinante, perché è un gioco su più livelli in cui si corre continuamente con le altre agenzie del farmaco degli altri paesi e con la EMA (*European Medical Agency*). Perché tutti i prezzi dei farmaci si fanno, tendono conto di cosa hanno fatto gli altri paesi. Quindi è una partita scacchi fra la compagnia farmaceutica che ha un nuovo prodotto e le varie agenzie in cui solitamente chiedono l'autorizzazione e il prezzo in un solito paese in cui pensano di avere più influenza, di poter strappare le condizioni migliori. Sono delle vere trattative per cui da una parte c'è l'AIFA, dall'altra le aziende farmaceutiche che devono negoziare le quantità, le modalità, il prezzo. L'AIFA ha quindi un compito molto commerciale, di trattativa, e non solo di regolazione legale. E credo che l'AIFA sia molto influente, ha un grande potere discrezionale. Che stiano crescendo i suoi poteri non lo so perché è diventata operativa nel 2004, quindi secondo me una volta che è entrata in funzione, è sempre stata molte influente. In quel settore li, in effetti decide l'AIFA e il ministero delega tutto perché è anche una materia molto complicata. Da quel punto di vista li, è il potere dell'AIFA e non del ministero.

Su eventuali politiche di protezionismo, ci sono delle aziende farmaceutiche tipicamente italiane, che da quello che so io, si occupano di alcuni prodotti molto speciali; si concentrano sui farmaci da banco. E credo che tutte le grandi compagnie farmaceutiche straniere abbiano poi delle sedi italiane, delle filiali italiane. Però alla fine vengono considerate anche loro, avendo delle sedi di ricerca, simili a quelle italiane. Anche se sono dei gruppi più grandi, vengono di fatto tramite la filiale italiana considerate come le compagnie italiane. Secondo me non c'è, però purtroppo non sono un esperto. Ho l'impressione che non ci sia quest'idea qua ma forse perché le aziende farmaceutiche italiane da sole non basterebbero e di fatto quelle straniere sono considerate come anche un po' italiane quando hanno una sede qua o quando sono operative qua. Non lo so se ci sia questo, non l'ho mai sentito dire che ci sia quest'intento politico. Credo che il principale problema sia di tipo economico, che l'obbiettivo sia sempre quello di far risparmiare il Servizio Sanitario Nazionale. Quindi è brava l'AIFA quando riesce a ottenere dei prezzi bassi, e se magari favorisce uno straniero piuttosto che un italiano ma fa risparmiare al servizio pubblico, credo che vada bene, anche se i farmaci arrivano dall'estero. Però non lo so, è un ambito molto affascinante quello del farmaco con questi giochi fra il livello europeo, poi forse anche appunto con la FDA.

Appendix 2: Interview with Mrs Christine Berling

CHRISTINE BERLING

Ministère des Solidarités et de la Santé - Paris - 25/04/2019 - 10AM-12PM

- *Pour commencer par une question un peu large, comment définiriez vous la santé publique en France aujourd'hui?*

On a une stratégie nationale de santé *(SNS)*, c'est un chapeau. Elle a été définie, adoptée, quand le nouveau gouvernement est arrivé au pouvoir, fin 2017. Dans la SNS vous avez 4 axes dont le premier est "prévention, promotion de la santé". Vous avez dans la SNS une préoccupation transversale qui est sur les inégalités de santé; ainsi, à chaque fois qu'il y a une stratégie ou un programme ou un plan de santé qui est lancé, les mesures sont évaluées à l'aune des inégalités de santé, pour être-sûr que les inégalités ne vont pas être accrues par certaines actions. Par exemple, concernant le dépistage, même s'il est gratuit, organisé, et que tout le monde est convoqué, ce sont toujours les mêmes personnes ? populations?qui vont se faire dépister. Ceci veut dire qu'en terme d'inégalité, vous n'arrivez pas à les réduire, alors que vous avez encore de très importantes inégalités de santé en France. Partant d'un certain nombre de constats, il y a une stratégie nationale de santé qui a défini les grandes lignes et qui met en place une approche populationelle, tout au long de la vie, et assez innovante. Donc on part des 1000 premiers jours jusqu'au "vieillir en bonne santé" globalement et tout au long de la vie il y a un certain nombre de mesures qui ont été définies pour arriver à identifier les problématiques (donc faire de la prévention) et traiter le plus en amont possible. Ce qui est important c'est que ce plan est porté par le Premier Ministre, avec tout le gouvernement, montrant ainsi un plan gouvernemental porté en interministériel. Il y a par exemple des mesures sur les ambassadeurs de? jeunes dans les écoles, portées par? l'Éducation nationale. Il y a aussi des mesures assez innovantes dans le service sanitaire, par exemple un service sanitaire a été défini et pendant le cursus des étudiants en médecine, pharmacie, dentaire, des cours théoriques en terme de prévention sont dispensés. Le fait qu'il y ait des interventions pratiques, par exemple dans les lieux publics, permettent aux futurs médecins de rencontrer la société avec des messages de prévention.

En sommes vous avez un certain nombre de plans qui sont en place, et qui remettent un petit peu au coeur finalement de notre système de santé, la prévention et la promotion de la santé. Ceci avec tout un autre pan qui est important aussi, le plan "Ma santé 2022". Celui-là concerne la réorganisation des soins, et la réorganisation par rapport à l'accès aux soins de la population des zones rurales par exemple. Il y a tout une grande problématique, qui dure en France, et dans le plan "Ma santé 2022", on veut à la fois mettre en oeuvre des outils innovants pour permettre de joindre les gens isolés, mais aussi redéployer les forces, réorganiser le système. Effectivement il y a des très gros chantiers en cours.

C'est sur ces activités que l'on s'appuie pour porter des messages à l'international. Il est vrai que l'on porte à l'international ce que l'on met en oeuvre finalement au plan national. On porte beaucoup la lutte contre les inégalités, la lutte pour une couverture santé universelle, ce que l'on a mis en place ici depuis des années avec la Sécurité Sociale. Donc ce que l'on va porter au niveau santé internationale reflète en tout cas ce que l'on est entrain de mettre en oeuvre ici. Juste pour faire une parenthèse, ceci n'est pas forcement le cas aux Etats-Unis. Avant d'arriver au Ministère de la Santé, je travaillais à l'INCA *(Institut National du Cancer)* qui est une agence de coordination et de mise en oeuvre d'un plan cancer. Ce qui était très intéressant dans nos relations avec les Etats-Unis, c'est qu'ils s'étaient fait les champions internationaux des plans cancer alors qu'ils n'en avaient pas chez eux. C'était assez intéressant de voir ce décalage là. Il se font les champions de l'égalité, or c'est un pays très inégalitaire; évidemment comme ici, je pense que tous les pays sont très inégalitaires. C'est interessant de voir que nous essayons de baser ce que l'on essaye de porter à l'international avec ce que l'on essaye de faire concrètement au niveau national. C'est très important et par rapport à ce que l'on porte au niveau international, nous avons une stratégie de santé mondiale.

C'est notre feuille de route qui définit les 4 grands axes, les 4 priorités stratégiques:

1. Renforcement des systèmes de santé sur toutes les maladies
2. La sécurité sanitaire au niveau internationale
3. La promotion de santé des populations
4. L'expertise en recherche et innovation

C'est notre feuille de route, qui a été négociée en interministériel et qui a été adoptée en 2017.

- *Oui, avec le nouveau gouvernement…*

Elle avait été bâtie avec l'ancien, mais les sujets restent, la lutte contre les maladies, la lutte pour la sécurité sanitaire… De fait, effectivement, nous l'avons adoptée avec le nouveau gouvernement, nous ne sommes pas revenus en arrière. Elle avait fait l'objet de nombreux groupes de travail, de discussions donc ça aurait été embêtant de ne rien avoir pour partir??? démarrer??. Mais actuellement ils sont entrain de faire une loi, je pense que c'est la première fois qu'il y a une loi, donc il faudra voir ce qui est dedans.

- *Justement, cette loi, sur quoi porte-t-elle?*

Dans un discours pour les 75 ans de l'IRD *(Institut pour la Recherche et le Développement)* M. le Ministre des Affaires Etrangères Le Drian, parlait de l'ambition française d'une diplomatie scientifique. Il a aussi rappelé une augmentation du budget 2019 pour l'aide au développement a hauteur de 1 milliard d'euros, dans le domaine de la santé, de l'égalité, de l'éducation et du climat.

- *Donc la France a aujourd'hui cette stratégie, mais quel rôle se donne-t-elle à l'international dans le domaine de la santé publique européenne et mondiale?*

Europe et monde sont deux choses très différentes. Europe, on construit *avec*, on est dans la co-construction avec les autres pays, avec la Commission Européenne, notamment à un niveau législatif avec actuellement des propositions de directives en négociation. Après nous avons l'Europe en tant qu'Europe dans le monde, et c'est vrai qu'il y a une coordination européenne de tout ce qui est par exemple déclaration ou analyse de ce qui se passe à l'OMS *(Organisation Mondiale de la Santé)*; nous y allons à la fois en tant que "France" et à la fois en tant que "Europe". Cette coordination est importante pour faire passer des messages, à un?? certain groupe de pays, avec beaucoup plus de poids. Il y a plusieurs niveaux, l'Europe des 27, qui construit une politique commune, dans laquelle est intégrée de façon concrête la santé, . Pour moi ceci est à part effectivement de ce que l'on peut faire avec l'OMS Euro, l'OMS, et les institutions internationales au sein desquelles la France siège du fait de ses territoires d'outremer.

Le Ministère de la Santé a plusieurs directions et la DGS *(Direction Générale de la Santé)* s'occupe effectivement de plusieurs sujets principaux:

- Sécurité des produits et pratiques, tout ce qui concerne la sécurité des produits médicaux et médicaments
- Sécurité sanitaire, c'est à la fois les attentats, mais aussi le sujet par exemple de Lactalys
- Santé, environnement et nutrition
- Santé des populations, qui concerne les maladies transmissibles et non transmissibles

Au niveau d'une direction telle que la DGS, il y a une coordination Europe/International. Au niveau du ministère, il y en a une autre qui coordonne des positions devant être consolidées au niveau inter-directionnel. Par exemple dans le cadre des négociations que l'on a actuellement au niveau européen pour le *Health Technology Assessment*, on a à la fois la DGS et la direction de la Sécurité Sociale, qui contribuent à une position "Ministère", qui est agrégée au sein de la délégation pour les affaires internationales et européennes. Au sein du Ministère il y a des positions que l'on consolide avant d'aller parler aux autres ministères. Quand on parle aux autres ministères au niveau de l'Europe des 27, ça se fait via un Secrétariat General des Affaires Européennes qui est piloté par le Premier Ministre, qui coordonne ces positions. Au niveau international cette coordination se fait directement entre les ministères avec le Ministère des Affaires Etrangères et les représentations permanentes.

Le rôle de la DGS est un rôle d'anticipation sur des enjeux qui vont venir. Par exemple au niveau européen on participe concrètement à des actions conjointes. Par exemple on co-pilote avec l'INSERM *(Institut National de la Santé et de la Recherche Médicale)*, l'action conjointe sur la vaccination qui répond aux recommandations du Conseil de mettre en oeuvre au niveau des Etats Membres un certain nombre de recommandations. Nous pouvons donc concrètement être dans des projets. Mais nous pouvons aussi être dans des projets internationaux, on co-pilote avec l'Australie et maintenant le Chili, le réseau international OMS d'étiquetage nutritionnel, faisant l'objet de discussions compliquées avec l'Italie. Nous avons en France le nutriscore avec une valeur ajoutée, notamment pour les populations les plus défavorisées. Il y a des questions qui se posent à chaque fois que vous prenez une mesure de santé publique, par exemple pour le tabac vous augmentez le prix ce qui induit une chute des consommateurs mais les gens s'habituent et le tabagisme reprend, et notamment sur la durabilité des actions. Cette durabilité des actions est un enjeu international sur lequel on échange beaucoup. L'intérêt du nutriscore est sur la reformulation des aliments puisqu'il s'appliquent aux aliments industriels. Nous avons vu que le nutriscore a permis de jouer sur une reformulation

des produits, ce qui peut avoir un impact durable sur l'obésité. L'intérêt c'est de lutter contre les maladies non transmissible, et aujourd'hui en terme de nutrition c'est la dénutrition qui va de pair avec l'obésité; on a l'augmentation de la dénutrition des personnes âgées mais aussi l'augmentation de l'obésité. Nous sommes aussi partie prenante donc de ce réseau international qui nous permet de comparer les stratégies et de discuter de la problématique. Il y a plein d'étiquetages qui sont en cours dans différentes parties du monde, mais avec une problématique identique de la mise en oeuvre dans l'industrie. Ceci permet un partage d'expérience par ce type de réseau.

Nous avons une stratégie nationale qui nous sert de base pour aller discuter avec les autres, et par exemple au niveau européen, le *sterring group* "Promotion et Prévention" a pour rôle d'essayer de decider dans quels domaines on peut avoir des échanges de bonnes pratiques, ou même simplement de pratiques, entre Etats Membres qui peuvent être financés par la Commission Européenne. Quand nous avons mis en place en France la vaccination obligatoire, l'Italie était entrain de faire la même chose, et donc on suivait de près ce qui se passait en Italie, car il était important aussi pour nous de voir comment les italiens ont fait et à quoi ils ont été confrontés. Il y a plein de choses comme ça qui sont très importantes pour nous, dans des domaines dans lesquels les pouvoirs publics ont une action.

Donc au niveau européen nous essayons de consolider (vaccination, nutrition…) de gros sujets que l'on porte et pour lesquels on peut travailler. Au niveau de l'OMS Euro, c'est très interessant parce qu'il y a tous les nouveaux pays de l'Est, qui étaient dans le bloc de l'Est, qui étaient fermés mais aujourd'hui font des choses qui sont intéressantes à voir en terme de santé publique et qui donnent un nouveau souffle à ce que l'on est entrain de faire. Les plans sont des plans qui sont plus adaptés à la zone, à la région. Quand j'étais à l'INCA, j'avais été invitée à Moscou pour une grande réunion sur le dépistage du cancer avec tous les représentants des sujets de la Fédération de Russie et anciennes républiques de l'Union Soviétique. L'organisation de leur système de santé est très interessante car il y a un chapeau commun, à peu près 20%, et ensuite des actions spécifiques avec une espèce d'autonomie, et un montage financier qui va avec. C'était donc très interessant de voir comment ils travaillaient ensemble sur des enjeux communs et très nouveaux.

Il n'y a pas de stratégie internationale. L'international c'est des stratégies de régions et des stratégies, par exemple la France est dans des réseaux francophones, de groupes d'Etats avec un dénominateur commun. C'est un découpage entre les enjeux internationaux, comme ceux

représentés par exemple par le réseau nutrition ou de la vaccination, et c'est vrai que l'on travaille à la fois avec l'OMS Euro et la Commission Européenne sur ces enjeux là car ce sont des enjeux qui dépassent les frontières. Vous avez des réseaux très différents avec une stratégie pays en fonction de quelque chose qui m'échappe un peu car je ne sais pas trop ce que veut dire une "stratégie d'influence". Pour moi les stratégies sont d'abords des stratégies collaboratives et ce que l'on met en oeuvre ici, ce sont des stratégies collaboratives. C'est ce qui a permis à l'Europe de se créer, de collaborer sur des sujets communs même si nous n'avons pas des intérêts nationaux qui convergent sur tout, ce sont quand même des sujets communs pour bâtir un espace commun. Pour moi l'international c'est d'abord de la collaboration car ça vous permet de connaitre des gens, d'échanger. Quand vous faites du projet collaboratif vous pouvez avoir des enjeux de recherche qui permettent d'assoir des actions de santé publique, de collaborer à plusieurs pour pouvoir mesurer les impacts de ces actions. Dans notre stratégie de santé publique, nous avons des actions avec une approche communautaire, le pass préservatif par exemple a été validé au Royaume-Unis. Sur la santé mentale, nous avons mis en oeuvre des actions qui viennent d'actions à l'international. C'est à la fois valoriser une approche et nos valeurs, et intégrer finalement ce que les autres ont réussi à faire en regardant comment ils ont fait, sur les voisins mais pas seulement. Nous avons toujours regardé ceux qui sont en avance, comment ils ont fait et si c'est transposable. La problématique c'est la transposition. Sur le pass préservatif avec l'approche communautaire des britanniques par exemple, ce n'est pas si évident ici car nous ne sommes pas sur du communautarisme en France comme au Royaume-Unis. C'est compliqué, mais c'est intéressant, pour moi l'international c'est ça.

J'espère que ce n'est pas ma vision trop personnelle que je vous donne mais c'est celle que l'on cherche à pousser ici; une approche projet, que ce soit au niveau européen ou pas, pour anticiper. Elle nous permet de confronter avec d'autres ce qui fonctionne et ce qui ne fonctionne pas. C'est aussi un peu ce que l'on a sous la présidence du G7 ici, ce que l'on veut pousser. Mais c'est compliqué. Le sujet qui a été choisi fais écho au sujet chapeau de la Présidence de la République qui est "Les inégalités", et nous avons choisi "Soins de santé primaires et lutte contre les inégalités de santé" pour le G7 santé. Dans ce chapeau, ce que l'on voudrait lancer c'est un échange de pratiques sur les soins de santé primaires car nous avons tous les mêmes problématiques. Je vous mentionnais la stratégie "Ma santé 2022", c'est aussi ça: soins de santé primaires, prévention, qui font que nous avons une réorganisation qui n'est pas que du soin mais de la santé au niveau national. C'est une problématique internationale avec la problématique de formation des professionnels de santé qu'on essaye de

pousser avec l'OMS et un certain nombre de pays. Ca c'est la problématique choisie pour le G7 avec une proposition de la France qui est passée mais qui va être compliquée à mettre en oeuvre, visant à la création d'une plateforme d'échange de pratiques en soins de santé primaires et qui permettrait d'avoir une visibilité G7 dans ce domaine là. Pour l'instant c'est en discussion et c'est compliqué, nous verrons ce qui en sort concrètement le 16-17 mai prochain.

Ce qui est important de comprendre est qu'il y a les principes, la stratégie, ce que l'on fait mais après il y a surtout comment on le porte. Nous essayons de porter en terme collaboratif et de s'impliquer, notamment dans les groupes de travail. Je pense que le Ministère des Affaires Etrangères a une vision du portage qui est un peu différente. On travaille ensemble et on essaye de travailler avec les autres, et c'est très intéressant. Dès lors que vous essayez de faire un programme sur des réseaux, ce qui est très interessant c'est de voir la réaction des pays, de comment ils peuvent s'inscrire dans un plan collaboratif, dans des réseaux. Ca fonctionne, il faut maintenant transformer l'essai, que le réseau soit actif, qu'il soit source de propositions, qu'il y ait des choses qui sortent concrètement, qu'il y ait un impact, des résultats mesurables. Toute la problématique internationale c'est la question de l'impact, a quoi servent les mesures. C'est la difficulté du multilatéralisme, et c'est un point important pour la France, le multilatéralisme, la difficulté du multilatéralisme et de la mesure de l'impact. Je pense que les relations bilatérales sont importantes pour porter de l'innovation, des sujets nouveaux, des dynamiques, mais le multilatéralisme est important pour avoir cette appréhension mondiale des sujets. C'est faire monter tout le monde avec de temps en temps des impulsions pouvant être portées par du bilatéral.

On croise plein de choses dans votre question, il y a la stratégie des régions, du contenu, et c'est une dynamique qui est en perpétuel croisement, en évitant que ça soit trop compliqué. Il y a beaucoup de groupes qui se forment mais on ne sait plus à quoi servent ces plateformes. Il faut rester simple tout en faisant et en restant inclusif. Le G7 était ainsi vu comme un petit club fermé, et le souhait d'Emmanuel Macron était de l'ouvrir notamment au G5 Sahel et de voir comment on pouvait ouvrir sur l'Afrique; afin que le G7 ait un impact, mais c'est très compliqué. D'un autre coté, il faut réinventer toutes nos structures multilatérales, en tout cas il faut qu'elles se réinventent, autrement on va retourner dans une espèce de contraction pouvant être dangereuse; on le voit avec le Brexit alors qu'on a rêvé l'Europe. Il y avait un rêve européen qui existe encore. Les critiques que l'on fait à la Commission Européenne sont des critiques de positionnement. On ne peut pas donner la faute à Bruxelles quand on n'a pas le

courage de porter sur des sujets compliqués, j'entends que c'est très compliqué, une position qui soit une position Europe. Il faut comprendre que construire le multilatéralisme est très compliqué, mais l'impact positif du multilatéralisme est à la hauteur de cette complexité. Je pense aussi qu'il faut réinventer le multilatéralisme. On a la chance d'avoir les Objectifs du Développement Durable, qui nous évite de reculer à l'âge de pierre sur certains sujets. Les ODD en santé ou autre, sur des sujets de droits humains, nous empêchent de reculer. On le voit avec plein de gouvernements élus qui sont sur des replis nationalistes, les ODD sont une barrière, qui a déjà sauté dans certains domaines comme l'agricole. Dans le domaine de la santé, les ODD tiennent et on ne peut pas faire moins. Il faut cependant voir combien de temps ils vont tenir, et c'est dommage car c'est une vision contemporaine de nos enjeux exprimée à tous les échelons. C'est un cadre dans lequel il faut inscrire nos actions, et surtout le faire en transversal. Ainsi souvent le Ministère de la Santé peut alerter et former.

L'intersectorialité est très importante. Sur des sujets comme la biorésistance par exemple, on a une feuille de route nationale, mais si nous n'avons pas une approche d'abord européenne puis internationale, nous n'y arriverons pas. Là-dessus, nous nous opposons aux stratégies des Etats-Unis, du Brésil, de l'Inde, et du Japon, des gros producteurs qui abusent des antibiotiques. C'est documenté, dans les pays où certains antibiotiques sont interdis chez l'animal, il n'y a pas de biorésistance chez l'humain. Mais dans les pays où ils sont sur-utilisés chez les animaux, il y a de l'antibiorésistance qui monte chez l'humain, et parfois à 50%. Dans les négociations du dernier Conseil Exécutif de l'OMS, on n'a pas réussi à se mettre d'accord sur autre chose qu'une déclaration très édulcorée, et pourtant nous avons fait front avec le négociateur au niveau Europe. Nous avons anticipé, essayé de mettre du contenu, mais il fallait rester à un niveau diplomatique, à une déclaration inutile montrant seulement que ce sont des sujets sur lesquels il n'y a pas de consensus.

Pour l'Italie je ne sais pas trop. Nous discutions également au niveau européen, du fait qu'il faudrait que nous ayons une approche plus visible et coordonnée sur ce que l'on fait à l'international. On négocie ensemble mais c'est toujours très compliqué de voir quel pouvoir de représentation on donne au niveau européen. La présidence allemande avait des velléités de mettre ceci à l'ordre du jour de sa présidence; une Europe de la négociation internationale.

- *La France a sa stratégie pour répondre à tous les enjeux dont nous avons parlé. Et nous avons beaucoup parlé du Ministère ainsi que de la transversalité, mais il y a aussi les acteurs privés et notamment les industries pharmaceutiques. Ces acteurs privés, quel rôle ont-ils sur ces enjeux, sur cette stratégie s'ils en ont un, et quelle est leur influence?*

C'est compliqué car à la fois nous ne pouvons faire une stratégie de santé sans parler aux différents acteurs, et notamment industriels, puisque nous avons quand même des enjeux communs de pénurie de médicaments, nous gérons la pénurie et ses enjeux de production. Il y a de vrais enjeux de sécurité, et c'est internationalisé. Ils sont donc partie prenante, mais tout en veillant à ce qu'il n'y ai pas de conflit d'intérêt en fonction des sujets. Les sujets pour lesquels il y a des décisions de politique de santé publique à prendre, bien sûr ils ne sont pas inclus. Mais on discute avec eux, on les reçoit régulièrement pour gérer l'approvisionnement en vaccins et médicaments au niveau national. Nous sommes obligés de gérer la sécurité du médicament. Tout ce qui est décision, santé publique, en tous cas dans nos comités, il y a une gestion des conflits d'intérêt qui est très dure, c'est une des plus dure au niveau mondial; avec les Etats-Unis qui étaient très en avance à un moment donné et qui sont entrain de regrignoter complètement. Le débat sur la gestion des conflits d'intérêt ne doit pas être réouvert, et la porte ne doit pas être ouverte aux intérêts industriels. Ce qui peut être choquant c'est que la présidence roumaine ait été sponsorisée par Coca Cola. C'est un débat très important à porter. Je ne sais pas quelle image ça donne d'une présidence européenne.

Après on a la société civile, et là l'enjeu est de savoir ce que représentent certaines associations. Vous ne pouvez pas leur poser la question sans qu'ils se fâchent et veulent partir de la table. Sur certaines pathologies nous savons ce qu'ils représentent, mais par exemple comment peut-on avoir des représentants des usagers de la société civile sur des sujets comme la vaccination? On a les anti-vaccins qui sont très organisés mais ça ne représente rien du tout. Ceux-là finalement comment on les insère dans un débat? C'est vrai que nos stratégies, avant quelles ne soient validées par le gouvernement, sont ouvertes systématiquement à consultation publique. Tout le monde peut contribuer. Mais par exemple dans des instances dans lesquelles on a envie d'avoir des avis et de consolider avec la société civile, sur certains sujets nous avons du mal à savoir qui nous devons inviter et ce qu'ils vont représenter. C'est un vrai enjeu pour l'ensemble.

Nous avons la présidence d'un petit réseau qui s'appelle "Diplomatie Santé" dans lequel nous avons mis ce sujet, qui parle de démocratie sanitaire et de comment travailler avec les usagers; qui d'ailleurs est une terminologie neutre, dépassant les malades, dont je ne trouve pas d'équivalence internationale.

Ce ne sont pas juste les pouvoirs publics qui décident, mais on co-décide, ce qui prend du temps. La question est de savoir avec qui co-décider à l'international. Dans le milieu associatif il y avait une grande question, celle de savoir si le milieu associatif ne freine pas le développement d'un pays. Car ils font à la place des pouvoirs publics sans avoir un suivi de ce qu'ils font ou sans avoir mis en place le vrai suivi que l'Etat ou le Ministère doit faire pour monitorer. C'est toujours compliqué dans une stratégie partenariale internationale, de savoir avec qui on travaille, à qui on va donner le pouvoir de faire finalement. C'est aussi un enjeu du multilatéral car on a les fonds verticaux, mais ceux qui ont les fonds et la façon dont ils travaillent vont influencer sur la façon dont les pays sont organisés pour recevoir les soutiens.

- *A l'inverse, certains acteurs privés français sont assez bien placés, sont des leaders sur des marchés émergents comme la Chine, qui est un pays qui s'ouvre et recherche des compétences en santé en Europe. Est-ce que le Ministère de la Santé aide ces acteurs privés d'une certaine manière?*

C'est très compliqué car ils n'ont pas forcement besoin de nous, mais ce que nous avons essayé de faire, et il y a eu de longues discussions, c'est de faire un *package* d'offres en terme d'expertise. Il y a le *package* technique, mais aussi l'offre d'expertise du montage global d'un plan et d'essayer de coordonner ces offres d'expertise pour répondre aux appels d'offre internationaux. On est partis de façon trop ambitieuse dans les discussions qu'on avait au lieu de se concentrer sur les choses non encore coordonnées, sur les problèmes spécifiques. La mobilisation de l'expertise est un enjeu ici. Nous sommes souvent sollicités pour aller aider à faire des plans à l'international. Le problème c'est qu'ici nous sommes déjà débordés, donc nous n'avons pas le temps. Nous avons réussi à nous réorganiser pour offrir au Maroc cette expertise qui nous était demandée. Nous avons ici au Ministère une expertise que l'on n'arrive pas a valoriser par manque de temps et de moyens, avec une difficulté à prioriser. Ici, en terme bilatéral, de ministère à ministère, si la Ministre se déplace, ça veut dire qu'il aura peut-être un accord bilatéral et qu'il va falloir le faire vivre. Il faut arriver à faire vivre ce que nous avons déjà. L'agenda international s'impose à nous. L'agenda s'impose, et il nous faut avoir

une présence, et une présence utile. Vous avez votre stratégie, l'agenda international et vos moyens. Quand vous croisez tout ça effectivement, vous faites ce que vous pouvez. Forcement, faire de l'international c'est passer du temps à discuter avec les autres, pour avoir quelque chose qui soit commun, ce qui prend énormément de temps.

- *Justement, parmi tous ces enjeux, est-ce que le Ministère prend en compte de nouveaux enjeux, ou des enjeux qui émergent, qui peuvent être très politiques? Je pense par exemple aux Etats-Unis qui accroissent leur arsenal législatif et judiciaire pour exporter leurs lois. Nous l'avons vu avec la BNP, mais dans la santé ça se fait de plus en plus; les Etats-Unis utilisant la FDA (Food & Drug Administration), et les TBT (Technical Barriers to Trade) pour servir leurs intérêts. Est-ce que la France ou l'Europe prennent en compte ce nouvel enjeu?*

Il est vrai qu'au niveau européen nous avons notre marché unique, et l'Europe est très vigilante à ce qu'il n'y ait pas de barrière dans notre marché communautaire. Tout est très imbriqué, et nous le voyons avec le Brexit, c'est l'exemple d'une industrie mondiale, la santé est une industrie mondiale. Bien sûr nous avons nos règles ici avec l'EMA (European Medical Agency) qui accorde ou pas la mise en circulation d'un produit, et après chaque pays définit ses systèmes de remboursement. Or pour faire court, un médicament non remboursé n'a pas de marché. Tous les enjeux de discussions internationales sont pilotés à la fois par des agences de régulation, et des dynamiques de marché avec des accords chapeaux comme les TRIPS (Accord on Trade-Related Aspects of Intellectual Proprety Rights). Vous croisez tout ça, mais vous pouvez très bien avoir des usages compassionnels qui vous permettent de balayer tout ça, en court-circuitant l'ensemble. L'OMS met aussi à disposition des pays des moyens de négocier l'accès à des packages de médicaments essentiels à un cout très interessant. Sauf que ça veut dire que nous payons pour les autres, et les Etats-Unis disent qu'ils payent pour le reste du monde mais ils ont un peu raison car chez eux le cout des médicaments est très élevé.

Personne n'a envie d'harmoniser quoi que ce soit et c'est très compliqué. Par exemple on aurait envie de créer une filière industrielle sur les antibiotiques car on a des problématiques d'approvisionnement et de maintien sur le marché de vieux antibiotiques qui fonctionnent encore et qui éviteraient que nous ayons de l'antibiorésistance sur les nouveaux. Toute la problématique du maintien d'une filière industrielle ou même la créer, c'est très compliqué car il ya la technicité et toute la problématique d'approche; adopte-t-on une approche prix/volume

ou une approche plus globale qui permette d'assurer un financement pérenne? Tous les pays réfléchissent à ça, nous y réfléchissons de façon collective au niveau européen. Ce sont des mécanismes à la fois compétitifs pour l'industrie et dans les négociations, et ça dépasse les seuls enjeux nationaux puisque ce sont des enjeux organisationnels d'entreprises qui sont des multinationales. Vous avez raison puisque de toute façon la FDA vient aussi vérifier ici, mais ça dépasse les seuls enjeux nationaux.

- *En parlant justement de l'Europe, il y a beaucoup d'experts qui prévoient une avancée forte des partis populistes et nationalistes à l'Europarlement suite aux prochaines élections. Dans un tel cas, doit-on s'attendre à un retrait du Parlement sur les questions de santé.*

Ça existe déjà. Mais vous savez c'est un trialogue, il y a le Parlement, le Conseil de l'UE et la Commission Européenne. Donc le Parlement dit ce qu'il veut mais il y a aussi le Conseil des gouvernements. C'est une démocratie à la fois d'élus directs et indirects donc nous verrons. J'espère que ça ne figera pas tout. Ce qui n'est pas gagné car vu que les partis traditionnels ne se sont pas remis de la dernière élection présidentielle ici, ce sera un vrai challenge, dans tous les pays.

- *Pour terminer, pensez-vous que la France peut utiliser le domaine de la santé comme un instrument de politique étrangère?*

Oui et non. Ca prend de la place dans tous les accords, dans l'Agence Française du Développement qui bénéficie de? milliards en plus, et dans la coopération entre pays; il y a toujours un volet un peu santé ou éducation. Oui, ça fait partie prenante d'une stratégie, mais c'est normal. Quand vous regardez la définition de la santé globale, c'est avec la globalisation des échanges et les enjeux de sécurité finalement, que la santé globale est arrivée donc avec toute cette dimension aussi d'inégalités entre pays et populations. Effectivement, les enjeux sont des enjeux de gouvernance et de fait que les pays puissent construire eux-mêmes une stratégie, qu'elle ne soit pas pilotée par des fonds extérieurs. Après oui, nous recevons en France des personnes qui viennent d'autres pays se faire soigner, on exporte de la technologie et même des musées; c'est une autre dimension, un peu plus culturelle et humaine dans les relations froides des pays?.

Mais je pense que tous les pays ont intégré la santé comme étant une dimension de leur collaboration avec l'avènement de cette globalisation des échanges. Mêmes si nous ne le voulons pas, la sécurité sanitaire fait que nous sommes obligés de parler aux autres et d'avoir une chaine. On le voit très bien avec Ebola et la rougeole, mais aussi avec les migrations, le tourisme… c'est tout ça qui fait que la santé globale est importante et que cette stratégie internationale doit s'affirmer. J'ai du mal à savoir ce que sont les stratégies d'influence. C'est le collaboratif pour moi qui est interessant, pour créer du lien. Et puis le fait que vous ayez des gens qui viennent étudier en France. L'ancien ministre chinois de la santé était venu étudier en France à l'hôpital St Louis. C'était donc intéressant car la dernière fois qu'il était à Paris, il racontait ce qu'il avait découvert en venant en France, qui était très très différent de la Chine, et comment certaines de ses propositions lorsqu'il était ministre s'en sont inspirées. Il y a ça aussi, tout ces échanges. La diplomatie c'est d'abord de faire ensemble et d'apprendre.

Il y a de grandes initiatives, par exemple le groupe GFAOP a été créé parce qu'à l'institut Gustave Roussy, où ils reçoivent des personnes du monde entier pour des formations, des professionnels ayant gardé contact ont créé un réseau francophone en cancero-pédiatrique. Ce réseau a notamment montré que ceux qui faisaient partie du réseau avaient une mortalité identique pour certains cancers à celle de la France. Donc que c'était possible d'avoir un impact positif par le partage de bonnes pratiques, protocoles et tout ce qui allait avec. L'impact de ce réseau était mesurable. Ca c'est ce que j'appelle la vraie diplomatie. Heureusement que les contacts perdurent, que les gouvernements sont élus temporairement mais que les personnes qui travaillent restent plus de temps. Il est important d'avoir une continuité, de préserver ce que l'on a bâti. Les enjeux que l'on retrouve à l'international sont les mêmes: l'accessibilité aux soins avec un écart entre les villes et les campagnes, de couts additionnels… On a une base d'enjeux que nous partageons, avec des réponses différentes car elles dépendent de l'histoire et des arbitrages. Reconstruire et maintenir le dialogue, passer d'une génération matérialiste à des générations qui montent vers quelques chose que je qualifierais de philosophique, de spirituel.

Sur l'Italie, ce qui est compliqué, c'est que c'est une Italie des régions et nous avons toujours eu du mal à savoir où étaient les prérogatives et comment collaborer. Car la France est beaucoup plus centralisée. La situation est similaire avec l'Allemagne et les "Lander". C'est un enjeu collaboratif vrai. Quand on a envie de savoir à qui nous devons parler au niveau italien, nous devons évaluer si ça concerne la région ou le ministère, même si c'est très bien

organisé en terme de communication et de réseau; ce qui n'est pas forcement le cas ici. En santé globale, ça doit être un enjeu globale pour l'Italie. Mais de fait, il y a des initiatives régionales très innovantes dans certains secteurs, et notamment des partenariats public-privés très innovants car elles s'appuient sur des régions fortes. Dire qu'ici on ne défend pas nos industries, je ne sais pas, nous Ministère de la Santé, nous ne sommes pas là-dedans, c'est quelque chose qui regarde plus le Ministère de l'Economie ou le Ministère de l'Agriculture avec qui d'ailleurs nous ne sommes pas toujours d'accord, comme sur l'alcool. La santé publique c'est très compliqué, et de surcroit quand on prend en compte tous les autres enjeux.

Appendix 3: Interview with Dr. Taraneh Shojaei

TARANEH SHOJAEI

Ministère de l'Europe et des Affaires Etrangères - Phone call[562] - 24/05/2019 - 2PM-2.30PM

- *Pour commencer par une question un peu large, quelles sont les priorités et stratégies du Quai d'Orsay aujourd'hui dans le domaine de la santé? Et quel rôle se donne la France dans le monde en terme de santé mondiale?*

La stratégie du Ministère de l'Europe et des Affaires Etrangères (MEAE), telle que définie par le MEAE en collaboration avec d'autres Ministères ainsi que la société civile et des instituts de recherche, pour les politiques de santé mondiale correspond très clairement à ce qui est actuellement porté par le gouvernement. C'est un cadre conceptuel qui guide l'action du Ministère. Aujourd'hui la France porte au niveau international le projet d'une couverture sanitaire universelle. Mais surtout, et c'est un élément à la fois nouveau et important, la France favorise le renforcement des systèmes de santé tout en luttant contre les maladies. Ces deux dimensions sont très importantes, si ce n'est cruciales et complémentaires, car on ne saurait négliger la lutte contre les maladies aussi bien infectieuses que chroniques. Autrement dit, cette stratégie constitue un cadre englobant et hollistique sans mise en opposition.

Si la sécurité sanitaire reste un axe important, la France se concentre aussi et surtout, contrairement à de nombreux pays, sur la santé des populations et donc les déterminants de la santé. La France favorise les actions préventives, de dépistage et de traitement des populations vulnérables telles que les enfants, femmes enceintes, personnes âgées ou migrants. Or si nous sommes en avance nationalement, au niveau international ce projet, ces concepts, sont difficiles à porter. Nous avons une expertise et un système reconnus. En faisant toujours référence à notre stratégie, nos actions visent donc à utiliser nos atouts pour diffuser et porter l'expertise française à l'international, pour favoriser notre rayonnement.

[562] The following interview has not been registered. The retranscription is based on the notes taken during the phone call with Dr. Shojaei

- *Quels sont le rôle et l'influence de l'Union Européenne dans le domaine de la santé mondiale et de l'aide au développement?*

En terme de développement, l'UE a identifié 4 priorités. Or si la santé avait été identifiée comme l'un des enjeux du développement, elle ne fait plus partie aujourd'hui de ces priorités, mais a été diluée dans celles-ci. L'action de l'UE en terme de santé est portée via des financements importants mais est beaucoup moins visible à l'international, même si les budgets de l'UE pour le développement en Afrique sont conséquents. Il en est de même pour les politiques de santé portées par l'UE à l'international. Par ailleurs, c'est en France le Ministère de la Santé qui est en lien avec les pays européens là où le MEAE se concentre sur l'Afrique de l'Ouest et l'OMS.

- *Sur quelles institutions se concentrent votre direction, et plus généralement le MEAE pour mener à bien ses politiques, stratégies et intérêts?*

Ceci dépend des axes dont nous parlons. Concernant le premier axe, nous nous concentrons sur l'engagement dans les fonds internationaux à hauteur de 500 millions €. L'atteinte de la couverture sanitaire universelle est très politique, et très difficile au niveau international. Car si ce projet est politiquement porté par tous, la mise en place reste très complexe. D'où une concentration première sur le renforcement des systèmes de santé via l'investissement dans les fonds internationaux. Bien sûr la France utilise aussi son réseau d'influence pour porter des messages à l'international. En d'autres termes, si la partie financière n'est pas négligeable, la part que jouent les partenariats et l'influence reste difficilement quantifiable.

En ce qui concerne l'axe 2, c'est principalement le Ministère de la Santé qui s'en charge, et le MEAE place l'OMS en chef de file. Concernant le troisième axe, nous pouvons constater que la prévention et la promotion de la santé restent souvent orphelines au niveau international, et le Ministère de la Santé s'attache à les promouvoir. Enfin, la prise en charge des populations vulnérables est promue via le financement des partenariats mondiaux, par exemple dans l'éducation, ou régionaux. Ainsi la France finance des fonds qui agissent au Sahel sur la mortalité maternelle et infantile et sur la santé sexuelle. Ces initiatives permettent de porter des messages sur les droits sexuels; messages qui sont aujourd'hui difficiles à faire passer au sein des institutions internationales en raison de l'opposition de certains pays occidentaux comme les Etats-Unis sur la question de l'avortement. En somme la France porte ses

politiques et concepts via des financements et l'Agence Française du Développement, d'où la forte augmentation en 2019 des aides au développement dans le domaine de la santé.

Toutefois il est important de savoir que le MEAE se concentre sur les pays d'Afrique de l'Ouest et francophones là où le Ministère de la Santé agit partout dans le monde en fonction des opportunités bilatérales. La concentration du MEAE s'explique par divers facteurs. Elle est tout d'abord historique et linguistique, c'est une opportunité pour faire vivre la francophonie. Mais il y a aussi une dimension pratique en cela que ces pays ont pris comme modèles administratif et sanitaire les systèmes français, et suivent ses évolutions. Il est important aussi de ne pas négliger les attentes fortes de la part de ces pays envers la France. Enfin, ces pays ont de très mauvais indicateurs de santé.

Le MEAE, promoteur de la stratégie française en santé mondiale, porte une vision globale ancrée dans le multilatéralisme via les fonds mondiaux relatifs à la santé comme le GAVI, ou en terme d'influence dans les institutions telles que le G7, le G20 et bien sûr l'OMS.

- *A propos de l'OMS, le Président Hollande souhaitait en 2016 faire du bureau de l'OMS de Lyon un véritable centre de préparation aux urgences sanitaires mondiales. Qu'en est-il aujourd'hui?*

La place du bureau de l'OMS à Lyon, et la volonté de l'organisation d'y installer son académie, fait partie des discussions du Quai d'Orsay avec l'OMS. Il est cependant encore beaucoup trop tôt pour pouvoir en dire plus. Lyon a beaucoup d'atouts, d'où les volontés conjointes de l'OMS et de la France de développer ce bureau; c'est d'ailleurs pourquoi le MEAE a versé près de 5000€ au bureau de Lyon pour accroitre sa visibilité.

- *La France, et de la même manière l'Europe, n'a-t-elle pas un rôle a jouer, alors quelle perd de son influence sur le monde, à essayer de "gouverner par les règles" et via le domaine de la santé; là où ses atouts sont probablement les plus importants? Selon-vous, demain, la France pourrait utiliser le domaine de la santé comme un instrument de politique étrangère et de pouvoir?*

Ca dépend du sens que vous donnez à la santé. Dans le sens large du terme, la France via le Ministère a un rôle à jouer, mais aussi les acteurs privés, les fondations françaises, les instituts de recherche. Personnellement je pense que la santé est un enjeu politique qui est une porte d'entrée car encore apolitisée. La santé permet donc de porter des actions et politiques difficiles à porter dans d'autres domaines. L'exemple le plus parlant est probablement la question des droits sexuels et de l'avortement. Nous n'allons en effet pas à l'encontre de la régulation des pays qui l'interdisent, mais via des initiatives portant sur la santé maternelle, infantile et sexuelle, nous pouvons porter une certaine influence sur ces problématiques, et donc porter des messages politiques.

Appendix 4: Interview with Mrs Modesta Visca

MODESTA VISCA

Ministero della Salute - Phone call[563] - 24/06/2019 - 1.30 PM-2.00PM

- *L'Italia è riconosciuta per la qualità e l'alto livello del suo sistema sanitario, sia al livello istituzionale che ospedaliero o farmaceutico. Come possiamo spiegare questa alta qualità?*

Il punto forte del sistema sanitario italiano è la sua universalità. Questa universalità del sistema è una garanzia costituzionale. In poche parole, il sistema garantisce a tutta la popolazione un pacchetto di servizi, tra cui per esempio le azioni di prevenzione o di presa in carica. Il sistema sanitario italiano è accessibile a tutti, indipendentemente dalle loro risorse economiche o dal loro statuto. Possiamo prendere l'esempio dei migranti sbarcati in Italia, i quali sono vaccinati gratuitamente prima di sbarcare. Il tutto per una spesa in rispetto al PIL più bassa degli altri paesi (circa 114 miliardi €).

Inoltre, il sistema italiano ritiene un'efficiente organizzazione che permette un'ottima presa in carica dei pazienti. Perciò il tasso di mortalità evitabile italiano è tra i più bassi al mondo. In parallelo, i tassi di trattamento delle patologie e di presa in carica ospedaliera sono bassi grazie ad una prevenzione efficace, e ad un'organizzazione che permette l'identificazione delle problematiche di salute al più presto. Su questo punto di vista, l'Italia ha resistito allo shock economico mondiale del 2008.

Un altro punto forte del sistema italiano è la sua prossimità con la popolazione. In effetti, se la strategia sanitaria viene definita a livello nazionale, le regioni erogano questa strategia e gestiscono il livello locale, costituto dalle LEA e ASL, le quali sono organizzate in distretti. Poi la strategia sanitaria nazionale comprende anche, a differenza di molti altri paesi, la sicurezza del cibo e la sanità animale e le zoonosi. Inoltre, questa strategia, definita dal Ministero, è legata a l'Agenzia del Farmaco (AIFA) e al Consiglio Superiore della Sanità.

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[563] The following interview has not been registered. The retranscription is based on the notes taken during the phone call with Mrs Modesta Visca

- *Quali sono le priorità delle politiche di sanità publica italiane oggi?*

Negli ultimi anni, il programma tende alla riorganizzazione della rete sanitaria, all'immagine delle riforme delle anni 70, in modo tale da essere più vicino al cittadino. Perciò sono stati sviluppati degli sportelli unici che permettono una presa in carica unica tramite degli strumenti di identificazione che valutano i bisogni del paziente. Ancora oggi molto deve essere fatto, e in particolare nella messa in relazione e la cooperazione tra i diversi professionisti e le diverse strutture del sistema sanitario e ospedaliero.

Questa riorganizzazione della rete e della sanità in generale è dovuta all'invecchiamento della popolazione. La volontà principale è quella di una maggior integrazione col sociale. Abbiamo una strategia incentrata su questo fenomeno, sulle patologie croniche e sulle persone sole. Gli altri campi di sanità pubblica sono ben gestiti dal sistema sanitario italiano, abbiamo per esempio visto una riduzione in termine di cancri, ma questi saranno sempre più importanti e ci concentriamo su di loro per preparare il futuro. Inoltre la strategia sanitaria italiana è anche centrata sui giovani e la prevenzione contro il consumo abusivo di alcol e tabacco.

Come lo sa, l'Italia va verso una forma di federalismo con delle regioni che ritengono una forte indipendenza; lo vediamo nel fatto che la sanità sia tra gli argomenti maggiore delle conferenze tra lo Stato e le regioni. Nel campo sanitario per esempio molte regioni subdelegano ai comuni, e alcune sono meglio organizzate. Però il livello nazionale non deve essere sottovalutato, soprattutto nel controllo e il monitoraggio delle disuguaglianze nell'accesso al sistema sanitario, ma anche nel controllo economico e qualitativo dei servizi sanitari.

- *Come possiamo valutare l'influenza dell'Europa sulle politiche di sanità pubblica italiane?*

L'influenza europea e internazionale si realizza soprattutto tramite gli investimenti e gli orientamenti.

- *L'Italia per quanto riguarda la sanità, è un leader europeo. Come questa posizione viene usata dall'Italia, sia nell'ambito economico che politico?*

L'Italia, partecipando a molti tavoli internazionali, ha un'influenza politica. Per esempio l'Italia è molto in avanti nel campo delle zoonosi. L'Italia è anche una referenza scientifica, ospitando sul suo territorio 3 dei 21 maggiori centri di ricerca scientifica. In poche parole, l'Italia prova a diffondere i suoi assets al livello europeo; tramite le best practices e il miglioramento di sistemi già esistenti.

Questa dinamica si verifica anche a livello internazionale, l'Italia provando ad aiutare i paesi, anche sviluppati, nell'implementazione della copertura sanitaria universale. In effetti molti paesi devono ancora sviluppare ed implementare le raccomandazioni internazionali in questo senso.

- *Chi sono gli attori più importanti, che influenzano di più la programmazione sanitaria italiana?*

Gli attori più importanti sono le direzioni del Ministero della Salute per la programmazione e la prevenzione. Aldilà del Ministero, gli attori principali sono le regioni che insieme al Ministero della Salute collaborano nel quadro della conferenza Stato-regioni. Questa collaborazione avviene tramite tavoli tecnici e politici. In effetti, le regioni nominano dei referenti che negoziano nel quadro della conferenza Stato-regioni. Le proposte di legge sono analizzate in una prima sede tecnica in cui le regioni prendono posizione. Poi il testo di legge viene negoziato e approvato in sede politica in consultazione con i referenti delle regioni.

L'AIFA ha anche un ruolo molto importante. L'EMA definisce le missioni però le strategie e implementazioni sono definite e gestite dall'AIFA, tra cui i prezzi. C'è quindi un coordinamento importante con il Ministero, e l'AIFA ritiene un ruolo di primo piano.

- *E oltre gli attori pubblici, quid degli attori privati?*

Esiste un sistema di accreditamento degli attori ospedalieri privati a seconda del fabbisogno regionale. Infatti, gli attori ospedalieri privati devono essere accreditati per potere partecipare ad alcuni tavoli. L'accredito viene consentito in base a criteri e requisiti regionali ma sono inquadrati da decreti e leggi nazionali.

- *Come le basi ideologiche dei recenti governi influenza l'attuale programmazione sanitaria italiana?*

Tutti i governi hanno lavori su ambiti sanitari importanti e ampi. La differenza è il tema su cui si concentrano, ma tutti lavorano sull'ambito sanitario in maniera importante. L'attuale governo lavora sulle consultazioni pubbliche che dimostreranno i temi precisi su cui si vuole concentrare riguardando la sanità. Oggi la priorità rimane però il rafforzamento della rete territoriale e la riduzione delle disuguaglianze nell'accesso alle cure.

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Master's Degree in International Relations
Major in Global Studies

Chair of International Public Policies

Global Public Health as a tool and instrument of power in contemporary foreign policies. The cases of Italy and France.

Supervisor
Professor Antonio La Spina

Candidate
Grégoire Rigoulot-Michel
Student Reg. n.638952

Co-supervisors
Professor Ivan Timofeev
Professor Daniele Mascia

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The outcome of those debates in the twenty-first century will depend, as it has always done, on national histories and cultures, international developments and political will.

Dorothy Porter - *Health, Civilization and the State*

Abstract

Silja Häusermann shows in his work that welfare and social spendings differences among States can be linked to the importance of politics on ones health and its power to shape society[1]. Indeed, in the words of Tabuteau, health is a major collective and political challenge[2]. Such theoretical thinking has been at the core of Michel Foucault's work and concept of biopolitics. It also constitutes one of the most important assumption on which is based this thesis. Foucault allowed a scientific jump in the understanding of health and its relations with power and politics. The *Birth of the Clinic*[3] is in this regard fundamental to seize health in its full spectrum. Evidently Foucault's work knows fragilities and has to be updated for the XXIst century. Yet, as explained by Roberto Machado, Foucault's entire work has to be understood as a research on modern knowledge in relation with death[4]. Therefore the present thesis acknowledges Foucault's importance without however discharging some of its critics.

Through the concepts of biopolitics and later biopower, Foucault tried to highlight the links between health and power; limiting himself however to the national scale. Nonetheless due to the high level of globalisation known by contemporary societies, his theories can constitute the basis to a similar analysis made in the frame of international relations sciences. Globalisation processes and global actors have been critical in globalising health and introducing some similarities in local biopolitics. Christensen advanced the impact of global actors, and especially actors that *became* global, on global processes of cooperation and competition[5]. By adding expertise and financial resources, global actors have impulsed a

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[1] Silja Häusermann, "Welfare State Research and Comparative Political Economy", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, June 2018, p.2

[2] Didier Tabuteau, "Droit de la santé et économie de la santé, *in* Bras Pierre-Louis & al., *Traité d'économie et de gestion de la santé*, Presses de Sciences Po, Paris, 2009, p.88

[3] Michel Foucault, "Naissance de la clinique", Quadrige 9th edition, *Presses Universitaires Françaises*, Paris, April 2015, 287 pages

[4] Roberto Machado, "Foucault, Philosophy, and Literature", *Contemporary French and Francophone Studies*, Vol. 16 (2), Routledge, London, March 2012, p.230

[5] Mikkel Christensen, Mikael Madsen, "Global Actors: Networks, Elites and Institutions", *Oxford Research Encyclopedia of Politics*, Oxford University Press, Oxford, October 2016, p.18

higher degree of flexibility within health governance[6]. Indeed, such actors have been key in incorporating health in foreign policies and strengthening global health governance. Nevertheless, health remains perceived as a so-called "low-politics" even in States that are at the peak of health-related technological development, as France or Italy. The paradox of States that are looking for renewed power but also neglecting a field within which they have assets, interrogates on the role and place of global public health within States foreign policies and strategies of power.

The primary aim of this thesis is therefore to study the impacts of global public health agendas in France and Italy's definition of foreign policy, and how it currently influences their strategy of power. Therefore the core of the present thesis is to understand how health can be understood as a source of power and why two European States, traditionally active in the field of global public health, are limitedly using their public health agendas as foreign policy tools and instruments in the framework of their strategy of power in the XXIst century.

Recalling the pioneering work of Foucault, and more particularly his famous book *Naissance de la Clinique* as well as his lectures on biopolitics at the Collège de France, the place of health in modern societies is more important than ever before. Nevertheless, such increasing relevance of public health in the life of the State and society does not undermine the role and place of power within them. That's why the first part of this thesis focuses on the relations of power and health in the XXIst century. Taking a step further, the core of this part lies on the concept of moving sources of power. From Sun Tzu in *The Art of War*, on to the most contemporary scholars, power has been a core concept of the study of international relations; most probably because of the legitimising dimension of such force. Yet, power remains today a highly debated concept that the international relations approaches, such as realism, liberalism or constructivism, only partially explained. Relying on the constructive-realist approaches, the first chapter explores the idea of power as a legitimising flow from moving sources. This understanding will moreover be enriched by its projection to the current change of world affairs. It would then be showed and argued that such concept of power strengthen the argumentation for global public health as a power source in contemporary world affairs. Based on the previous conceptualisation of power, the relevance of public health as a power source for European powers in the XXIst century blossoms. Indeed, the past decades have

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[6] Wolfgang Hein, *The New Dynamics of Global Health Governance,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.60

acknowledged a geopoliticisation of health that nurtured its power-capital. Thus, in this era of health governance mutations, setting the rules of global public health is of a great potential for power and could become a game changer for European States.

France and Italy are two European States that, above the influence that temporarily have elected governments, are more and more challenged on the international stage. Former global powers, they currently seem unfit to the XXIst century, a century of large ensembles and spheres of influence. Yet both countries are looking for renewed powers and influences; Rome to be regional power through a European influence, Paris to be a global power thanks to its perceived status of European power. The Italian strategy of power for the XXIst century is first of all based on making Italy a primary power within the European Union. Despite Rome entertaining a swinging relationship with Bruxelles, its foreign policy is focused on the European Union. This is why within European health governance, Italy evolves between technicality and political influence. Paris however is developing a rather different approach than Rome, focusing on using its status and strengths as European power to unfold, or revive, its global power status. Indeed, France appears to be stuck between its past as world power and its uncertain future. However, and because its status of European leader is criticised, health could constitute a bridge from power to effective influence.

If a reconceptualisation of power, in order to assess its fluid and actor-specific origin, and an understanding of the geopolitical dimension of public health are undertaken, one can see that public health is, or can be, a new power source for France and Italy in the XXIst century. Indeed, both countries possess unexploited leadership and market potentials regarding health governance. It is shown that public health integration into foreign policies has had geopolitical consequences and introduced new dynamics in both European and global health governance. Moreover it appears that health could constitute a power capital for France and Italy, especially since the empowerment of global public health within the European arena, and because health constantly swings between apoliticisation and high-politicisation. Nonetheless, no States have by far developed an ambitious and constant power strategy regarding regional and global health governance. The unexploitation of such potentials for power in a highly competitive world can however be explained by an unstable political involvement toward a global health strategy. It is therefore argued in this thesis that France and Italy have neglected this political capital, going back and forth in this field due to high uncertainties regarding a European biogeopolitics.

Céline Paillette showed that the fight against epidemics constituted during the XXth century a *force profonde*, as theorised by Pierre Renouvin, in a way that they participated to the internationalisation of public health and its governance[7]. Indeed, public health has always been, since the United-Nations creation, of primary interest for many developed economies, and especially European States. Even before 1945, international institutions were created to strengthen cooperation and advance interests in the field of public health. Another underlying fact is the permanent willingness of the World Health Organisation (WHO) to expand its powers and fields of actions, as highlighted by the famous case on nuclear weapons legality. Currently, health remains of primary importance, France being a major actor in health institutions and on medicines' production, Italy remaining a leader in advanced surgery and medicines' production. Combining several sets of both internal and external interests, global public health remains crucial in the French and Italian foreign policy, and strategy of power for the XXIst century.

Nevertheless both France and Italy recently encountered backlashes: France having failed in securing its interests regarding the nomination of the WHO's General Director in 2017, and Italy loosing the race in hosting the new headquarters of the powerful European Medicine Agency. Furthermore, these two meaningful failures are mainly due to the French and Italian governments lack of continuous, strategic and relevant efforts. In addition, France and Italy are facing since the 2007 economic crisis a significant economic slow down and a declining influence on both regional and international stages.

That's why, in the frame of the rising multipolar world and the renewing of both French and Italian leadership and strategies of power, studying the impacts of global public health on their strategies of power for the XXIst century, would help scholars, private actors and politicians to better understand these strategies and how it affects the global public health agenda. Furthermore, by providing an insight on the roles and impacts of global public health on the French and Italian foreign policy, it would give scholars, private actors and politicians a basis to further secure French and Italian interests in this field. In the end, because Ann Burlein highlighted the deep interlinks between biology, health, culture and politics[8], this

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[7] Céline Paillette, "De l'Organisation d'hygiène de la SDN à l'OMS. Mondialisation et régionalisme européen dans le domaine de la santé, 1919-1954", *Bulletin de l'Institut Pierre Renouvin*, Vol. 32, IRICE, Paris, 2010, p. 194

[8] Ann Burlein, "Knowledge is Made for Cutting: Foucault, Cognitive Science, and Intellectual Taste", *Method and Theory in the Study of Religion*, Vol. 24, Brill, Leiden, 2012, p.119

would help understand why and how France and Italy could improve their geopolitical power and influence on the European and global stages by using their potential in public health .

Thus, the core idea of this thesis is that there are fields of international relations that can be understood, seen and studied as privileged sources of power. These fields are evolving according to megatrends, world order, and international actors. But these sources are also and above-all « country-type » specific. If everyone agrees that BRICS will, in a more or less near future, implement and assure their supremacy on the world affairs, some voices are rising saying that they are still far from the American power. But what about Europe, the European Union and European States? Always seen as threatened, weak, condemned to international insignificance, the opposite would be argued here. Precisely because of the increasing transformation of the knowledge on life[9] and the growing importance of global public health in international relations and power distribution in the XXIst century. It is found and argued in this thesis that global public health can provide to West European States, and especially to France and Italy, a room for power in the XXIst century. It can also strengthen their position in the world affairs facing the growing power of emerging and emerged countries such as India, China, Brazil or Russia.

Health, public health, global health governance, health in foreign policies, these concepts rose in the last decades and especially since the 1990's as various forms of biopolitics' crystallisation. Health in social studies and more acutely health in international relations has yet been largely labelled and viewed as low politics. Even more, it would be argued that health in social sciences and international relations but also, and probably above all, in national and international politics, has been stringed to human rights and global justice theories. Such tendency, despite its brief fading during the era of health security prioritisation, importantly undermined the full assessment of public health and its governance realities. If the dominance of global justice and human rights scholars on international health affairs allowed the necessary improvement of global health determinants and favoured the growing importance of health in contemporary societies, it also on the short and long term damaged the unfoldment and understanding of health governance.

"Determinants of global health include a complex mix of biological, social, economic, political, environmental and security issues many of which, as Lee, describes are driven by

[9] Philippe Raynaud, "Michel Foucault. Philosophie, histoire, politique et littérature", *Commentaire*, N° 153, Commentaire SA, Paris, 2016/1, p.17

aspects of globalisation"[10]. Indeed, global health as a fragmented definition and unfolds in a myriad of ways that are driven and drivers of globalisation. As such, global health appears to have, when distancing ourselves from the social studies and global justice approaches, a fundamental interplay with power and its unfoldment in the XXIst century. Foucault showed the growing importance of biopolitics in modern and contemporary societies. It has been demonstrated here that, taking a step forward from Foucault, contemporary global affairs are characterised by the rise of power sources which requires a moving and fluid understanding of power and its implementations. In this regards, public health can constitute a source of power for the most technologically advanced States such as the European ones, and more particularly France and Italy. The two sister countries are looking for renewed powers and influences on both the European and global stages. If Rome concentrates on being a regional power through a European influence, Paris seeks to be a global power through its perceived status of European power. Yet if, as already said, one makes the effort of reconceptualising its understanding of power to asses its fluid and actor-specific origin, and an understanding of the geopolitical dimension of public health are undertaken, one can see that public health is, or can be, a new power source for France and Italy in the XXIst century; within the possibilities and limits drawn here.

In fine the core question of international relations' studies based on realism and constructivism is the question of power. Power as handled by the State because power precludes, conditions and legitimises the basic existence of the State itself. This thesis is fundamentally impregnated in realism and constructivism precisely because it lies on the idea of power ; studying it as many before have studied it, and as many after will study it. This thesis studies the State's desire, understanding and use of power in a highly competitive and power-creating domain of international relations; in this case, global public health. That's why, even if acknowledging the crucial role of institutions and non-State actors on global public health and international relations, it cannot be detached from a realist and constructivist's understanding of the world and international relations. It cannot be stretched-out from an understanding of the world and international relations with the State as the keystone of it, a keystone for which power is the mainly (if not only) object of attention and efforts; precisely because power is the only justification and resource for its existence.

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[10] Graham Lister, Michaela Told, *Current and Future Issues in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.28

Although power has been understood mainly through security/military dimension by realists and constructivists this thesis remains deeply rooted in these theories by opening up a new horizon to the study of power and security by realists and constructivists. A horizon lying on a reality: global public health is far more than people's wellbeing. But it has to be studied in international relations as a source of power in all its dimensions and an arena for competitiveness in broader agendas for both States and institutions but also megatrends. Understanding this, scholars and States would open up their understanding of international relations and the current world affairs and order. More specifically, for States, this would be a way to develop better strategies that would secure interests, and so provide power which sustains their proper existence.

Nonetheless, focusing too much on power itself would obscure the specificities of health governance. In this regards the adopted constructivist approach recalls that health issues are perceived as global because of the material conditions interplayed with social construction phenomena[11]. Moreover, and according to McInnes, the social construction of health as global, and so shared, rose along and contemporarily nurtured material and non material conditions such as the interpretation by a global actor or group of actors of health issues as global and promoted as such[12]. Giving in this regards more room for power and biogeopolitics.

It may appear to the reader that this paper is focusing exclusively on power and reject any right or cooperation approach to health governance. Indeed, it is here argued that health governance and global public health can be new sources of geopolitical power and influence in the XXIst century for France and Italy. Moreover, it is also argued that the over-studied right based approach and above all global justice approach to health have been crooking the understanding of global health and appear at best preventing the assessment of health governance as a source of power, at worst dangerous to the improvement of people's health. Yet it is important to recall that health being and public good and requiring cooperation, Paris and Rome wouldn't succeed in transforming health power capital into effective influence without cooperating. It would even be argued that cooperation is one mandatory side of such process.

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[11] Colin McInnes & al., "The Transformation of Global Health Governance", *Palgrave Macmillan*, New-York, 2014, p.97

[12] Ibid, p.99

Within this context, many scholars suggested health governance forecasts. In this regards, Owain and Rushton drawn two main forecasts. The first theorises that because of geopolitical changes and financial crisis solving, health governance priorities, flux and challenges will be restructured[13]. The second forecast is that global health governance will be marked by elements of continuity[14]. Both of these forecasts are general and therefore could not be highly criticised. Indeed it appears highly probable that in the XXIst century global health governance will be characterised by elements of continuity but will also be affected by the moving power relations. It also appears that, unfortunately, neither France or Italy will, for the reasons previously detailed, fully and efficiently take health governance as a power opportunity. Yet, Owain and Rushton wrote that as priorities wax and wane, "the bigger surprise should be that (health governance) 'golden age' even came at all"[15]. Indeed, and it has largely been commented, health governance importance rose in the 1990's along with the dual basis that constituted human rights based philanthropism and biosecuritisation. However it would be argued here that the power potential of health governance and the search for power from France and Italy, once acknowledged and fully embraced by the two studied States, could impulse a new so-called "golden age". More, it would be argued here that above the fragile prediction of a past, present or future golden age, health governance *should* have a golden age in XXIst century.

Furthermore, if one relies on Castel's description of post-disciplinary societies[16], the consequent increase management of the population's health by the State rather than the clinic[17] should give increased opportunities for the State to handle health governance power capital. Such phenomenon had already been theorised by Foucault himself whom wrote about a progressive increase in individual bodies political control and populations' global management[18]. In addition, this trend known by health governance on national, regional and

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[13] Simon Rushton, David Williams Owain, *The End of One Era and the Start of Another: Partnerships, Foundations and the Shifting Political Economy of Global Health*, in Rushton Simon, Williams Owain David, "Partnerships and Foundations in Global Health Governance", *Palgrave Macmillan*, London, 2011, p.254

[14] Ibid

[15] Ibid, p.267

[16] Paul Rabinow, "L'artifice et les lumières : de la sociobiologie à la biosocialité", *Politix*, N° 90, De Boeck Supérieur, Paris, 2010/2, p.30

[17] Ibid

[18] Alexandre Macmillan, "La biopolitique et le dressage des populations", *Culture & Conflits*, Vol. 78, L'Harmattan, Paris, December 2010, p.44

international levels, has been favoured by the copernican revolution - or profound change in the conceptual framework[19] - it has been engaged into since the 1970's.

Meanwhile many scholars are tempted to reduce health governance importance in contemporary politics, it appears important to acknowledge the longterm processes it embraces. It would be of a great mistake to break the link of global health governance, biogeopolitics and Foucault's biopolitics. This why, one could not but agree with Lister and Told that "global health diplomacy herald a major reform of global health governance"[20] to "provide multiple pathways through which the many different actors can exercise legitimate influence to achieve agreement on action for the common good"[21]. Regional and global health governance requires important reforms from States that can drawn and implement them, such as France and Italy could be with consistent and ambitious strategies that would not undermine health governance power potential. Evidently such reform calls for investments, but as stated by Perinne Ramé-Mathieu and Laurence Caté, these multidimensional investments are indispensable and demanding but are above all a collective stake[22].

In a sentence, quoting Dorothy Porter, the outcomes of the current health governance debates will depend on national and regional histories and cultures, international developments and political will[23]. France and Italy therefore have a great opportunity and responsibility in assessing health governance's power potential and drawing a subsequent foreign policy strategy, that Paris and Rome should recognise and blossom.

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[19] Santiago Alcázar, *The Copernican Revolution: The Changing Nature of the Relationship Between Foreign Policy and Health,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.324

[20] Graham Lister, Michaela Told, *Current and Future Issues in Global Health Diplomacy,* in Drager Nick, Kickbush Ilona, Lister Graham, Told Michaela, "Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases", *Springer,* New York, 2013, p.34

[21] Ibid

[22] Laurence Caté, Perinne Ramé-Mathieu, "Investir dans la promotion de la santé et la prévention" *in* Direction Générale de la Santé, "*Soixantième anniversaire de la Direction générale de la santé"*, Vol. 12 (1), Ministère des Solidarités et de la Santé, Paris, October 2016, p.12

[23] Dorothy Porter, "Health, Civilisation and the State. A history of public health from ancient to modern times", *Routledge,* London, 1999, p.319