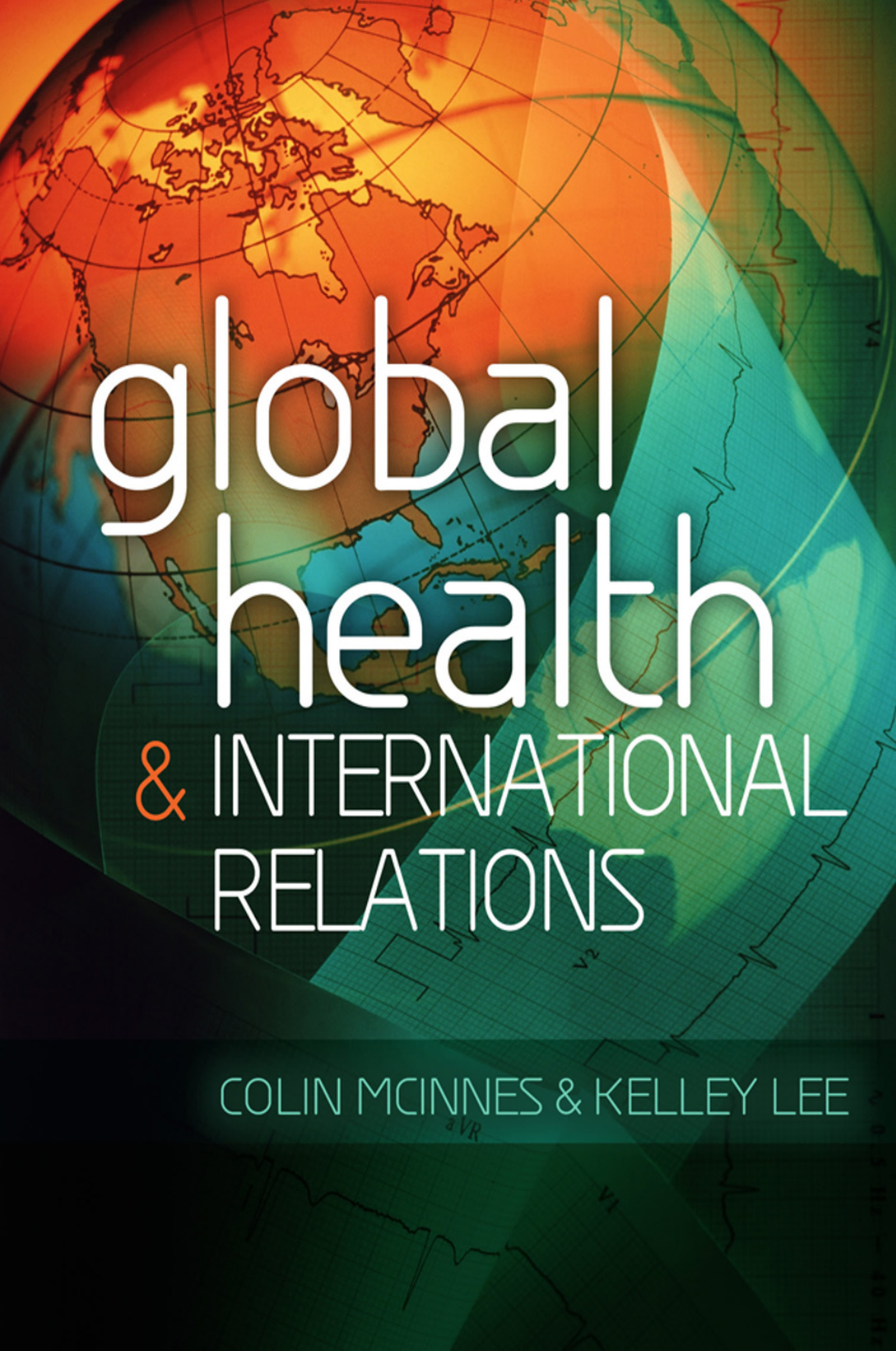
global
health
& INTERNATIONAL
RELATIONS
COLIN MCINNES & KELLEY LEE

Global Health and International Relations

For John Wyn Owen

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Short Contents

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List of Abbreviations

AMC	advanced market commitment
APOC	African Program for Onchocerciasis Control
ARVs	anti-retrovirals
ASCI	AIDS, Security and Conflict Initiative
BMGF	Bill and Melinda Gates Foundation
BRIC states	Brazil, Russia, India and China
BSE	bovine spongiform encephalopathy
BWC	Biological Weapons Convention
CAGR	compound annual growth rate
CBRN	chemical, biological, radio-nuclear terrorism
CDC	Department of Health and Public Services, Centers for Disease Control and Prevention (US)
CIA	Central Intelligence Agency
CMH	World Health Organisation Commission on Macroeconomics and Health
CSIH	Canadian Society for International Health
CSDH	WHO Commission on the Social Determinants of Health
CSOs	civil society organizations
CVD	Cardiovascular disease
DALYs	Disability-adjusted life years
DfID	Department for International Development (UK)
DCPP	Disease Control Priorities Project
DNDi	Drugs for Neglected Diseases Initiative
ECDC	European Centre for Disease Prevention and Control
EDR-TB	Extensive Drug-resistant tuberculosis
EIP	Evidence and Information for Policy (WHO cluster)
ERIDs	Emerging and Re-emerging Infectious Diseases
FBI	Federal Bureau of Investigation (USA)
FCO	Foreign and Commonwealth Office (UK)
FCTC	Framework Convention on Tobacco Control
FIND	Foundation for Innovative New Diagnostics
G8	Group of Eight (G7 group of advanced industrial democracies plus Russia)

G20	Group of 20 (major advanced and emerging economies)
GATT	General Agreement on Tariffs and Trade treaty
GDP	gross domestic product
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GHD	global health diplomacy
GHG	global health governance
GHSI	Global Health Security Initiative
GISN	Global Influenza Virus Sharing Network
GOARN	Global Outbreak Alert and Response Network
GPA	Global Programme on AIDS
H1N1	Swine flu
H5N1	Avian influenza
HINARI	Health InterNetwork Access to Research Initiative Programme
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HMN	Health Metrics Network
HPA	Health Protection Agency (UK)
IAVI	International AIDS Vaccine Initiative
ICG	International Crisis Group
IFFIm	International Financing Facility for Immunization
IGWG	Intergovernmental Working Group
IHR(s)	International Health Regulations
IMF	International Monetary Fund
IHP+	International Health Partnership Plus
IPPR	Institute of Public Policy Research
IPE	international political economy
IPRs	intellectual property rights
IR	International Relations
ISA	International Studies Association
IUATLD	International Union against Tuberculosis and Lung Disease
JALI	Joint Action and Learning Initiative on National and Global Responsibilities for Health
LMICs	low and middle-income countries
MAP	World Bank Multi-country AIDS Programme
MCH	maternal and child health
MDGs	Millennium Development Goals
MDR-TB	Multi-drug-resistant tuberculosis
MEDCAPS	Medical Civic Action Programs
NCDs	Non-communicable Diseases
NGO	Nongovernmental organization

NIC	National Intelligence Council (US)
NHS	National Health Service (UK)
NPM	new public management
OECD	Organization for Economic Co-operation and Development
ODA	Overseas Development Adminstration (UK); Official Development Assistances (US, OECD)
OHA	Office of Health Affairs (USA)
PATH	Program for Appropriate Technology in Health
PDPs	Product Development Partnerships
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	People's Health Assembly
PHEIC	public health emergencies of international concern
PIPF	Pandemic Influenza Preparedness Framework
PPPHW	Public–Private Partnership for Handwashing with Soap
R&D	research and development
RF	Rockefeller Foundation
SAPs	Structural Adjustment Programmes
SARS	Severe acute respiratory syndrome
SWAp	Sector-wide approach
TRIPS	Trade-Related Intellectual Property Rights
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDPKO	United Nations Department of Peacekeeping Operations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
vCJD	Variant Creutzfeldt-Jakob disease
WDR	World Development Report
WHA	World Health Assembly
WHO	World Health Organization
WMA	World Medical Association
WTO	World Trade Organization

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Introduction

Historically, health and International Relations have largely existed as separate academic fields and policy arenas. The study of health, concerned with the physical, mental and social state of an individual and population groups, most narrowly focuses on human biology – how the body works, how it breaks down and how it can be repaired. However, it is now accepted that there are diverse determinants of health which must be taken into account. Along with biology and genetic endowments, these include personal health practices, health services, income and social status, education, gender, cultural factors, employment and working conditions, and social and physical environments. As recognition has grown of the importance of the broad determinants of health, study and practice has evolved accordingly.

Similarly the academic discipline of International Relations was long dominated by concerns about war, peace and security among states, concerns mirrored by the foreign and security policy communities. This focus, to a large extent, reflected its formal establishment as an academic discipline in the wake of the First World War, and in attempts to understand how such wars could be prevented in future. Over the next century, however, this focus has broadened to address new actors, new issues and new ways of seeing the world, a broadening of perspective also seen in the foreign policy world.

Like two cities with sprawling suburbs expanding into greenbelt, it was perhaps only a matter of time before health and International Relations would find themselves in closer proximity. While previously an occasional emissary would link the two, today there is not only the rapid construction of roads to connect them, but their boundaries are beginning to spill over. Both, as multidisciplinary fields, continue to struggle with questions of identity, of what they are – and are not – concerned with. Both, in practice, also struggle with a world of ever greater complexity and interconnectedness. Two distinct fields have thus been brought together in the early twenty-first century by the development of shared concerns, of uncertain disciplinary boundaries,

and of a mutual need for more effective policies in a changed and changing world.

The main backdrop to this development, as for so many other fields of endeavour, has been globalization. Health issues which cross national jurisdictions are nothing new, and collective responses to them form the very foundations of the World Health Organization (WHO) and other types of international health cooperation. By the late twentieth century, however, the scale and intensity of crossborder health issues faced by countries became far greater than ever before. Moreover, for many health determinants and outcomes, territorial space was being rendered irrelevant – infectious disease outbreaks, cigarette smuggling, counterfeit medicines, advertising of junk food via the internet, and the changing distribution of disease vectors due to climate change all challenge traditional notions of national health policy. To what extent could health continue to be considered as largely a domestic policy concern? How was health being re-territorialized, requiring new understandings of changing geographies of health and disease, their determinants, and the polities needed to govern them? The era of 'global health' had arrived.

Alongside the need to reconfigure how we understand the geography of health has been the reigniting of longstanding debates about the relative importance of biological versus social factors, the nature of health inequities within and across countries, the criteria for allocating scarce health resources, and even the definition of what health actually means. In other words, the paradigmatic shift from *international* to *global* health has challenged the health community to reflect on the intellectual boundaries of the field. Much has been found wanting. Few within the health world understand how the global economy works, why specific trade measures are adopted, what factors shape a country's foreign policy, how to conduct diplomatic negotiations and, above all, how such things impact on human health. These considerations are the stock in trade of International Relations scholars.

Conversely, this intellectual, pragmatic and moral struggle by health researchers, policy makers and practitioners on the effects of globalization has coincided with equally vigorous reflections on the study and practice of International Relations since the end of the Cold War. These concern not only what the 'new world order' looks like, and should look like, but what this tells us about the nature of the international system. Questions revolve around the continued dominance of states in the system and how we define state sovereignty; the emergence of new transnational forces and actors; and correspondingly, what power is in a globalized world, who holds it, and how it is wielded and to what

ends. The boundaries of what is termed 'international relations' are also in question.

Most accounts to date of this growing common ground between health and International Relations point to 'real world' developments linking the fields either directly or indirectly. These developments include infectious disease outbreaks such as severe acute respiratory syndrome (SARS) and pandemic influenza; the HIV/AIDS pandemic in sub-Saharan Africa with fears of its potential to undermine the political and economic stability of states and regions; the broadening sense of what constitutes security amid the possible use of pathogens by terrorists (bio-terrorism); the impact of international trade agreements on access to vital medicines especially in the developing world; the increasing mobility of health professionals and patients across state jurisdictions; and the panoply of both old and new public, private and civil society actors in health policy making whose allegiances and resources crisscross the globe. All of this has prompted a perceived need for a qualitative shift in the nature of international health cooperation, a search for something called global health governance (GHG), coinciding with more flexible understandings of International Relations after the 'bonfire of the certainties' following the end of the Cold War.

This account, or 'narrative', on how health and International Relations have come together is common to much of what has been written so far in both the academic and especially the policy world. The implication is that developments 'out there in the real world' have made these links possible, desirable, necessary or potentially worrying depending on the writer concerned. The theoretical underpinning of this book, however, is quite different. For us, there is nothing natural, evolutionary or inevitable about these links. Although we accept that there is a material world which exists independent of our understanding of it, and which can produce risks and hazards to us, the way we explain and understand that world does not exist independently of us. We impose meaning on the world. The world, in turn, is thus *made* by individuals and communities (academic and policy). This places us in a broad theoretical grouping known as social constructivists. Crucially, therefore, the links between health and International Relations are not simply a natural and inevitable development arising from what is happening in the 'real world'. Rather these links are made, or socially constructed, in such a way as to reflect the ideas, interests and relative power of individuals and communities. These communities are not simply states, governments or political actors, but can include other groups such as practitioners and academic disciplines, in this case, within the health and International Relations fields. Each brings their own way of seeing

the world, their own sets of explanations and their own priorities to the object of study. Indeed the very nature of the object of study, what it involves and what is excluded, is determined by these understandings of the world.

This social constructivist approach, as a starting point, has an important implication for this book from the outset. For us, differences in understandings are not the result of poor data, weak method or inadequate explanation, but rather a product of varied communities holding different values and interests. These differences are not readily resolved by reference to evidence or 'facts' drawn from the material world, not least because there may be differences over what pieces of evidence are considered important and how they may be interpreted. Oftentimes, these differences cannot be resolved, and competing understandings remain. On other occasions, these differences may be obscured by the use of common, yet ill-defined, terminology such as 'security' or 'globalization'. But when differences are resolved, they reflect the power and priorities of a particular community, including the power of ideas, rather than an independent understanding based on objective observation of the material world. The intersection between global health and International Relations is, in a word, political. Crucially, however, and an important contribution this book seeks to make, is the idea that these differences are not constructed by the simple binary divide of 'health versus International Relations'. Although on some occasions the different interests of the two communities may produce competing visions of the world, such a divide obscures the often contested nature of both health and International Relations, both as academic disciplines and as policy arenas. Indeed interests and perspectives (or what we describe as 'frames' in chapter 1) may be shared by elements of both communities but contested within each.

The aim of this book is to illuminate the social construction of the links between health and International Relations, premised on a shared focus on 'global health'. The numerous initiatives on global health that have sprung up over the past decade embrace the academic, policy and practitioner communities across both fields. Indeed, global health has become a major growth industry within higher education institutions (including a doubling of US undergraduate and graduate enrolments between 2006 and 2009), philanthropies, nongovernmental organizations (NGOs), consultancy firms, government departments and well-meaning celebrities (Wolinsky 2007; Macfarlane et al. 2008; Lederman 2009). Amid this enthusiasm, we begin by asking in chapter 1 what has been meant by global health, a question not as straightforward as it appears.

International Relations is by no means the only discipline to climb on board this juggernaut (Janes and Corbett 2009; Leach et al. 2010). International Relations, by virtue of its field of endeavour, however, seems perhaps the most obvious of the social sciences to offer substantive engagement with global health. Historically, health has never been confined by territorial geography, and great civilizations have been rocked, and even destroyed, by major disease outbreaks. In more recent times, the globalization of health determinants and outcomes suggests a close and natural synergy between the two fields. It is thus even puzzling that the two fields have remained so distinct for so long, and indeed, important to understand why, and on what terms, this estrangement appears to be being overcome. Why are bridges now being built between the two domains and what is the nature of these connections? This is the focus of the second chapter, which explores how and why International Relations has begun to engage with selected health issues.

The next four chapters of the book survey the common ground between health and International Relations, not to provide answers to major policy and scholarly questions such as 'what is global health security?' or 'how should global health governance be organized?', but rather, the purpose of these chapters is to understand and explain these agendas, the links between health and foreign policy, the global political economy, global health governance and security, in terms of their social construction. Our goal is to probe the intellectual parameters of this new field and the practical actions deemed appropriate to pursue in its name. How can we more fully explain the goals being pursued, the resources being deployed, the values being declared, and the curriculum being taught in the name of global health? We reflect on the nature of this emerging field – what Sara Davies has termed the 'global politics of health' (Davies 2010) – not simply in an attempt to identify what the field is or should be, but to ask why it is what it is. In this way, we seek to encourage more critical reflection, both in theory and practice, on the global health enterprise than it has received to date.

CHAPTER ONE

What is Global Health?

There is something ubiquitous about the term 'global health'.[1] In a little over a decade, it has come into common usage not only within scholarly circles, but as part of key policy debates about how health care services should be financed and delivered. Health cooperation is now no longer described as merely 'international' but 'global', as the scope for national responses to address a growing number of health issues (especially those with crossborder implications) is seen to have diminished in the face of globalization. Global health, in other words, has arisen in response to 'real world' developments that have led to the closer integration worldwide of the determinants and outcomes of human health.

At the same time, however, the use of the term global health can be understood, not only as a reflection of a profound shift in the ingredients that influence health policy, but as a concept that has contributed to that shift. In the creation and use of the term 'global health', a multiplicity of trends have been given a shared meaning which encourages us to see the world differently. Statements such as 'health is global' (Department of Health 2008a), therefore, are not simply a reflection of an external reality, but a rallying call to reinterpret how we understand health in a particular way. Health as global, in this sense, is normative in its framing or social construction of the subject.

This chapter explores these ideas in three main sections. The first identifies the orthodox explanation for global health as a product of, and response to, new trends, notably globalization and its impacts on health. The second discusses the manner in which global health is subject to different meanings because it occupies contested terrain. The final section argues that the manner in which we use the term global health is not value-neutral, but promotes certain issues, interests and institutions over others.

The Emergence of Global Health

Global health has grabbed the imagination of the academic and policy communities, as well as the general public. Within the academic world,

the volume of articles, journals, books and book series has proliferated over the past two decades. This has included support for increased accreditation and training on global health, backed by professional health bodies and associations (Hotez 2008; Hogan and Haines 2011: 317–18; Lee et al. 2011: 310–16). This has been matched, and arguably exceeded, by interest within the policy world. New institutional mechanisms, arrangements and initiatives have flourished, many explicitly 'global' in orientation such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria[2] and President Obama's Global Health Initiative.[3] Indeed global health issues have become *de rigueur* among the world's most powerful people, whether at the World Economic Forum, G8 summits or the Organization for Economic Co-operation and Development (OECD). Regional and multilateral development banks, led by the World Bank, and other non-health institutions, including the UN General Assembly, have also given unprecedented attention to global health. This interest has been backed by resources. Health has received the lion's share of increases in aid funding since the 1990s (see chapter 3). There has been a boom in global health philanthropy since the 1990s, led by the Bill and Melinda Gates Foundation (BMGF), and with substantial donations from Bloomberg, Open Society (Soros), Warren Buffett, Ted Turner, and the Skoll Global Threats Fund (Stuckler et al. 2011a). Further afield, in policy terms, global health has featured as a rising *issue* in foreign and security policy circles, and as an *instrument* in the soft/smart power toolkit. Finally, global health stories (most frequently in the form of acute infectious disease outbreaks) have become regular fodder in the mass media including news, current affairs and entertainment.[4] In some cases, these different worlds have come together, as in the examples of media funding by the BMGF including *The Health Show* (British Broadcasting Corporation) and *Be the Change, Save a Life* series (American Broadcasting Corporation), and *The Guardian* newspaper's global development website (Doughton and Heim 2011).

So why has this remarkable growth in interest in global health occurred? One explanation is that it is in response to real world change; that is, as the world has become more globalized, so too has health. Up until around the mid-1990s *international health* was the more commonly used term, although it too suffered from definitional variation. Broadly speaking, within the public health field, four 'delineations' are often made between national and international health:

- international health referred to health in countries where imperialist powers extended their military and commercial reach, and after the Second World War to former colonies (empire delineation);

- international health focused on 'tropical diseases', reflecting a geographical focus on the countries of the tropics which suffered from such diseases (geographical delineation);
- international health referred to the health status and needs of populations in developing countries (socioeconomic status delineation); or
- international health was used to refer to comparative analysis of national level health systems and problems (policy delineation).

All contrast with the strict use of the term 'international' in International Relations as meaning between countries or states. In the second edition of his *Textbook of International Health*, Paul Basch lists a wider range of topic areas to potentially include under the rubric of international health such as humanitarian responses to disasters and emergencies, the ethical aspects of research and practice in poor and marginalized populations, and the social and environmental consequences of human population growth. The list is a long one and his warning, that 'a subject that pretends to cover everything covers nothing, or at least nothing very well' (Basch 1999: 7) certainly appears apt.

The replacement of the term *international health* by *global health* from the mid-1990s appears to have been prompted for two reasons. First, the new term offered a political boost to long neglected public health problems, notably but not exclusively in developing countries (Garrett 1994). These problems were not necessarily new but were either worsening, or becoming more visible, as a result of globalization. Stark inequalities in health between rich and poor countries drew particular attention. To some extent, one can see this as a rebranding exercise, putting 'old wine into new bottles', to generate political leverage. Linking health in developing countries to new agendas, such as security, foreign policy, environment and development, helped boost the political profile of health development.

A second, and related, argument was the call for a paradigm shift in response to how human health is being affected in new ways by global interconnectedness (some of which are identified in box 1.1). The emergence of 'global health' was presented, in other words, either explicitly or implicitly as a natural response to changes in the material world. As stated in the US Institutes of Medicine influential 1997 report, *America's Vital Interest in Global Health*,

> The health needs of diverse countries are converging as the factors that affect health increasingly transcend national borders. Among those factors are the globalization of the economy, demographic change, and the rapidly rising costs of health care in all countries. In a world where nations and economies are