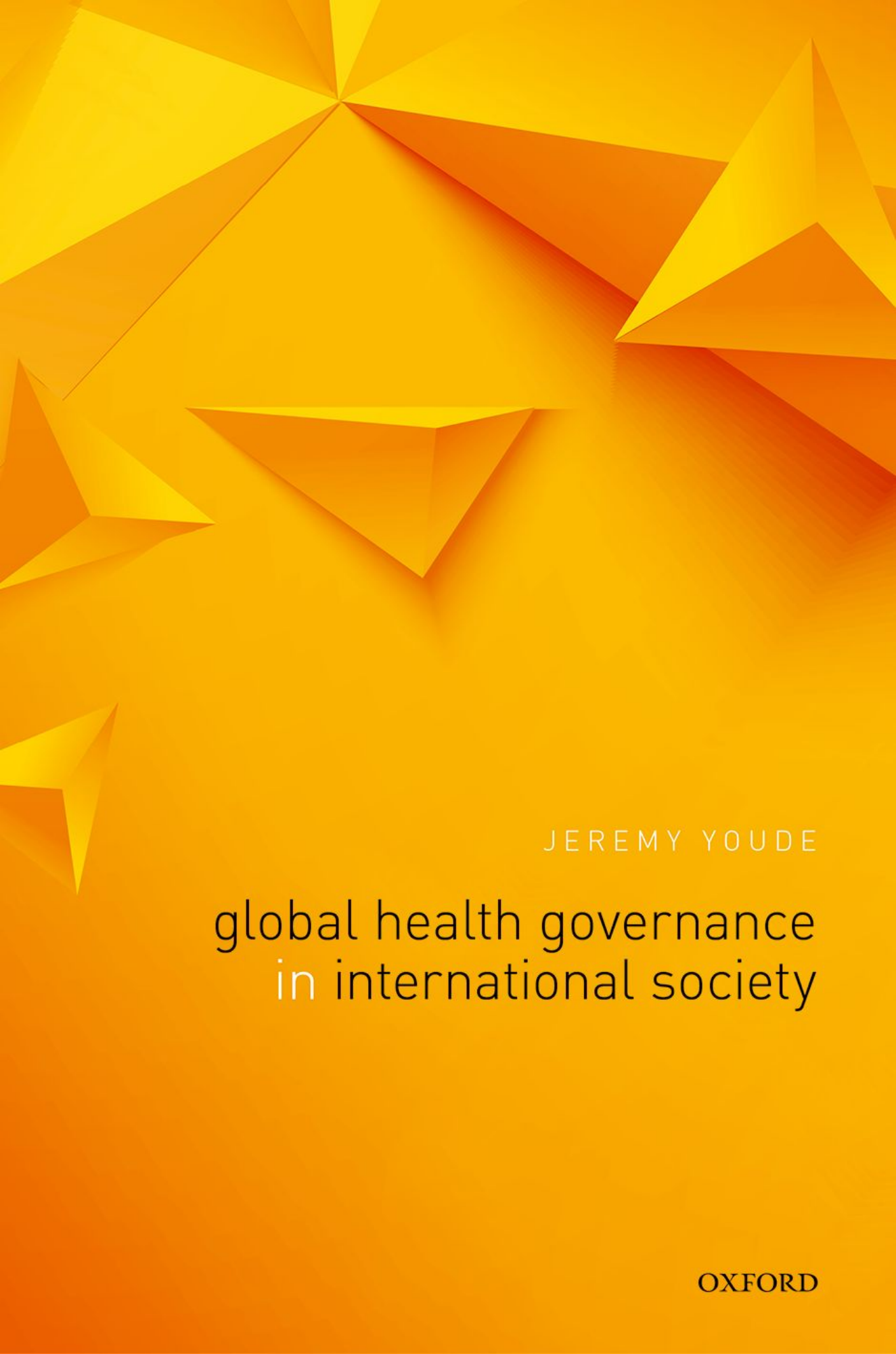

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global health governance in international society

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For Ben

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Finally, this book is for Ben. I can't even begin to repay him for all that he's done for me in so many different ways.

Contents

List of Abbreviations

AFRO	World Health Organization Regional Office for Africa
ART	antiretroviral therapy
BMGF	Bill and Melinda Gates Foundation
BRICS	Brazil/Russia/India/China/South Africa
CCMs	Country Coordinating Mechanisms
CDC	United States Centers for Disease Control and Prevention
CIA	United States Central Intelligence Agency
CZI	Chan Zuckerberg Initiative
DAC	Development Assistance Committee
DAH	development assistance for health
ECOSOC	Economic and Social Council of the United Nations
FOCAC	Forum on China–Africa Cooperation
G8	Group of Eight
GAVI Alliance	Global Alliance for Vaccines and Immunization
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GPA	Global Programme on AIDS
GPEI	Global Polio Eradication Initiative
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HSS	health systems strengthening
ICJ	International Court of Justice
IHD	International Health Division of the Rockefeller Foundation
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IHR (2005)	International Health Regulations (2005)
ISC	International Sanitary Conferences
ISR	International Sanitary Regulations
LNHO	League of Nations Health Office
LSHTM	London School of Hygiene and Tropical Medicine

MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
MSF	Médecins Sans Frontières/Doctors Without Borders
NATO	North Atlantic Treaty Organization
NCDs	non-communicable diseases
NGOs	non-governmental organizations
OAU	Organization of African Unity
OECD	Organisation for Economic Cooperation and Development
OIHP	Office International d'Hygiène Publique/International Office of Public Hygiene
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PHEIC	Public Health Emergency of International Concern
PMI	President's Malaria Initiative
PPPs	public–private partnerships
PRC	People's Republic of China
R2P	Responsibility to Protect
RF	Rockefeller Foundation
SARS	severe acute respiratory syndrome
SDGs	Sustainable Development Goals
SIM	Serving in Mission
SPHC	selective primary health care
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNMEER	United Nations Mission for Emergency Ebola Response
UNSC	United Nations Security Council
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization
XDR-TB	extensively drug-resistant tuberculosis

Introduction

On 23 March 2014, the World Health Organization's Global Alert and Response division released a four-line news item. It announced that the Ministry of Health of Guinea had confirmed the presence of human cases of Ebola in the southeastern part of the country. By the time the announcement came, the Ministry had identified forty-nine cases of the disease, causing twenty-nine deaths (World Health Organization 2014a). This simple announcement triggered one of the largest responses to a global health event in history.

Though the World Health Organization (WHO) has received widespread criticism for its slow response to the outbreak, the international community mobilized rapidly and in an unprecedented manner after WHO declared the Ebola outbreak in West Africa to be a Public Health Emergency of International Concern (PHEIC) on 8 August 2014. By the end of 2014, donors had pledged $2.89 billion in support of the international response to Ebola—an amount that outstrips the amount requested by international leaders (Grépin 2015). The United Nations Security Council (UNSC) passed Resolution 2177 on 18 September 2014, which, for the first time in the organization's history, explicitly declared an infectious disease outbreak to be 'a threat to international peace and security' (United Nations Security Council 2014). The next day, the United Nations General Assembly authorized the creation of the United Nations Mission for Ebola Emergency Response (UNMEER)—an organization tasked with coordinating the UN response to Ebola and the first time the UN had ever created a mission solely dedicated to a matter of international public health (Kamradt-Scott et al. 2015: 8). Outside of the UN system, numerous governments and non-governmental organizations mobilized to respond to the outbreak. Médecins Sans Frontières (MSF), known in English as Doctors Without Borders, took an early leading role in calling the world's attention to the outbreak and in prompting WHO and UN to take a more aggressive response. MSF and other non-governmental organizations (NGOs) like Samaritan's Purse had already been delivering significant levels of health care in the affected countries and provided a large portion of the on-the-ground medical treatment

in the affected countries (Henwood 2016: 18). The United States, United Kingdom, and China deployed military personnel to set up treatment centres and offer logistical support to transport materiel to the region (Kamradt-Scott et al. 2015). The US Centers for Disease Control and Prevention (CDC) redeployed its polio vaccination teams in Nigeria to work with that country's government to provide contact tracing and implement programmes to stop Ebola's spread when it appeared in Lagos (Osterholm and Olshaker 2017: 154). The Bill and Melinda Gates Foundation pledged $50 million to fight the outbreak, and Paul Allen, the co-founder of Microsoft, personally committed $100 million. Taken altogether, the response to this outbreak represented a massive undertaking that eventually helped to stop the largest recorded Ebola outbreak in history.

The response to the 2014–16 Ebola outbreak was flawed in many ways, and the delays and problems allowed the virus to take hold in a significant way and increased the death toll. At the same time, and not in contradiction to the previous point, the international community clearly recognized that responding to cross-border health issues like Ebola is vital. It may fumble around, and it may make mistakes, but no one seriously argued that the international community did not have a vital stake in addressing the Ebola outbreak. The question was never *whether* the international community should respond; the question was always *how* the international community should respond. A wide variety of actors—intergovernmental organizations, developed states, developing states, non-governmental organizations, philanthropic organizations, and private business—came together to address a cross-border health challenge, even though it directly affected very few of them. They mobilized an unprecedented effort to raise the necessary funds. They found various ways to coordinate and cooperate. This does not imply that they did it perfectly or that the international community will avoid any future health crises, but the fact remains that these members of the international community did it because they viewed it as part of their obligation and responsibility to each other and the larger international project.

The response to Ebola is emblematic of a larger change when it comes to global health. Over the course of a single generation, the international community has undergone a radical shift in its views on its collective obligation to address health on a global scale. Health has moved from the realm of technocratic, domestic politics to being a vital and important issue on the global political agenda. Rather than leaving health up to states to handle on their own, the international community has embraced a sense that it has a moral obligation and responsibility to respond to health issues, particularly those in low- and middle-income countries. This shift towards accepting the need to respond to global health concerns is both rhetorical and financial—and has (thus far) been maintained even in the face of the incredible economic

issues and austerity policies that have faced high-income states since 2008. The Ebola outbreak is simply the latest manifestation of a movement towards recognizing the significance of global health that the international community has seen developing and growing since the late 1980s. These shifts in attitude and practice represent a wholesale change in the collective understanding of the importance and relevance of global health to the international community.

The elevation of global health governance reflects a larger transformation within the international community. There is a growing recognition that there exists a sense of moral responsibility and obligation within international society. Actors have a responsibility to address those issues that seemingly may not directly affect them but present negative repercussions for the greater international community. This sense of moral responsibility and obligation is reflected in the ever-increasing importance of humanitarian intervention (Wheeler 2000), environmental protection (Falkner 2012), and freedom from hunger (Gonzalez-Pelaez 2005) for international society. It draws on and expands Vincent's notion of basic subsistence rights to recognize a shift towards putting more teeth and institutional force into the recognition and realization of rights (Vincent 1986). This sense of moral responsibility and obligation does not necessarily have a formal structure in all cases, and there remain debates within international society over how to realize these ideas, but the underlying institution itself exists. Health, with its long history of innovative efforts to bring together a wide array of actors to address cross-border concerns, fits nicely within this larger framework.

What explains this shift in the international community's sense of obligation and the necessity of actuating an effective response? In this book, I argue what is most unique about global health governance in the contemporary era is that *its diplomacy, initiatives, and commitments reflect its emergence as a secondary institution in support of a larger primary institution of moral responsibility within international society—a group of states with common and institutionalized interests and values bound by a set of common rules—as described by English School of international relations*. This approach counteracts the pessimism and instrumentality of realism, incorporates a normative consideration that is lacking in liberalism, and offers a more explicitly normative framework than that offered by constructivism. Global health governance has emerged as an ethical project. The question is why, and this is where the English School is particularly well suited and useful. English School theorizing is neither myopically optimistic nor needlessly pessimistic. It acknowledges the shared interests in working together to achieve common goals while understanding that there exist limitations on the ability to satisfy those desires. It does not require a belief that states always act altruistically or that they always sacrifice their selfish interests, but rather offers an opportunity for understanding how

these sorts of common bonds can develop and be sustained even in instances when individualized interests are not at work.

It is important to realize that the emergence of a secondary institution of international society is only part of the process. The members of the international society may share common ideas and rules, but that does not mean that those ideas and rules are correct or appropriate for the situation. They will change and adapt over time as their limitations become apparent. Traditional primary institutions described by the English School, like diplomacy and international law, have evolved over time in response to changes in the international system, past failures, and other problems, so it is entirely consistent to both criticize the ability of global health governance structures to respond to a problem *and* argue that this institution will evolve in response to these flaws. Indeed, we can argue that there exists a certain degree of counterfactual validity at work (Kratochwil and Ruggie 1986: 767)—the fact that members of international society are talking about the need to reform the global health governance system in light of its shortcomings is evidence that they believe such an institution exists, has value, and is worth preserving for the future.

In the case of global health governance, its emergence as a secondary institution of international society reflects the burgeoning recognition of the importance of cooperation in order to achieve collective health goals. If states want to decrease the likelihood that they will face negative effects from the outbreak of infectious diseases and prevent future outbreaks from occurring, they must work together; no state can adequately address these concerns on its own. At the same time, though, these efforts to promote cooperation through global health governance challenge traditional notions of sovereignty because they expand the range of relevant actors who help implement global health strategies. Understanding the emergence of global health governance as an institution of international society while examining where its shortcomings exist is at the core of this book.

The idea of an extensive global health governance architecture would have made little sense and had little purchase at earlier times. Global health was largely synonymous with WHO, but, as will be described over the course of the book, WHO now shares the global health space with a dizzying mixture of state and non-state actors. As a result, WHO's status as the dominant actor within global health is part of a contentious debate. International society has shown a willingness to embrace a more expansive notion of global health and its governance as it recognized the relationships between globalization and the spread of illnesses, saw the need for fostering cooperation, and witnessed the failures that occurred when institutional responses and frameworks were inadequate to address problems like HIV/AIDS.

The emergence of global health governance as a secondary institution of international society, though, does not imply perfect adoption. Institutional

development is a process of various actors trying to tease out meanings, implications, and proper policies and implementing different organizations and strategies to realize these goals. It is an effort to bring a large number of actors together in a useful way. It is also an important and vital reminder that international society is *not* determinative; the existence of norms and values that encourage and promote collaboration on global health matters does not automatically translate into policies that actualize these norms. Changing norms and values enable new actions, but they do not automatically mandate that these actions will be embraced or implemented. It is the fact that actors recognize these failures and shortcomings, though, that demonstrates the existence of global health governance as an institution within international society.

This book is unique in that it specifically seeks to engage the global health governance literature with international relations theory. To its detriment, the global health politics literature has engaged with the international relations theory literature sporadically and relatively superficially (for examples of engagement between global health politics and international relations theory, see Davies 2010; McInnes and Lee 2012; Price-Smith 2001; Youde 2005). This has impoverished the global health politics literature in two key ways. First, failing to engage with international relations theory contributes to the marginalization of global health within the larger political science and international relations literatures. The lack of engagement leads to an image of global health politics being more focused on the *health* side of the equation and largely removed from the *political* element. Global health becomes peripheral to understanding larger questions about how actors interact in the global arena and try to achieve common goals.

Second, the global health politics literature lacks a firm foundation by not engaging with international relations theory in a more meaningful way. Without a theoretical framework, global health politics can become too rooted in the immediate—lacking the tools to put the immediate into a broader perspective that speaks to a larger audience and provides a historical context for present health crises and the range of available international political responses. An atheoretical approach privileges the problems and crises without offering the framework for understanding how and why the situation exists and how it might change in the future. International relations theory cannot predict the future or explain every instance of an event, but it does offer a useful heuristic for interpreting when and how the community of states and international agencies operate at the international level (Snyder 2009).

At the same time, this book is not an uncritical endorsement of the English School. It demonstrates how engagement with global health governance reveals important theoretical oversights. To date, English School theorists have not consistently considered vital issues of international political economy, foreign

aid, and development. Its treatment of non-state actors, which have played an incredibly significant role in supporting the inclusion of global health on the international agenda and international relations more generally, remains fairly underdeveloped. If we want to appreciate how the international community has developed an obligation to respond to global health concerns, we need to develop sophisticated, nuanced representations of foreign aid and non-state actors. This will not only benefit our understanding of global health's place on the international agenda, but also flesh out relatively neglected elements of English School theory.

Finally, this book aims to show both the successes and failures of how global health governance has engaged with international society and vice versa. While the argument presented here sees this engagement as largely a positive arrangement reflected in changes like increased development assistance for health (DAH) over the past twenty-five years, larger-scale responses to global health emergencies, and an increasing number of actors involved in framing the diplomacy of global health governance, it is also worth highlighting some of the flaws in this current iteration of global health governance. These include the ambiguous role of China, disjunctures between the health conditions that cause the most death and illness and those that receive the most funding, and the difficulties in coordinating action between state and non-state actors engaged in global health governance. The argument presented here will be informative without being shortsighted, theoretically engaged without being too abstract, and will draw on case studies without losing sight of the overarching narrative.

This book aims to make four key contributions. First, it will explicitly integrate the literatures on global health and international relations theory. Providing a firm theoretical grounding for the global health politics literature will enable a longer-term perspective on global health governance rather than focusing primarily on immediate crises.

Second, it will engage with the existing literature on the English School while also trying to push its boundaries. Through a discussion of the role of DAH, it will make the case for the English School to engage more systematically with international political economy. By recognizing the role of non-state actors in realizing the ideals of global health governance, it will show the value of expanding the range of actors recognized as members of international society. By identifying global health governance as a *secondary*, rather than primary, institution, it will demonstrate both the need for the English School to engage more with the role of secondary institutions and highlight how primary and secondary institutions interact with one another.

Third, it will trace how the current global health governance system emerged and has evolved over the years. Global health governance has dramatically changed over the past generation, but its origins go back to the mid-nineteenth

century. To understand how and why the current global health governance institution came to be, it is imperative to recognize its evolution.

Finally, this book shows the benefit to the English School in seriously engaging with secondary institutions and their role within international society. The English School has traditionally relegated secondary institutions to other theoretical traditions, assuming that they are simply the concrete manifestations of larger ideals. This book aims to show that secondary institutions play a significant independent role in international society and deserve sustained analytical attention in their own right.

Chapter Outline

The book is divided into three main sections: understanding the English School and international society (Chapters 1 and 2); understanding global health governance (Chapters 3 and 4); and global health governance in action in international society (Chapters 5, 6, and 7).

The first two chapters situate the book within the English School of international relations theory. Chapter 1 focuses on why English School theorizing is particularly relevant for understanding why and under what circumstances actors choose to contribute to coordinated international actions. Though it receives relatively little attention within the American international relations academy, English School theory has both a rich history and a nuanced understanding of the international environment. This makes it an 'underexploited resource', to use Buzan's (2001) phrase, for understanding the emergence of complex systems like global health governance as an institution within international society. This chapter describes the foundations of the English School and highlights why this theory is of particular relevance for understanding the expansion and resilience of global health governance over the past generation. At the same time, this chapter expands upon the traditional notions of the English School, pushing it to modernize in order to understand how the international environment has shifted over the past half-century. In particular, the chapter calls attention to the need to address the role of non-state actors as potential members of or contributors to international society and the value of explicitly incorporating political economy into English School theorizing.

Chapter 2 digs into English School theory more intensely by discussing the role of different types of institutions and their effects on international society. Since this book takes the position that global health governance is a secondary institution within international society and operates in conjunction with an emergent primary institution of moral responsibility and obligation, it is of utmost importance to explain the differences between primary and secondary institutions. This chapter also holds a challenge for the English School to take

secondary institutions more seriously. Too often, secondary institutions are dismissed simply as formal organizations or international regimes—which are then, in turn, consigned to the realm of regime theory or seen as too far removed from the English School's central concerns. This chapter argues that such an approach impoverishes the English School and prevents us from recognizing the role that secondary institutions actually play in international society. Far from being just formal organizations, they have their own constitutive powers and help us to understand international society.

Chapter 3 begins to focus on global health governance as an institution. In particular, this chapter looks at how global health governance has emerged over time. While global health governance has become prominent over the past generation, it grew out of an evolutionary process that we can trace back to fears about the international spread of disease in the 1800s. Tracing these changes over time not only helps us to understand the contours of the current system, but it also provides a window for seeing where efforts to instantiate global health governance and its normative precepts more firmly within international society have not worked. This chapter pays attention to seven key moments or processes that help us to understand the evolution of global health governance: the International Sanitary Conferences; the League of Nations Health Office; the World Health Organization; the Health for All by 2000 movement; the International Health Regulations; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the Bill and Melinda Gates Foundation.

While Chapter 3 focuses primarily on the evolution of global health governance, Chapter 4 pays more attention to its contemporary manifestation. This chapter will discuss the current state of the global health governance framework—who the important actors are, how the various governance structures have changed over the past twenty-five years, and what the fundamental beliefs and attitudes of the global health governance system are. In particular, the chapter will discuss the relationship between state-based and non-state actors, as well as public versus private actors. International organizations play an important role within international society, facilitating activity that states cannot or will not do in a bilateral fashion. By drawing on financial, personnel, and information resources from a variety of states, international organizations can foster the sort of collective action that is necessary in order to bring desired goals to fruition. This chapter highlights five key players within contemporary global health governance: states; WHO; multilateral funding agencies; public–private partnerships; and private philanthropic organizations.

Chapters 5, 6, and 7 provide an opportunity to look at areas that challenge global health governance and raise questions about its current form and future orientations. Chapter 5 looks at the incredible growth in DAH from the