

MODULE 4: GLOBAL HEALTH

KEY CONCEPTS

Access to medicines: the ability for people to get affordable and needed access to safe, effective, and high-quality medicines and health products; as such it is a fundamental component of the full realisation of the right to health

Disease control: refers to the actions and programs directed towards reducing disease incidence (new infections), prevalence (number of people currently infected) or completely eradicating the disease

Epidemic: a disease that affects many people within a community, population, or region

Global health: the health of human populations within a world-wide context

Global health politics: actions, practices, and policies that govern the sphere of global health

Global health governance: world-wide regulation of health that includes state and non-state actors

Infectious disease: disorders caused by pathogenic microorganisms, such as bacteria, viruses, parasites, or fungi and can be spread from person to person, either directly (via skin contact or blood) or indirectly (via contaminated water or food)

Intellectual property: creations of the mind, such as inventions, literary and artistic works, designs, and symbols, names and images used in commerce (WIPO)

Non-communicable disease: chronic diseases that tend to be of long duration and are the result of a combination of genetic, psychological, environmental, and behavioural factors (WHO)

Pandemic: an epidemic that is spread over multiple countries or continents

Patent: an exclusive right granted for an invention, which is a product or a process that provides a new way of doing something, or offers a new technical solution to a problem

Public health: all organised measures (private or public) aimed at preventing disease, prolonging life, and promoting health and well-being for the whole society

Right to health: a fundamental part of human rights encompassing the right to the enjoyment of the highest attainable standard of physical and mental health (and not merely absence of disease and infirmity)

World Health Organisation: a specialized agency of the United Nations responsible for international public health

Zootic disease: an infectious disease that is transmitted between species (from animals to humans or from humans to animals)

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1. WHAT IS GLOBAL HEALTH?

Why is health a global issue?

Health has emerged over the course of the last two decades as a prominent field of inter- and transnational cooperation and with the COVID-19 pandemic became truly global. Although the cross-border dimensions of **public health** have already been recognised in the 18th and 19th century, they have been Euro- and West-centric at best, i.e., focused on the potentially detrimental impact of the spread of communicable diseases on health in imperial/colonial powers and less on improving the health of the local populations in colonised regions (McInnes et al., 2019, p. 3). Davies et al. (2014) identify four stages of public health development. In the first stage (1830-1900) international community started addressing physical and environmental conditions such as clean water, air, public sewerage, food safety and safe working conditions. The second stage (1890-1950) was characterised by scientific advances resulting in the production of the first vaccines for communicable diseases such as smallpox. The third stage (1940-1980) focused on the development of treatments (for bacterial and viral infections, or cancer). The fourth stage began in 1960 and established the link between health and socio-economic factors, i.e., that ill health usually has roots in poverty, gender discrimination and inequality (see Module 2: Globalisation, Wealth and Poverty).

It was only in the 1990s that health appeared as a global rather than a national issue. Three reasons for this can be identified. Firstly, human health has been recognised as significantly affected by processes of **globalisation**. These processes have increased the speed and reach of **disease outbreaks** due to the increased intensity of cross-border interactions (such as trade and travel). More than 30 new infectious diseases (aviation flu, AIDS/HIV, SARS, Hepatitis C, West Nile virus, COVID-19), while other diseases have re-emerged with new drug-resistant strains. At the same time, globalisation facilitated the global operation of the pharmaceutical industry and advanced the ability of the international scientific community to prevent or limit the detrimental effects of diseases on health. This generated a growing awareness that global health challenges transcend national borders and require collective action beyond mere international cooperation between states (Sparke, 2019).

Secondly, the regular emergence of health-related crises in the 21st century (periodic outbreaks of Ebola, 2002-2003 SARS, 2003-2005 aviation flu, Zika in 2016, and most recently the COVID-19 pandemic and monkeypox), saw populations and economies of both the **Global South** and the **Global North** at risk. The potential impact of **infectious diseases** and other health issues such as antimicrobial resistance, **non-communicable diseases** (cancer, diabetes, etc.), or the threat of bioterrorism on national security and state stability is therefore no longer only a problem for low-income countries but affects middle- and high-income countries (the Global North) just as well (McInnes et al., 2019). Moreover, poor health is not only a health-related problem but also a global economic, trade, human rights, and development issue (Stoeva, 2016) (for more see Global health and development).

Thirdly, the relative failure of international development and health assistance programs (in disease prevention and providing access to medicines) has left the Global South countries disproportionately at risk from disease, while at the same time, it has increased the cost of **global regulation of health** (Davies et al., 2014). Global health has been one of the fundamental objectives of Sustainable Development Goals (SDGs), reflecting the belief that it is the obligation of the “rich” to help those in need (McInnes et al., 2019). As established in a study by Gill and Benatar (2016) “what distinguishes health outcomes in a global community is not so much *where* you are but *which* social group you belong to”, meaning that the poor in high-income countries (such as Japan) have more in common in terms of

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health with the poor in low-income countries (such as Venezuela) than they do with the rich in high-income countries.

Box 1: AIDS

The acquired immune syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which weakens a person's immune system by destroying cells that fight disease or infection. The disease is a zoonotic infection that crossed from animals (primates) to humans. It first appeared in the 1980s in Central Africa (first cases were reported in 1983) and rapidly spread worldwide in the following decades (Global Fund, 2022). In 1987 the name HIV was confirmed to differentiate between the periods when a person is infected (HIV) and when a person falls ill (AIDS) (Whiteside, 2019). HIV is transmitted through anal or vaginal sex, sharing needles or other drug injection equipment. Only certain fluids from a person who has HIV can transmit HIV, such as blood, semen, pre-seminal fluid, rectal fluid, vaginal fluid, and breast milk. HIV cannot be transmitted through saliva, tears or sweat, by hugging, shaking hands or "social" kissing, nor by mosquitos, ticks or other insects (Global Fund, 2022).

Although there is currently still no cure for AIDS, science has made great progress so that HIV can be controlled. Infected people can expect to live long and healthy lives similar to HIV-negative people if treated with antiretroviral (ARVs) therapy. To prevent an HIV infection in an HIV-negative person antiretroviral medication called PrEP (pre-exposure prophylaxis) can be used. PrEP is used by people who have had or may have a specific high-risk exposure to HIV through sex or injection drug use (CDC, 2022). However, due to high-prices and better awareness the access to these medicines is mostly limited to the Global North and discriminates those most in need, namely countries in the Global South that have high infection rates and the poor that cannot afford such treatment.

Potential biases in studying global health

While studies on global health are not new and this issue been vigorously researched as an area of international politics, there are still several biases in the literature dealing with global health. Most of the studies **marginalise** certain international actors based on geography, race, gender or socioeconomic status and remain **West-centric**. On the one hand, health issues have been perceived to be predominantly a problem of the Global South, of low-income countries and of "the poor". On the other hand, global health politics and governance is still mostly dominated by the privileged, especially white, and male leaders, scientists and researchers. As such they merely sustain, replicate, and exacerbate existing power differentials within the global system .

Recently, global health issues have also been predominantly perceived and understood as security rather than a public health issue in international relations. Such **securitisation** of global health is apparent in defining health concerns (such as HIV/AIDS) as potential risks to international peace and security or by including them in national and global security strategies (Harman, 2023) that have consequences for racism, xenophobia, and discrimination. The practice of states also confirms this as was most vividly seen in the reactions of states during the COVID-19 pandemic in declaring national security crises and emergencies. According to Harman (2023) the concern is that "this creates new forms of discrimination and restriction and exacerbates existing practices, particularly against marginalized or minority groups".

It is also reflected in Studies on global health have also been **idealised** and overly focused on the successful responses to disease outbreaks and the effective role of international institutions in their prevention and regulation. Some parts of the world, that have been living with health security threats for decades, have deserved little or no attention by the global politics, public and media.

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Box 2: Ebola

Ebola, also known as Ebola Virus Disease (EVD), was first detected in 1976 near the Ebola River in Sudan and in the Democratic Republic of Congo. The origin of the virus is still unknown, although scientists believe EVD is animal-borne. It occurs in bats, humans and other primates (CDC, 2022) and transmits from animals to humans (through tissue or bodily fluids by handling or butchering animals) or is passed between people through direct contact (with blood or other bodily fluids or secretions). Traditional funeral and burial practices (washing the body by hand or paying respect through physical contact) also play a key role in the transmission (Kaner and Schaack, 2016). Since Ebola was for long considered to be the disease of the poor and the Global South not affecting the rest of the world, there has been little effort invested in finding a cure for it. Only when it started to periodically spread worldwide and pose a direct threat to the Global North the efforts to find a vaccine have been intensified. As a result, in 2019 the first Ebola vaccine (called Ervebo) was approved, followed by a second (Zabdeno and Mvabea) in 2020.

Defining global health

Global health can be defined as the health of the human population in a worldwide context (McInnes et al., 2019). This means that health challenges extend beyond defined geographical territories or boundaries of states and cannot be solved by states working on their own, rather they demand global solutions. Accordingly, **global health policy** and practice include a wide range of **state and non-state actors** – international organisations (such as the World Health Organisation (WHO), the World Bank (WB)), private or transnational corporations (such as pharmaceutical companies, research institutes), civil society organisations (such as AIDS Society, *Médecins sans Frontières*, Global Fund, Oxfam), charitable foundations (such as the PanAfricare, Rockefeller Foundation or Wellcome Trust) and individuals (such as Bill and Melinda Gates) (Harman, 2023).

Another characteristic of global health is its **transdisciplinary nature**, this means that health interacts with other (global) policy spheres such as trade, security, development, and human rights. For example, in development aid (international cooperation) global health is a key element in reducing poverty and providing basic needs; in security, global health is a means for reducing existential threats to the state; in trade, global health is considered a core element for macroeconomic stability; and in general, global health is considered to be a fundamental human right in itself (McInnes et al., 2019).

2. GLOBAL HEALTH AND GLOBALISATION

Globalisation has shaped global health in a number of ways. The emergence of a complex web of interconnectedness and interdependence has led to a situation where “our lives are increasingly shaped by events that occur, and decisions that are made, at a great distance from us” (Heywood, 2015, p. 8). As such, globalisation has **decreased the relevance of geographical distance and territorial borders**, in the sense that local, national, international, and global events constantly interact. This means that in a globalised world, health emergencies can neither be contained within state borders nor determined by solely domestic factors and that international decisions affect national health policies and individual well-being (Stoeva, 2019, p. 105). This not only applies to outbreaks of infectious diseases but is also evident in other health issues, such as the practices of large multinational food and drink companies (tobacco), the widespread use of antibiotics and potential antimicrobial resistance, or the rising popularity of potentially harmful foodstuffs (McInnes, 2019).

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At the same time, worldwide economic, cultural, and political processes have substantially altered the context in which global health operates. Economic globalisation has created a **single global economy**. On the one hand, it allowed for the intensification of international travel and trade, internationalisation of (pharmaceutical) production, better access to medicines, and created global trends for better public health standards and consumption. These interdependencies confirm that “no part of the world can remain isolated from emerging and re-emerging communicable diseases, nor from the prevailing non-communicable diseases” (Stoeva, 2019, p. 106), and that global problems demand global solutions. On the other hand, economic globalisation has also had some damaging impact on (global) health in both the Global South and the Global North. The prevalence of neo-liberalism in the development strategies of all main international economic organisations such as the WB, the International Monetary Fund (IMF) and the World Trade Organisation (WTO), has promoted trade liberalisation, privatisation, deregulation of business and finance, public sector austerity and reduced taxation, as the most appropriate means to adjust to global market forces. In general, this has (directly or indirectly) caused severe **budget cuts for health spending, education, and other forms of social protection**, imposed user fees for health services and undermined wages in the health sector (Sparke, 2019, pp. 10–11). Not only did the idea that economic growth would eventually lead to good health prove brittle, but in certain cases (in particular the Global South) the exact opposite has happened. According to Oxfam (2018), in-country inequalities in income have risen and reduced the availability of treatment and prevention options for the poor and the economically precarious worldwide. Access to life-saving medicines was compromised due to the monopoly pricing of pharmaceutical companies and the drug patent protection built into free trade agreements protected by the Trade in Intellectual Property Rights Agreement (TRIPS) of the WTO (see Global health and access to medicines).

Simultaneously, globalisation has also affected political processes and structures in a way in which policy-making responsibilities for global health have been (at least partly) passed from national governments to non-state actors, such as inter-governmental institutions, civil society organisations, philanthropic foundations, charities, and private corporate organisations (Heywood, 2015; McInnes, 2019). They all interfere with government policymaking in the field of health in different ways. Philanthropic foundations and charities have been shown to modify national health systems by determining national health campaigns and pre-selecting health priorities for recipient governments (Harman, 2023). Pharmaceutical companies, as was vividly shown in the past (AIDS pandemic) but also in the most recent COVID-19 pandemic, have affected pandemic preparedness planning and antiviral stockpiling (Davies et al., 2014). Inter-governmental organisations (see *Global health governance and politics*) became agenda setters and mainstreamed global health into their initiatives that were then introduced in national policy statements on development, foreign policy, and security (McInnes et al., 2019, p. 6). Whereas some of these non-state actors’ initiatives and actions did have a positive impact on global health, especially by providing the necessary human and financial resources, they also **limited the role of governments** in national health planning, global (public) health security regulations, and pandemic preparedness. All this raises concerns about the lack of democratic accountability of non-state actors and their market-oriented approach to global health which potentially creates new health vulnerabilities and race-to-the-bottom in health rights (Sparke, 2019, p. 16; Harman, 2023). It also calls for global regulation of health issues.

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3. GLOBAL HEALTH, DEVELOPMENT and ACCESS TO MEDICINES

Global health is closely attached to development assistance and international cooperation. Health issues are particularly acute in low- and middle-income countries. Not so much because their more frequent appearance in some geographical areas but because these countries are dependent on bilateral aid from other states and/or global health institutions in addressing health-related concerns and crises (Sparke, 2019). As a result, a donor-recipient relationship between rich and poor countries, and between international organisations and poor countries has been created that not always serves the wants and needs of recipient countries. Often most attention and funds are given to infectious diseases and risks (such as viruses) that are considered as potentially bigger threats to donor states and not to deficiencies in health systems of recipients such as infrastructure, health education or medicine supply. Donor countries also design their own projects or policies that are sometimes accompanied by specific non-health related conditions (such as economic or political reforms) that recipient countries have to meet, and that in turn negatively impact their health systems. Such development raise concerns that global health creates new forms of dependency and exploitation of recipients (the poor) by the donors (the rich) that resemble the legacy of colonialism (Harman, 2023).

Access to medicines has been defined as a fundamental component of the full realisation of the right to health. It is understood as the ability for people to get affordable and needed access to safe, effective, and high-quality medicines and health products, and it has been the predominant way of addressing global health issues in the 20th century (McInnes et al., 2019). We need medicines to alleviate suffering, prevent, diagnose, and treat diseases, to control or stop outbreaks of infectious diseases, and to provide security or even save lives (Moon and ‘t Hoen, 2019). However, because new diseases appear more frequently and spread faster, provision of help by enabling access to medicines to the ones in need has become more challenging. High medicines prices, the concentration of the pharmaceutical sector into a small number of companies (monopolies), and patent protection have created massive inequalities in and between countries. They have also sparked heated political debates “about the appropriate roles and responsibilities of states versus markets in global health, and about the appropriate balance between the right to health and economic interests” (ibid., p. 2).

Box 3 – COVAX and vaccine nationalism

The COVID-19 Vaccine Global Access (COVAX) is a global initiative by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and the WHO (with UNICEF) to ensure fair, equitable access to COVID-19 vaccines, treatments, and diagnostics for all participating countries. Soon after the start of the COVID-19 pandemic, it became clear that to end this health emergency we not only need COVID-19 vaccines, but we must ensure that everyone in the world, regardless of their wealth, has access to them once they are available. Without such universal access, there is a very high risk that most of the people in the world remain unprotected which would allow the virus to spread unabated (Gavi, 2022). COVAX planned to deliver more than 2 billion doses of vaccines (20 percent of vaccine needs) by the first quarter of 2022 to over 92 low-income countries while also supporting middle- and high-income countries (WHO, 2022).

However, the implementation of COVAX has faced several obstacles and was subject to harsh critiques for its underperformance. As of early 2022, COVAX was only able to distribute one billion vaccine doses to low-income countries (Clinton and Yoo, 2022). Vaccine nationalism and hoarding in the Global North were identified as the major reasons for the COVAX’s failures to allocate and distribute COVAX-19 vaccines more equally and efficiently. “Vaccine nationalism is an economic strategy to hoard vaccination from manufacturers and increase supply in their own country” (Riaz et al., 2021). The idea is to stock up (even far beyond the population’s projected needs) and vaccinate the nation as soon as possible, regardless of the effect this might have on the

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rest of the world given the limited manufacturer's ability to supply globally (Clinton and Yoo, 2022). For example, more than half of the doses produced in 2021 have been bought in advance by high-income countries although they only represent 13 percent of the world's population. This creates a bias towards the Global South that already has lower economic status and struggles to pay for vaccinating their populations (Riaz et al., 2021). Vaccine nationalism and hoarding also reveal the limits of global health governance and fail to recognise that to reduce the virus's ability to transmit across populations, a significant section of the global population must be vaccinated.

Prior to the 1990s access to medicines was largely focused on the use of affordable (cheaper) generics of essential drugs that were widely available and needed in the Global South. It was part of broader international efforts to enable primary healthcare worldwide and reflected the idea that the selection and supply of essential medicines is a government's core responsibility (Moon and 't Hoen, 2019, p. 4). In the 1990s this changed due to the WTO TRIPS Agreement that enabled patent protection (which increased medicine prices) and created a situation in which cheap generic drugs would not be accessible in countries where they are most needed (Whiteside, 2019). Paradoxically, this development coincided with the growing global HIV crisis and the lack of affordable HIV medicines and had a detrimental effect on vulnerable populations in both the Global South and the Global North (see Case study 1 on AIDS/HIV).

Ever since, the price of medicines and patent protection have polarised debates about the importance of access to medicines for global health. Although increasing access to medicines has been included as a target in both the Millennium Development Goals (MDG target 6: combat HIV/AIDS, malaria and other diseases) and SDGs (Goal 3: Health and wellbeing for all), progress has been limited at best, very asymmetrically distributed and has further divided the Global South from the North (Harmer and Kennedy, 2019). At least three reasons for this can be identified. Firstly, on average medicines comprise 20-30 percent of states' total health expenditure. They are of special concern for the Global South since low-income countries spend more on medicines (in some cases up to 60 percent of total health spending) than higher-income countries (Moon and 't Hoen, 2019). AIDS, malaria, and tuberculosis are still the leading causes of death in low-income countries, especially in sub-Saharan Africa (WHO, n.d.). As such, low-income countries face higher disease burdens, are less capable to pay for, and are more dependent on medicines. Additionally, some other global issues such as ageing populations and the growth of chronic diseases have also increased the demand for medicine use worldwide, making it even more difficult for low-income countries to access medicines.

Secondly, healthcare and medicines are also economically very profitable, with the health sector accounting for almost 1/10th of the global economy (estimated US\$9 trillion) and medicine spending rising at a pace of over 6 percent a year in a US\$1,135 billion pharmaceutical market (Moon and 't Hoen, 2019). According to a report by Quintiles IMS (2017), most of the medicine spending is used on new drugs and less so on generics. Worldwide investment in research and development in the health sector is valued at US\$240 billion but is mostly privately funded (60 percent) and concentrated in high-income countries. Pharmaceutical companies that develop medicines mostly originate from the Global North and advocate strict intellectual property rules (even for essential medicines). This means that medicines are protected by patents which sustain high prices of medicines and deny access to them for countries in the Global South. Patent protection and the high prices of medicines are usually economically justified by the high cost of research and development needed to produce medicines and technologies. Without such protection and profit, pharmaceutical companies would not be able and willing to invest. However, there is also a normative argument against rigid applications of patent protection, particularly in cases of public health emergencies (such as disease pandemics) and provisions of essential medicines at affordable

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prices for all that need them. Even in cases where generic medicines are allowed, the question remains where generic medicines could be manufactured and sourced (Moon and 't Hoen, 2019). Often low-income countries lack the know-how and/or resources needed to produce generics.

Thirdly, whilst medicines are mostly available for the main global priorities such as AIDS/HIV, tuberculosis, malaria, and childhood vaccines, for other diseases such as hepatitis C and cancer medicines, IPR protection and prices for medicines remain high, and only available to those who can pay for them. Medicine innovation has also neglected certain diseases that were long characteristic of the Global South but have proven to have a pandemic potential such as Ebola, Zika, SARS and aviation flu. Moreover, non-communicable diseases formerly mostly linked to the Global North (such as diabetes, cancers, cardiovascular diseases (heart attack and stroke) and chronic respiratory diseases) have been globalised as well and now affect a large part of the world population.

CASE STUDY 1: The epidemiology and economics of the AIDS/HIV pandemic

At the turn of the millennium the AIDS/HIV pandemic reached a point where it was not only considered a health and medical emergency but also a security, economic, and human rights issue, and as such a global crisis (Sparke, 2019). The AIDS/HIV pandemic has created a broad constituency for action and unparalleled levels of funding. It has also played a central role in providing access to medicines in the Global South, so that of 37.7 million HIV-infected people, 27.5 million are on antiretroviral therapy (Global Fund, 2022).

However, at the peak of the pandemic in the 1990s, access to ARV therapy was limited for most people living with HIV, of whom 95 percent were in the Global South. The high cost of medicines (US\$10,000 per patient per year) and the implementation of the WTO TRIPS agreement prevented the production of cheaper generic medicines in countries where the disease was most widely spread, and where it could save lives (Hein and Moon, 2013). This has caused global public outrage and put pressure on pharmaceutical companies to allow for the production and use of generic medicines that were widely patented in cases of urgent public health concerns (Moon and 't Hoen, 2019, p. 8). South Africa was one of the countries that were hit hardest by the HIV pandemic and one of the first to lift the monopoly effect of patents for ARV therapy (Harman, 2023). However, access to affordable and available HIV medicines would not have been possible without the Indian generic pharmaceutical industry. In contrast to some of the most affected countries of the Global South, India possessed both the knowledge and sources for large-scale generic production of medicines. In 2001 the Indian drug manufacturer Cipla started to produce ARV therapy at the cost of less than a dollar a day. This not only showed that cheap medicines could be manufactured but also that HIV treatment is feasible in resource-poor settings. What followed was a change of WTO rules on IPRs in Doha that allowed for the purchase of generics medicines by governments and donors to protect global public health (Moon and 't Hoen, 2019, p. 9–11).

AIDS/HIV has also revealed that merely a bio-medical approach to epidemics/pandemics (providing access to medicines) is insufficient and that other root causes of vulnerability (besides poverty) should be addressed as well. HIV is an example of a gendered disease, i.e. women are (twice) more likely to be infected than men due to their social and economic marginalization (Global Fund, 2022). On average, women face more violence and lack empowerment in controlling sex, they are the primary caregivers for the sick and economically dependent on men (Whiteside, 2019, p. 12). Besides women, other key populations for HIV include gay, bisexual, and other men who have sex with men, transgenders, sex workers, drug users and people in prison. These groups face social marginalisation (stigma), are criminalised, subject to human rights violations which prevent them from accessing health services and put them at greater risk for HIV infection (Global Fund, 2022).

4. GLOBAL HEALTH GOVERNANCE and POLITICS

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Access to medicines or other pharmaceutical interventions are not enough to guarantee global health security to all, and they need to be supported by other forms of international cooperation and regulated at the global level. The international efforts to contain infectious disease epidemics (such as Ebola, SARS, Zika, avian flu) already appeared in the 20th century and were the major contributing factor for the establishment of the first regional and global inter-governmental institutions in this field (Stoeva, 2016). However, 20th century health issues were still predominantly the domain of domestic (national) politics and as such considered “low politics” in international relations, i.e. not of strategic importance, with only some technical aspects (such as vaccines delivery and disease notification) requiring international cooperation (McInnes, 2019, p. 2). This has changed at the beginning of the 21st century with various disease outbreaks that called for a more active role of the international community in helping those in need and in promoting global health as part of poverty reduction strategies (see Module 2: Globalisation, Wealth and Poverty). Furthermore, the alarming spread of communicable diseases made it clear that in order to limit the negative effects of global health emergencies providing access to medicines is not enough and needs to be complemented by further domestic measures aimed at improving both the domestic standards of public health and the degree of (international) political cooperation (McInnes et al., 2019). Most recently, with the COVID-19 pandemic, global health was acknowledged as a “high politics” issue on the international agenda, having a significant impact on national and global security, as well as foreign policy, trade, and human rights (Harman, 2023). What emerged was a multilevel governance in global health that consists of multiple different forms of national, international, and transnational actors in the promotion of global health.

In 1948 the **WHO**, a specialised agency of the United Nations responsible for international health cooperation, was established. In its preamble, health was defined as a fundamental human right, meaning a “complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Packard, 2016, p. 89). Moreover, governments were made responsible for the protection of citizens’ health “through the provision of adequate health and social measures” (ibid.). With the creation of the WHO universalising health rights became a common goal globally (Harman, 2023), which improved standards of public health, increased access to medicines such as antibiotics and antivirals, and allowed for collective initiatives for the global surveillance of (communicable) diseases to prevent and limit the effects of health emergencies. For long, the WHO has been the main source of political debates, setting international guidelines and regulations to protect and promote health (Moon and ‘t Hoen, 2019). However, even prior to the COVID-19 pandemic, the WHO has come under scrutiny as some countries have openly been questioning the usefulness, management, and effectiveness of its operations and the global health system in general (McInnes, 2019). The Ebola 2014-2016 outbreak is an illustrative example of the significance of global health governance (see Case study 2 on Ebola outbreak 2014-2015).

Case study 2: Ebola outbreak and the importance of global health governance

On March 23, 2014 the WHO declared the largest outbreak of Ebola Virus Disease (Ebola) in history that started in a forested area of Guinea and soon reached its bordering countries (Liberia and Sierra Leone). Although the epidemic spread to other parts of the world as well (Italy, Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States) the largest impact was in West Africa. By April 2016 a total of 28.652 cases were reported of which 11.325 (40 percent) were fatal (Kaner and Schaack, 2016). Previously, Ebola outbreaks killed a relatively small number of people and remained brief and limited to confined rural communities. There are two major contributing factors that help explain how and why this outbreak was different from previous episodes. Firstly, the health systems in all three countries (Guinea, Liberia and Sierra Leone) have been weak, under-staffed, under-

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sourced and unable to provide basic health care services to their populations (CDC, 2022). According to a report by the Save the Children Fund (2015), in 2012 the Liberian government spent US\$20 per person per year on health, Sierra Leone US\$16 and Guinea US\$9, which is far below the US\$86 recommended by the WHO for a minimum package of essential services. This lack of health spending is also visible in the number of doctors, nurses, hospitals, clinics, and medical equipment. In Liberia there was one health worker for every 3.472 inhabitants and in Sierra Leone one for every 5.319. By comparison, Norway has one health worker for every 56 people and spends US\$7.704 on health for each citizen. All this contributed to the spread of the virus into densely populated urban centres where transmission was even faster.

Secondly, the international response was slow and insufficient. Existing disease surveillance systems did not work or were hampered by different regional infection control practices and prevailing cultural and traditional practices in West Africa (Save the Children, 2023). Only in August 2014, the WHO declared the situation a Public Health Emergency of International Concern, admitting that there is a risk of potential international spread that requires a coordinated international response. This decision followed after the first detected case of Ebola was diagnosed outside Africa and the outbreak began to be viewed as a threat to developed countries (MSF, 2015). International donors did also not provide sufficient and quick enough funding for the emergency response (Save the Children, 2023). The outbreak confirmed that the interconnectedness of the modern world means that the international community can no longer ignore health crises in the Global South and that more needs to be done for the development of drugs and vaccines for diseases like Ebola that hold the potential to cause future epidemics (Kaner and Schaack, 2016).

Other international intergovernmental organisations have also included global and public health in their actions. The **World Bank** has evolved from an inter-governmental organisation, primarily focused on alleviating poverty in developing countries by providing funds (loans, credits or grants) for reconstruction and development (and having no presence in global health), to being the largest donor to health programmes worldwide (Sparkle, 2019). It is committed to helping governments achieve universal health coverage and is one of the world's largest supporters in the fight against HIV/AIDS (Ruger 2005). Because the bank allows long repayment periods (up to 40 years), it also provides the time and resources to address special problems, such as widespread disease epidemics (Ruger 2005). At the same time, the WB has been one of the main proponents of the so-called Washington Consensus that pushed for privatisation and deregulation of public health with detrimental effects on health globally, most drastically in poorer countries (see Global health and globalisation) (McInnes et al., 2019; Harman, 2023).

Similarly, the establishment of the **World Trade Organisation** in 1995 has not only marked the biggest reform of international trade in the 21st century but it has also changed the relationship between global trade and health. If, prior to its creation the WTO, has mainly dealt with trade in goods, the Marrakesh agreement in 1994 included trade in services and intellectual property in global trade as well. This altered the delivery of health services worldwide, especially the access to and affordability of medicines (e.g. by increasing restrictions on the use of generics that poorer countries could afford) (Stoeva, 2019, p. 98) (see Global Health and Access to Medicines). One such case is the access to antiretroviral therapies for AIDS/HIV, where states that suffer the highest prevalence of the disease are amongst those least able to pay for these life-prolonging drugs (McInnes, 2019) (see Case study 1 on AIDS/HIV).

The 21st century has also marked a shift in power and authority in global health governance away from the state and the public realm (Harman, 2023). Some of these new actors include:

- **The Global Outbreak and Response Network** (GOARN) was established in 2000 by WHO and over 250 partners. Its main objective is to provide global public health

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resources (human and technical) to control (i.e. identify, confirm and respond) communicable disease outbreaks and emergencies of international importance.

- **The International AIDS Society** is a transnational network with members in more than 180 countries. It aims at uniting professionals and experts to accelerate scientific progress against and response to AIDS/HIV by building global solidarity, educating, and advocating.
- **The Global Alliance for Vaccines and Immunisations (Gavi)** is a public-private partnership created in 2000 bringing together donors, including governments, inter-governmental organisations (WHO, UNICEF, WB), the private sector, non-governmental organisations, professional organisations, vaccine manufacturers, researchers, and technical institutes. It has an annual budget of US\$1.5 billion and plays a critical role in improving primary health care in lower-income countries by providing access to newer and under-used vaccines and improving immunisation rates.
- **The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)** is a worldwide initiative to fight infectious diseases and strengthen health systems in more than 100 countries. It unites governments, civil society, health workers, technical agencies, the private sector, and the people affected by the diseases. It mostly focuses on providing international financing of antiretroviral treatment of AIDS/HIV to lower-income countries. It has an annual budget of US\$4B (equal to the WHO).
- **Bill and Melinda Gates Foundation** is a non-profit charitable organisation also active in the field of global health. It aims to reduce inequalities in health, provides resources for the prevention of infectious diseases and child mortality in developing countries. Due to its budget (annually US\$1B) it has emerged as one of the most significant actors in global health.

Whereas the emergence of **new global private actors and networks** has the potential to increase the capacity (resources) and political attention needed to respond to health emergencies globally and locally, the proliferation of (private) health actors has also caused a diffusion of authority (as to who is primarily responsible for global health governance), policy overlap and duplication of resources, incoherence, and competing agendas (e.g. privatisation of public services and goods, including healthcare) (McInnes, 2019; Stoeva, 2019). For complex global health governance to work, these actors need to act together and avoid underperformance and competition (Harman, 2023).

5. CONCLUSION

The extent of diseases and disruption recently caused by the COVID-19 pandemic show that global health is inseparable from global politics. Global health can therefore also no longer be considered an issue only of the Global South but a global issue where the focus is not so much on the North-South divide but on the gap between the 'rich' and the 'poor' (Moon and 't Hoen, 2019, p. 18). With public health expenditures likely to increase in the decades to come due to more health emergencies and crises, a world in which states close their borders and protect their interests, ignore international health laws, and allow for medicines to only be available to few will not be politically and economically sustainable. This also has the potential to lead to increased tensions between states that have strategic health assets and those that do not as well as additionally widen inequalities in global health. Therefore the idea that global health is a collective problem that requires collective and common solutions needs to prevail (Harman, 2023).

DISCUSSION POINTS/QUESTIONS

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- How has globalisation shaped global health (politics)?
- What will be the new patterns of health and disease?
- How will global environmental challenges (the growing effects of climate change and food security risks) influence international and domestic health politics?
- How do international trade and intellectual property rights affect global health?
- How will artificial intelligence or genetic manipulation affect global health?
- Does the right to health ensure better health for all?
- What is the role of private foundations and pharmaceutical companies in global health governance?
- Should global health focus more on protecting individuals or states from emerging health threats?

FURTHER READING

Davies, S. E., and Wenham C. (2020). Why the COVID-19 Response Needs International Relations. *International Affairs*, 96(5), 1227–1251. Focuses on the role of international relations for the governance of global health, particularly in the context of Covid-19 pandemic.

Harman, S. (2023). Global Health (25th Chapter). In J. Baylis, S. Smith, and P. Owens (eds.), *The Globalization of World Politics* (9th Edition). Oxford University Press. Comprehensive overview of the evolution of global health in the context of globalisation. Introduction to core concepts and current issues related to global health such as politics, governance and global health security.

McInnes, C., Lee, K., and Youde, J. (2019). *The Oxford Handbook of Global Health Politics*. Oxford University Press. Outlines the complex relationship between global health, international relations and foreign policy, including core concepts and issues with respect to global health security, governance, and the political economy of global health.

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