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From Imperialism to the "Golden Age" to the Great Lockdown: The Politics of Global Health Governance

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Abstract

This article reviews the state of the literature on the politics of global health governance and associated political dynamics of actors involved in this issue space. We identify seven eras in the field, beginning with the period of empire and colonialism and ending with the COVID-19 outbreak. The field of global health has long had a focus on infectious disease, often rooted within a state-centered approach to transnational global health problems with recurrent debates about whether and how restrictions on trade and travel should be imposed in the wake of disease outbreaks. This statist focus is in tension with more cosmopolitan visions of global health, which require broader health system strengthening. In the mid-2000s, a golden age emerged with the influx of new financing and political attention to addressing HIV/AIDS and malaria, as well as reducing the risk posed by infectious disease outbreaks to economies of the Global North. Despite increased awareness of noncommunicable diseases and the importance of health systems, events of recent years (including but not limited to the COVID-19

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outbreak) reinforced the centrality of states to global health efforts and the primacy of infectious diseases.

INTRODUCTION

In late 2019, news reports of a novel respiratory virus emerged from China. Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization (WHO), convened an emergency committee in January 2020 to determine whether a Public Health Emergency of International Concern (PHEIC) ought to be declared. That declaration was intended to be a global call to arms for action to prevent, and latterly respond to, an emerging infection and to help coordinate a global response. The WHO, the predominant intergovernmental organization for health, advised governments not to impose draconian restrictions on trade and travel that might upend the global economy (Eccleston-Turner & Wenham 2021). At the same time, Dr. Tedros flew to Beijing to seek permission from the Chinese government for a WHO delegation to gather more information about the origins and clinical traits of this new virus. Dr. Tedros praised the Chinese government's response, drawing the ire of the Trump administration in the United States. The administration believed that China's response was far from transparent, reminiscent of similar interactions during the outbreak of SARS almost 20 years earlier (Davies & Wenham 2020). Simultaneously, governments, the private sector, and public–private partnerships (PPPs) embarked on crash investments into vaccines and therapeutics research and development (R&D), with many actors championing equitable distribution of any medical countermeasures (Jung & Rushton 2021).

The unfolding COVID-19 pandemic challenged the structures of global health governance. States imposed travel bans despite the WHO's objections, the United States announced its decision to withdraw from the WHO, and the rapid development of vaccines and therapeutics offered potential to slow COVID-19's spread but then were hoarded by wealthy countries. These episodes are at odds with the normative cosmopolitan foundations of global health governance and underscore some key actors, challenges, and politics that beset the field of global health governance—and are, as our review demonstrates, nothing new.

While outbreaks of pathogens have periodically commanded short-run attention, other infectious diseases, principally HIV/AIDS (Benton 2015), have been the source of enduring attention, resources, and fraught politics within the global community in recent history. That said, global health governance extends beyond communicable diseases. Noncommunicable diseases, such as obesity, and issues like road traffic accidents also concern actors in global health, but these have received far less attention despite the levels of mortality and morbidity they cause (Bollyky 2019).

Globally, an ever-expanding plethora of actors supports health activities. This includes traditional intergovernmental organizations like the WHO and the World Bank (the Bank); private philanthropies, notably the Bill and Melinda Gates Foundation (BMGF); nongovernmental organizations (NGOs) that offer services and/or advocacy, such as Doctors Without Borders; and PPPs such as Gavi and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) (Youde 2012). Often overlooked are states themselves, which finance multilateral efforts, support bilateral programs such as the US government's President's Emergency Response for AIDS Relief, and indeed are the location where global health decisions are made and delivered (Dietrich 2007).

This article provides a review of the literature on the politics of global health governance. We first focus on the historical trends of global health as a sector. Second, we elaborate on the contemporary politics of the key actors: states, the WHO, the Bank, PPPs, and philanthropies like BMGF. Finally, we situate the recent engagement of international relations (IR) in the COVID-19

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pandemic amid our broader historical narrative, and demonstrate what IR can offer to global health. Much of the empirical literature unwittingly engages with IR themes, but due to a lack of meaningful interdisciplinary work, it has emerged as its own field of enquiry, rather than using the wealth of theoretical understanding from IR to inform our understanding of global health governance.

The early 2000s was the "golden age of global health," when resources for global health concerns, principally HIV/AIDS, expanded dramatically. During that period, advocates championed a cosmopolitan worldview, and actors working in the global health space, whether states, international organizations (IOs), NGOs, or philanthropies, all promoted an ideal of a rights-based universal approach to health. Some analysts went so far as to describe global health governance as entering a post-Westphalian era (Fidler 2003). However, this golden age with its cosmopolitan ethos has been continually tested by narrower disease-focused conceptions of health, which we term statist or Westphalian (Brown & Stoeva 2014).[1] States increasingly prioritize the needs of their electorates, economies, and social structures over altruistic health for all (Rushton 2011). These developments underscore that (Global North) states remain the dominant—though not the only prominent—actors in global health, and we situate the competing institutional interests of different actors within the larger IR literature (Paxton & Youde 2019).

ERAS IN GLOBAL HEALTH

We divide global health into six distinct previous eras, with a seventh (post) COVID-19 era developing now. Anchoring our discussion temporally can help us understand that there are recurrent debates in the field between control of infectious diseases and facilitating commerce, as well as tensions over disease-specific interventions versus broader health system–wide approaches. The historical origins of the field in empire also reveal patterns of inequality and injustice that continue to shape access and health outcomes.

Trade and Imperialism: Nineteenth Century through World War II

For many scholars, international health considerations begin with colonialism. Emergent health policies were developed by colonizing states to protect their militaries and economic actors from the infectious diseases they were exposed to upon occupation. For example, the vector-borne diseases malaria and yellow fever diminished the productivity and survival of both expatriates and locals in tropical zones, which threatened capital production and political stability (Packard 2016). The substantial increase in the trade from colonized states back to Europe was further responsible for transmitting diseases across its trade routes worldwide.

The increasing spread of cholera resulted in trade complications as quarantines were placed on infected boats, negatively affecting imperial coffers. This led to the first International Sanitary Conference in 1851, where Mediterranean states sought to enforce quarantines on trade ships. This proposal faced strong opposition from the British because it threatened to increase costs of goods, putting public health and economic interests at loggerheads (Zacher & Keefe 2008, pp. 27–28). After decades of disagreement, the International Sanitary Convention was eventually adopted in 1892, regulating the quarantine system of the Suez Canal (Fidler 2005). Subsequent negotiations established precedent for the interaction between trade and public health, which continued to feature prominently in global health governance and denoted the first statist tendency within international health cooperation.

[1]Davies (2010b) summarizes this as a contest between globalism and statism.

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Dominance of the World Health Organization: 1950 through 1970

This imperial period was followed by the establishment of the WHO in the post–World War II era. The WHO was intended to unify the regional health organizations, including the Office International d'Hygiène Publique and the Pan American Health Organization. Its aims were to be the leading and coordinating organization for international health and to foster collaboration between states amid postwar reconstruction efforts (Lee 2008, Cueto 2019).

During this period, the WHO enjoyed unparalleled influence as it faced few competitors and saw early success with the Smallpox Eradication Campaign. This helped to solidify the role of the WHO and demonstrate its importance to member states (Manela 2010). This period was characterized largely by technocratic approaches to health that were highly optimistic about the ability to reduce disease mortality and morbidity through vaccines, insecticides, and other interventions. Interestingly, this era included more disease-specific interventions, but as the international health system grew, a clash appeared between competing visions for global health: one a cosmopolitan focus on horizontal interventions and the other a statist approach to vertical disease-specific control.

The WHO also updated standards related to disease control (World Health Assembly 1951), designating the WHO as the authority to enact global surveillance and public health responses which are "commensurate with and restricted to public health risks, and which avoid unnecessary interference with international trade and traffic." While hotly contested between the Global South and North, these new standards sustained earlier tensions between promoting trade and controlling disease, and divisions between imperial, industrialized states and "the rest" continued (Zacher & Keefe 2008, p. 39).

Health for All: The 1970s

By the mid-1970s, it was generally recognized that stopping a disease through strengthened health and surveillance systems would be more effective than trying to mitigate spread at state borders (Zacher & Keefe 2008, p. 42). This led to a reconsideration of global health. Following the broader human rights movement, states recognized the importance of primary health care as central to all health and agreed to the Declaration of Alma-Ata in 1978 (Int. Conf. Primary Health Care 1978). Alma-Ata positioned primary health coverage as the top health goal for all states worldwide. This emphasis on health for all embodied an expansive cosmopolitan approach to health witnessed at the time.

The Declaration of Alma-Ata's agenda, however, became bound up with newly independent countries' program for the New International Economic Order. This was challenged by wealthier countries who saw it as a turn to upend the balance of power and were not interested in supporting rights-based visions (Birn 2018), including health systems, at a time when conservative political leaders were ascendant. With only modest resources available, instead of support for comprehensive health systems capacity, the WHO's agenda was reduced to a limited, selective set of primary care policies such as widespread vaccination against childhood diseases (Cueto 2004). This fervent activity by Global South countries to challenge the status quo in global health perhaps maps most closely onto then-fashionable efforts in international development to overcome dependency, as captured by debates in international political economy (Crane & Amawi 1997).

Structural Adjustment and HIV/AIDS: The 1980s and 1990s

Alma-Ata's agenda foundered in the 1980s as a debt crisis beset countries in Latin America and Africa, leading to a "lost decade" of development (Singer 1989). With countries insolvent and in

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arrears to international lending institutions, the Bank and International Monetary Fund imposed structural adjustment policies.

The Bank and International Monetary Fund initially made aid conditional on cuts in government spending, the privatization of state-held resources, and increased reliance on market actors for service delivery. This led to governments paring back spending and introducing user fees for health services. The cosmopolitan framing of health as a right shifted to a neoliberal vision of health as a market-based good. The result of this was the collapse of health services for vast swaths of the population in the Global South.

As criticism mounted, the Bank altered its conditionality to an approach of "adjustment with a human face" (Jolly 1991, p. 1807). It increased its financial support for health, becoming one of the largest donors. The agenda maintained its focus on market-based mechanisms but recognized that the burden of disease was a drag on economic development of Global South countries (Youde 2012).

This period coincided with the emergence of HIV/AIDS, which redefined the field of global health. Though HIV/AIDS first came into global consciousness for its impacts on gay men in wealthy Western countries (Shilts 1987), the greatest impact has undeniably been across sub-Saharan Africa, where tens of millions died. In the United States and Europe, the development of antiretroviral therapies (ARVs) in 1996 transformed HIV from a death sentence to a long-term chronic disease for those who could afford access. This excluded both those in high-income settings without private or social insurance (Mullard 2014) and almost the whole infected populations of the Global South.

Advocates from affected communities in the Global South aligned with partners from the Global North to press for access to ARVs. They framed access as life or death, pitting human rights against corporate profits (e.g., Sell & Prakash 2004, Busby 2010, Patterson 2010, Kapstein & Busby 2013). In so doing, they challenged the neoliberal orthodoxy of the market and made equity of access central to their advocacy (Seckinelgin 2009, Parker 2011). They applied pressure to the world's wealthiest governments to buy ARVs and donate them to low-income countries, ultimately leading to the creation of GFATM (Chorev et al. 2011), and challenged patent laws that allowed pharmaceutical companies to restrict competition from generic drug makers (Cullet 2003, Youde 2007, 't Hoen et al. 2011).

This important role for activists, combined with the increasing role of the Bank, reflected a direct challenge to state-based decision making for health and the need for thinking beyond Westphalian structures to understand global health. This broadening of the landscape facilitated a change of terminology from "international health" to "global health" to reflect the diversified landscape of new actors (Brown et al. 2006, McInnes & Lee 2012).

The Golden Age of Global Health: The 2000s

The early twenty-first century has been described as the "golden age of global health" (Fidler 2010). Building on the HIV/AIDS crisis response, dramatic funding increases and institutional developments emerged to solve national and transnational health crises (Shiffman & Smith 2007, Shiffman 2009). This coincided with a broader human development and human security movement (UNDP 1994), leading states in the Global North to support new PPPs that brought dynamism to the sector. Importantly, the efforts during the golden age embedded cosmopolitan ideas of transnational disease dynamics, requiring collective, global efforts.

Between 2000 and 2010, development assistance for health increased by 171%, rising from $14 billion to $38 billion in constant dollars (IHME 2023). This was facilitated by the establishment of the GFATM in 2002, which brought collective focus to the challenges posed by the "big three" (AIDS, tuberculosis, and malaria) globally. Other PPPs, including Gavi, brought private

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support and underwrote efforts to extend childhood immunizations globally. BMGF came to prominence as a global health actor during this same period. Recognizing the importance of these changes to the landscape of global health governance is vital in understanding the shift to more cosmopolitan norms of health. The new institutions also demonstrated the limitations of a state-based system, as they were able to partially fill gaps that the older system had left open.

There remains debate in the field as to the driving factors for the emergence of the golden age, with Busby (2010) arguing that moral drivers of the HIV response catalyzed the start of the broader expansion in global health. Others challenge the importance of the cosmopolitan worldview and highlight that this golden age occurred in parallel with the securitization of health (Drezner 2008, Youde 2011, McInnes & Lee 2012). As the era closed, and more pressing issues such as a series of epidemics emerged, this debate has quieted within the literature.

During this same period, efforts to prevent, detect, and respond to emerging pathogenic threats quickly became framed as global health security. This framing did not correspond with which diseases caused the highest rates of mortality and morbidity; rather, the frame focused on infectious diseases that had the potential to do damage to wealthy countries' interests (Waever 1995, Davies et al. 2015). The global health security frame also prioritized vertical, disease-specific interventions rather than horizontal efforts to promote health system strengthening. Arguably, this began with the Clinton administration's reframing of HIV/AIDS as a security concern (Vieira 2007, McInnes & Rushton 2013), which in 2000 led to the United Nations Security Council passing Resolution 1308, declaring HIV a threat to international peace and security (McInnes 2006, Rushton 2010, Poku 2013). This securitized rhetoric took a more prominent role in global approaches to health in the post-9/11 era, spurred on by the anthrax attacks in the United States in 2001 and the emergence of SARS in 2002 (Labonté 2008). The security framing of disease retained strong support in the Global North. This was reinforced by post–golden age events such as the West African Ebola crisis (Harman & Wenham 2018).

Consolidation and the Pre-Pandemic Era: 2008–2020

With the Global Financial Crisis of 2007–2009, resources for global health, which had been increasing dramatically over the previous two decades, plateaued. Funding remained focused on vertical interventions and securitized health concerns. This in turn led most analysts to argue that the golden age had come to an end (Fidler 2010). In the absence of additional new monies, the realization of long-term needs of AIDS patients meant that the global health agenda was locked into a period of maintenance and consolidation (Over 2008, Williams & Rushton 2010). While foreign aid resources were stagnating, philanthropic funding became more prominent as foundations like BMGF still were expanding their resources to support a range of (disease-specific) interventions.

The emergence of H1N1 influenza (swine flu), Ebola outbreaks in both West Africa and the Democratic Republic of Congo, Zika, and the re-emergence of polio threatened this period of consolidation. States still tended to rely on securitized responses to outbreaks. In the periods in between outbreaks, actors from the Global North sought to build capacity in the Global South to prevent, detect, and respond to infectious disease, to protect themselves as much as the affected countries (Fischer & Katz 2013, Davies 2019). The WHO came under increasing scrutiny during these epidemics, in particular for Ebola in West Africa; its delayed PHEIC declaration and deficiencies of its overall approach led to considerable introspection and institutional reorganization, as well as a second resolution by the United Nations Security Council (McInnes 2015, Kamradt-Scott 2016, Enemark 2017).

This included the creation of an operational Health Emergencies Program. The program was not entirely of the WHO's own making, as its budget for pandemic disease control had been slashed in the wake of the financial crisis (Philips & Markham 2014). Such failures were

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compounded by a lackluster response to Ebola in the Democratic Republic of the Congo, followed by sexual exploitation of WHO emergency responders (UN News 2021). In 2017, Tedros was elected as the WHO's new Director-General. He brought a more cosmopolitan worldview, in contrast to the previous emphases on vertical health interventions and statist approaches to global health (Pillay et al. 2017), which had helped bring new attention and resources to the space but left wider aspirations for health system strengthening unfulfilled.

COVID-19 and the Pandemic Age

The COVID-19 era has more fully revealed contradictions and limitations of the cosmopolitan aspirations for global health that the WHO and advocates championed during the golden age. While this article's opening vignette captured dynamics of the early COVID-19 crisis, the centrality of statist approaches to global health largely persisted even after COVID-19 vaccines were developed.

On January 30, 2020, Tedros declared COVID-19 to be a PHEIC—one week after he declined to make such a declaration. COVID-19's early spread to northern Italy and then outward to the rest of the world meant many of the traditional state contributors to global health financing were driven to shut their borders and direct funding, expertise, and attention to their own domestic plights (Davies & Wenham 2020). The pandemic made clear that despite the cosmopolitanism of the golden age, when powerful states are threatened, national sovereignty and securitized approaches hold primacy over global public health objectives and more expansive worldviews of health for all.

This was never clearer than during the race to produce and supply vaccines for COVID-19 through both the United Nations' Access to COVID-19 Tools (ACT)–Accelerator, which includes the COVID-19 Vaccines Global Access (COVAX) initiative, and negotiations on the waiver of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) at the World Trade Organization (WTO). Early in 2020, those working in public health sought to develop, manufacture, and distribute medical countermeasures in an equitable manner. The ACT-Accelerator brought together many of the leading actors in global health, including the United Nations institutions, Gavi, the Bank, BMGF, GFATM, the Coalition for Epidemic Preparedness Innovations, and the Wellcome Trust, within a shared mandate of providing vaccines, tests, and treatments to everyone, everywhere.

Indeed, the concept of COVAX has been challenged for being structured as a donations-based model (Eccleston-Turner & Upton 2021) at a time when states were prioritizing their own security (Storeng et al. 2021). For critics, this design meant that COVAX was destined to fail (Harman et al. 2021), since wealthy countries initially hoarded available supplies of vaccines and even India's Serum Institute, a major source of vaccines, was challenged by national export bans as India's COVID-19 situation reached crisis proportions (Cohen 2021).

Meanwhile, states in the Global South started the process of negotiating such access through the WTO, arguing for a People's Vaccine that would be available to all at low cost. The Global South wanted the ability to grant compulsory licenses for COVID-19 vaccines (as well as medicines and diagnostics) to allow generic manufacturing and export to least-developed countries and those without their own generics industries (Chattu et al. 2021).

Such a mechanism was intended to emulate the TRIPS agreement of 2003, which allowed ARVs to be produced by generic producers. The 2003 TRIPs agreement emerged due to HIV/AIDS activism during the golden age, when equity and access were center stage and the Global South stressed the need for the availability of affordable medicines (Aginam et al. 2013, Scott & Harman 2013, Shadlen 2017).

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However, as the WTO negotiation progressed on COVID-19, states in the Global North largely opposed loosening intellectual property restrictions on new vaccines and therapeutics. While COVAX and wealthy states have delivered some doses of vaccines to the Global South, the donations have paled relative to the need. Supply constraints may have attenuated in 2022, and it is not clear these problems have been or will be overcome (Cohen 2021). By one report, more than 80% of populations in wealthy countries had been vaccinated for COVID-19 as of early 2022 compared to less than 10% in low-income countries (Clinton & Yoo 2022). These displays of vaccine nationalism and the hoarding of supplies are in direct opposition to the cosmopolitan vision of global health.

In response to these perceived shortcomings of the WHO, the Global North proposed a Pandemic Treaty in May 2021, and the negotiations have begun amid the newly formed Intergovernmental Negotiation Body. This remains a point of great contention amid the global health landscape. Those in the Global South see the treaty as an empty vessel, one that claims to champion solidarity while the same member states who support the treaty are seeking to block meaningful technology transfer in WTO negotiations (Ramakrishnan et al. 2021). Others characterize it as seeking to create a new structure rather than understand what went wrong with the old one (Karunakara 2021). At its center, however, is a tension between, on the one hand, the cosmopolitan ideals of equality of health access and human rights globally, and on the other, the reality of Westphalian structures and sovereign decision making, which tend to prioritize the needs of powerful countries (Wenham et al. 2022).

ACTORS IN GLOBAL HEALTH

A complementary way to understand the field of global health is by reviewing the evolving roles of key actors and organizations. Global health enjoyed unprecedented salience in the early 2000s, with a plethora of interest and new actors. Scholarship on global health governance has often highlighted the rise of new approaches and actors. States remain the key actors in domestic and international health politics, but they increasingly share power with other actors in the public and private spheres.

States

States have been understudied in the global health literature, even though they are the major sources of finance, policy development, and implementation for health around the world (Youde 2018, p. 76). Indeed, Ricci (2009) suggests that the literature has underemphasized the state and overemphasized nonstate actors in global health governance. Within states, a population's health constitutes part of the social contract between the electorate and government. States have also shaped and implemented the global health agenda (Porter 1999, Harman 2009, Bump 2010, Patterson 2010, Ventura 2013, Harris 2015). In 2018, donor governments were responsible for about 70% of development assistance for health.

The agency of wealthy states to shape global health policy is one research focus, but scholars have also highlighted the agency of low- and middle-income countries to negotiate their own health programs beyond those championed by states and philanthropists of the Global North. Global health programs have always needed state acceptance to implement activity, including permission to operate within a given territory and participation in cofinancing programs (Harman 2012, p. 28). While for the most part states have welcomed global health actors and programs, Elbe's (2010) analysis of the Indonesian virus-sharing controversy demonstrates that states can impede global health activity. Dionne (2017) further shows how a mismatch between the health priorities of donors and recipient states can imperil programmatic success.

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States also shape the global health agenda of intergovernmental organizations. States act as the principals who delegate responsibility to IOs in global health to serve as their agents (Clinton & Sridhar 2017). This principal–agent role includes everything from negotiating patent rights for pharmaceuticals at the World Trade Organization (WTO) to shaping and constraining the WHO through policy guidance, funding, and appointment decisions. We discuss these dynamics further in the next section.

Global health is also a location for states to compete for power (Davies & Wenham 2020). States have used the health space for strategic positioning and support, as the United States and the Soviet Union vied for leadership in efforts to eradicate smallpox during the Cold War. States can also more overtly bring their geostrategic disputes into the health space. For example, contestation between the United States and China spilled over into the WHO's COVID-19 response, which undermined the organization's ability to generate a unified global effort (Davies & Wenham 2020, Kahl & Wright 2021). During the COVID-19 pandemic, the United States brought its dispute with China over the origins of the disease to the WHO and sought to hobble the WHO by notifying the United Nations of its intent to withdraw from the organization. That move might have had major financial and governance repercussions for the WHO had it not been for the election of Joseph Biden as the US president, who reversed that decision the day he was inaugurated in 2021.

The World Health Organization

The delegation of functional responsibility to IOs staffed by technical experts is foundational to our understanding of international relations (Abbott & Snidal 1998). In the global health space, the WHO has historically been the central organization.

The WHO's mandate is "the attainment by all peoples of the highest possible level of health" (WHO 1946). It was created to be the directing and coordinating authority on international health work and to furnish appropriate technical assistance to eradicate epidemic, endemic, and other diseases. This charge includes preventing, detecting, and responding to health emergencies, and providing technical advice on a range of routine health issues including universal health coverage, health-related Sustainable Development Goals, HIV/AIDS, malaria, tuberculosis, antimicrobial resistance, noncommunicable diseases, road safety, mental health, and more.

Trying to strike a balance between its aspirational mandate and its technical capacities has proven challenging for the WHO, as the organization possesses limited operational reach. This tension emerged prominently during the West African Ebola outbreak in 2014–2016 (McInnes 2015) and re-emerged during the COVID-19 pandemic, wherein the WHO used the powers bestowed upon it by its principals to declare a PHEIC and issue temporary recommendations to best respond to the disease. Yet, many states failed to adhere to these recommendations, instead charting their own course to mitigate the emerging infectious disease, rooted in a security logic of self-protection (Davies & Wenham 2020). This in turn meant that the WHO was seen to have failed in stopping the pandemic and faced a legitimacy crisis as some vocal groups questioned the role of the institution.

Yet, critique of the WHO's failures is nothing new. There has been increasing critical awareness of the institutional limitations. These have been characterized as problems of position, money, and politics (Davies 2010a,b).

The WHO suffers from its position as a member state organization. It is governed through the World Health Assembly, composed of 194 states setting the overall strategic direction. Meanwhile, the WHO Secretariat, alongside six regional offices and country offices, implements programs. This structure creates a principal–agent relationship whereby the WHO is unable to act independently; it is reliant on the compliance and consensus of states and is subject to political interference,

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while attempting to remain an apolitical technical actor. The regional offices are a result of the historical legacies that existed at the time of the WHO's founding, bringing together former regional institutions in a semifederal structure (Hanrieder 2015). Drawbacks of regional offices include competition for budgets, competing work streams, and confusion at times of crisis (Lee 2008).

In terms of money, the WHO is underresourced. Its 2022–2023 biennial budget is $6.72 billion—the same as a mid-sized hospital in North America. That sum cannot sustain the competencies expected of the WHO, and it is divided between assessed and voluntary contributions. Assessed contributions are paid annually by states, dependent on their GDP, and comprise 17% of the overall budget. Voluntary contributions make up 80% of the WHO's budget (WHO 2022). Voluntary contributions are earmarked, allowing stakeholders to direct funds to their own political and strategic priorities—not necessarily the WHO's technical priorities. Nonstate actors like BMGF and Gavi also make voluntary contributions to the WHO, thereby allowing nonprincipals to shape the organization's priorities by choosing to fund particular programs. This can further distort the WHO's mission and agenda, which can further weaken the legitimacy of the institution as an agent of its member states.

Finally, while it strives to be a neutral technical arbiter, the WHO is inherently a political institution. Internally, it has to navigate the tension within the organization at differing levels of governance; externally, it must balance its roles as both a technical and political institution and negotiate the politics of its prominent agents, as evidenced by the battles between China and the United States in the early months of COVID-19 (Davies & Wenham 2020).

The World Bank

Another theme in IR theory is the notion of regime complexes: overlapping, increasingly fragmented spaces where different organizations jockey for influence and decision making (Alter & Raustiala 2018). As actors have proliferated in the global health space, scholars of global health have evoked the notion of a regime complex for health (Fidler 2010). The Bank's entry into the health space, along with PPPs and nonstate entities, has added further complexity.

Though the Bank may lack a formal health mandate, it is impossible to understand the dynamics of contemporary global health governance without considering the Bank. When Robert McNamara became Bank president in 1968, he argued that the "health of man" needed to be central to the Bank's model of socioeconomic development (Harman 2012). Countries could not develop without addressing education, sanitation, nutrition, and health, and healthy societies were more likely to be productive—and thus wealthier (Ruger 2005). The Bank's conception of health as beneficial to economic growth has fueled a worldview of health for the economy, as opposed to an economy for health. Between 1980 and 2003, the proportion of Bank loans going to social services, such as health services, increased from 5% to 22% (Ruger 2005, p. 61).

The Bank's (financial) influence on policy makers at the national and international levels carries substantial weight in establishing agendas and reaffirming existing global governance systems. The *1993 World Development Report* is emblematic of these efforts (World Bank 1993). This report celebrated the improvement in global health indicators since 1960 but lamented the rising costs for health services amid limited budgets of states in the Global South. It called for dramatic shifts that reduced state expenditures on health, encouraged greater private investment in health systems, and emphasized targeting the most cost-effective measures—all of which were in line with contemporary neoliberal economic models.

To promote cost-effectiveness, the Bank introduced the disability-adjusted life year (DALY) to quantify the effects of ill health into a single indicator (World Bank 1993). One DALY is the equivalent of one healthy year of life, and the most cost-effective policies are therefore those that

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promote the greatest number of DALYs for the greatest number of people. Given limited health budgets, the Bank encouraged states to invest in programs with lower costs per DALY to see the greatest return on investment. Critics chastised the DALY for taking a reductive approach to health, valuing certain groups over others, and lacking a firm theoretical foundation (Abbasi 1999).

More recently, the Bank has assumed greater roles in global health through its responses to outbreaks like Ebola, Zika, and COVID-19. In 2016, the Bank launched its Pandemic Emergency Financing Facility to provide money to affected states immediately. Funded by catastrophe bonds, this mechanism aimed to catalyze the process of financial distribution to prevent outbreaks becoming epidemics. However, it became apparent that the model prioritized returns to investors over the needs of global health security (Brim & Wenham 2019).

By combining its financial clout with its agenda-setting power, the Bank has come to assume a significant role in shaping global health. While the Bank's official powers in the health space come through its project and policy lending abilities, its ability to shape the discourse is just as—if not more—important (Clinton & Sridhar 2017, p. 196).

Public–Private Partnerships

PPPs bring together the public and the private sector, such as NGOs and business, often in partnership with IOs. Their origins are closely linked to the market-based approach (Turkelli 2021) and were motivated by the unreliability of public funding, disillusionment with the ineffectiveness of state and nonstate actors, and recognition of the need for cross-sector collaboration. Champions of PPPs consider them more efficient and effective than traditional IOs because of innovations in management and governance, seeing them as largely financial pass-through mechanisms with limited bureaucratic overhead (Clinton & Sridhar 2017). The most prominent and influential PPPs in global health remain Gavi and GFATM, established in 2000 and 2002, respectively.

Gavi was established to improve vaccine access in low-income states by mobilizing new funding from both private and public sources. Gavi partners include donor and recipient states, pharmaceutical companies, BMGF, the WHO, UNICEF, the Bank, and biotech organizations. Its chief mechanisms for financing are the Advance Market Commitment and the International Finance Facility for Immunization. Activities include "strategy and policy setting, advocating, fundraising, providing support to states, and developing, producing, and delivering vaccines" (**https://www.gavi.org/our-alliance/operating-model**).

Like Gavi, GFATM is a financing, rather than implementing, organization, funded wholly through voluntary contributions from both state and private sources. The idea for the GFATM was first mooted by the G8 in 2000 to scale up funding to combat HIV/AIDS, malaria, and tuberculosis. By 2011, GFATM was financing approximately 85% of tuberculosis programs across Africa, as well as more than 70% of HIV/AIDS medicines, and it has become a model for public–private cooperation in health (York 2011). Its governance structure is distinct, including representatives of both donor and recipient states, the private sector, and civil society. Country Coordinating Mechanisms support state applications to ensure participatory decision making and country ownership. Because of this, GFATM is considered less donor-driven than other initiatives; however, a heavy reliance on the WHO and UNAIDS (Joint United Nations Programme on HIV/AIDS) consultants and staff has been reported (Sridhar & Tamashiro 2009).

Others have highlighted the substantial burden placed on states in both applying for and administering GFATM priorities, particularly the extensive audits required to show impact (Strathern 2000). These activities can act to divert limited state resources to the needs and priorities of donor states and organizations. Additional criticisms of GFATM include the disconnect between its aims and its implementation, particularly regarding meaningful stakeholder

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participation and accountability (Youde 2012, p. 79), and a focus on outcomes that are easily measurable, influencing which kinds of health care are considered desirable (Stein & Sridhar 2018).

Further concerns around PPPs include the lack of harmonization between them and other national initiatives, the emphasis on vertical programming to the exclusion of cosmopolitan ideals of health systems strengthening, and the embeddedness of biomedical solutions that do not recognize the social or commercial determinants of health. Indeed, Ruckert & Labonté (2014) suggest that the reason PPPs ignore the social and commercial determinants of health is exactly because of private sector interests.

PPP advocates argue that increasing the diversity of provision in healthcare R&D, infrastructure, and services facilitates better outcomes with more efficient prices and risk distribution (Kwak et al. 2009). However, Gallien et al. (2017) attribute increased stockout risks in several African states to the unpredictability of GFATM disbursements. Moreover, when health programs are closely tied to the financial system, health services are vulnerable to the cycles of boom and bust. This was evident after the Global Financial Crisis, when GFATM canceled the fourteenth round of financing in 2011 and halted new grants until 2014 (Ruckert & Labonté 2014).

Despite these drawbacks, PPPs have become one of the chief governance mechanisms for global health and represent a substantial transformation from the more traditional interstate bilateral and multilateral cooperation for health (Brown et al. 2006).

Philanthropies

Philanthropy receives relatively little attention within the broader IR and political science literatures, but its influence is central for understanding global health politics (Youde 2019). During the first half of the twentieth century, philanthropic support from the International Health Division of the Rockefeller Foundation made it possible to establish and support many international health organizations, such as the League of Nations Health Office and the Office International d'Hygiéne Publique and set the international health agenda (Youde 2013). In the twenty-first century, BMGF has played a similar role in supporting and determining global health priorities.

With an endowment of nearly $50 billion at the end of 2020, BMGF is the world's wealthiest philanthropic organization and the largest in global health. Its Global Health and Global Development Divisions award more than $1 billion annually to support global health-related projects (**https://www.gatesfoundation.org/about/financials/annual-reports**). This level of financial interest in global health has provided BMGF—and Bill and Melinda Gates themselves—a prominent role in shaping the global health agenda. Those same resources and influence, though, have raised concern about accountability, legitimacy, democratic oversight, and private influence versus public need.

Philanthropic involvement in global health is emblematic of the larger move toward including nonstate actors to fill gaps that states are unable or unwilling to address (Clinton & Sridhar 2017, p. 119). Moreover, philanthropy can provide the necessary risk capital to undertake exploration without having to answer to shareholders or electorates (Moran 2011). For example, because BMGF does not face the commercial pressures of pharmaceutical companies, it can invest in R&D to address diseases that primarily afflict people living in less wealthy states—projects that hold relatively little commercial appeal for for-profit companies (Matthews & Ho 2008). Interestingly, while McGoey (2015) is strongly critical of philanthropic actors, she posits that involvement in this area has largely spurred governments to increase their own spending on these activities. In this way, philanthropies catalyze governments to focus on overlooked areas.

Philanthropies can also act as partners for governments doing global health work. Instead of weakening national institutions, philanthropies can build useful relationships with governmental

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bodies to create more robust health programs. Leon (2015, p. 133) posits that "the activities of these [philanthropic] actors are deeply linked to existing networks of governmental activity." The BMGF's involvement in India evolved from initially circumventing state structures to developing an ongoing partnership with the Indian government—in part because it has realized that it cannot achieve its aims without engaging the national government in a cooperative manner.

The role of philanthropy in global health is not without critics. First, they point out that philanthropies are accountable to no actors other than themselves, yet they can have outsized agenda-setting influence publicly. At issue is not whether philanthropies are good or bad but whether they are legitimate actors within global health governance (Harman 2016). BMGF's legitimacy largely comes through its ability to deploy its wealth for health and development needs as well as the charismatic authority of its founders, far from traditional understandings of democratic legitimacy. McGoey (2015) argues that the public esteem in which they are held is more a result of good public relations than positive, demonstrable outcomes or genuine engagement with affected communities. Similarly, Ruckert & Labonté (2014) posit that philanthropies privilege private solutions over those from the public sphere, further extending the logic of neoliberalism.

Second, critics raise concerns surrounding the lack of accountability for foundations. If the Gateses and other wealthy philanthropists were truly interested in promoting more responsive public policy, they would support a wealth tax that would increase the public treasury and facilitate oversight for their efficacy within the normal bounds of democratic accountability. Instead, BMGF uses its resources to remake public institutions according to the founders' own predilections but is not accountable to any outside group (Schwab 2020). For example, BMGF has played a major role in the collection and dissemination of global health metrics through new institutions like the Institute for Health Metrics and Evaluation, which is then beholden to BMGF for continued funding, instead of bolstering the data collection capabilities of a public organization like the WHO. Shiffman & Shawar (2020) note that the criticisms of global health metrics, such as their lack of transparency and their outsized influence over national health strategies, receive too little attention because BMGF holds so much more power than the critics do—the "Bill-Chill" effect (Harman 2016).

These criticisms notwithstanding, philanthropies have played an important role, particularly during and subsequent to the golden age of global health. They use their financial resources to support scientific and technical development of new methods to control disease as well as to support advocacy. That advocacy, in turn, has helped create the groundswell of attention from governments to provide more public finance to support global health.

COVID-19 AND THE FIELD OF INTERNATIONAL RELATIONS

Thus far, we have focused our review on the works of those we consider thought leaders in the politics of global health. Yet, these works as an academic subfield have largely evolved in relative isolation from IR. Until COVID-19, major field journals, particularly in the United States, largely ignored global health. In a March 2020 tweet, Gunitsky noted that the word pandemic had appeared 0 times in the *American Political Science Review*, *International Organization*, *World Politics*, and the *Journal of Conflict Resolution*. Similarly, Voeten tweeted that between 2004 and March 2020, *International Organization* had received only 27 submissions in the field of global health, 0.4% of all submissions, with even fewer published.[2]

[2]The Gunitsky tweet can be found at **https://twitter.com/sevaut/status/1239266714866548741**, the Voeten tweet at **https://twitter.com/erikvoeten/status/1243958137180348417**.

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In this context of relative neglect by the wider field, global health scholars developed a rich interdisciplinary community of scholarship with a dedicated section in the International Studies Association. With a stronger critical studies research tradition, British and European IR, in particular, has been far more open and accommodating in publishing global health–related research than IR journals in the United States, and has also developed a tranche of new journals that focus on global health politics per se (e.g., *Critical Global Health*, *Global Public Health*, and *Global Health Governance*).

Yet, we believe this isolated development of politics of global health is a missed opportunity for IR to engage more with the field of empirical global health and vice-versa. Indeed, many traits of mainstream IR theories can be seen in empirical examples from global health. As we highlight, a tension between Westphalian sovereignty and cosmopolitanism is central to understanding institutional and situational analysis in global health. Yet, other engagement between IR theory and global health is limited. COVID-19 has proven to be the wake-up call spurring many in IR to consider the politics of global health, but IR theory's engagement with global health has been limited.

For example, if one were to ask, "What is the realist approach to global health?" the answer would have to be that there is none. For a theoretical tradition largely preoccupied with the possibility of great power war, global health has not been worthy of study. Certainly, one could recast the arguments about statist, self-interested approaches to disease as consistent with some understandings of realism.

Price-Smith (2001) sought to build an argument for the importance of global health within the realist tradition by pointing to the potential negative effects of HIV/AIDS on military readiness and effectiveness as that pandemic would change the power dynamics within the international system. The risks of military and societal collapse from HIV/AIDS, however, proved to be short-lived, both as a policy concern and as an area of academic inquiry.

Prior to the COVID-19 crisis, one example of quasi-health-related works was Drezner's *Theories of International Politics and Zombies*, a tongue-in-cheek text meant to expose students to how different theories would explain responses to a zombie apocalypse. One could replace zombies with transmissible disease without too much struggle. Drezner (2014, p. 42) writes that, in the event of a new plague, realists "would be unimpressed with the claim that a new existential threat to the human condition leads to any radical change in human behavior."

To the extent that IOs like the WHO have a role, realists argue that these organizations are largely the instruments of great powers, subject to limitations imposed upon them through the ability of states to withhold finances and appoint leadership. Much about the COVID-19 experience suggests that realist logics of self-interest, relative gains-seeking, and IOs serving as instruments of state power have some validity. Drezner (2020, p. E31) himself has concluded "the pandemic has highlighted the nationalist and protectionist tendencies in both great powers. In neither dimension, however, has COVID-19 had a transformational effect."

Liberal theories can also unpack IOs and global health. Abbott & Snidal (1998) argued that states delegate to IOs to centralize authority and pool sovereignty so as to further the interests of states, once again relating to the statist approaches described above. Technical expertise and multiple principals potentially give IOs slack to pursue their own interests, although such agency has been limited by state interests. That is one reason why principals created new PPPs: to reestablish state control over IOs to deliver better results (Clinton & Sridhar 2017).

From a liberal perspective, the prospects for cooperation in the global health space may be favorable because of the potential for joint gains, with strategic situations resembling either Harmony or Stag Hunt games rather than Deadlock or the Prisoner's Dilemma (Oye 1985, Sandler 2004, Barrett 2007). In Johnson's (2014) account, IOs have accreted power through the generation

of additional institutional progeny, including in health, where the relatively low salience of health amid broader IR has led to some insulation from state interference. The same forces of insulation also make IOs vulnerable to charges of incompetence when bad things happen, as occurred during the COVID-19 crisis (Johnson 2020).

Constructivist theories have had more engagement with global health. Examples of such engagement include activists decrying the effects of milk formulas on infants (Keck & Sikkink 1998); the AIDS advocacy movement (Sell & Prakash 2004); and shaming wealthy governments into action, which catalyzed the golden age of global health (Busby 2010).The mobilization of norms and ideas has been taken up by Shiffman (2009) to explain why some health movements succeed while others fail. Barnett (2020) views similar dynamics in the context of COVID-19, where sacrificing to save lives was a commanding normative ideal set against the reality that in practice there was a hierarchy of humanity, with some lives first in line to be saved. McNamara & Newman (2020) suggest the COVID-19 crisis has had a more fundamental impact on identities in a post-globalized world of increased inequality, including inequality of access to vaccines, mobility, and wider economic development. Indeed, constructivism seems to be the entry point for engagement between IR and global health, and most of the work we identify in this review as the politics of global health is broadly situated within this theoretical framework.

Other recent work has also sought to more explicitly combine an understanding of global health politics with IR theories. Wenham (2021) draws on feminist IR to highlight how women are disadvantaged by global health security policies. Youde (2018) draws on the English School tradition to explain how and why global health gained purchase on the international political agenda.

Conversely, the field of global health politics has broadly ignored much of traditional IR, despite being riddled with inadvertent engagement with IR theories and trends. The debates between statist/vertical health programming and more cosmopolitan/horizontal support for global health have relevance to realist and neoliberal conceptions of the breadth of state self-interests. Another example is the recent trend of studying "power" in global health (Abimbola et al. 2021, Topp et al. 2021); much of this scholarship has failed to engage with the work that has been going on for decades to understand power in global politics. There is much that could be gained from both fields engaging more meaningfully with each other, rather than trying to reinvent the wheel (Paxton & Youde 2019). As IR turns to embrace global health, and global health seeks to engage more with politics, we hope their interaction leads to greater methodological pluralism and theory development.

CONCLUSION

As long-time scholars in the field of global health, we anchored our review of the politics of global health governance in a periodization dating back to the nineteenth century. In our depiction of the COVID-19 era, we come back to where we began: Despite cosmopolitan norms of health for all promulgated by advocates, the reality throughout much of the history of this field has been narrower, focused mostly on protecting rich countries from transmissible diseases.

Even more altruistic efforts to support the health needs of the Global South during the golden age in the early 2000s were largely vertical, disease-specific interventions rather than more expansive efforts to support or strengthen health systems. The COVID-19 crisis, for its part, also laid bare that even rich countries with robust public health systems can also experience terrible public health outcomes under bad leadership and amid wider discord among leading powers in the international system.

The future is uncertain. Whether through the emergence of new infectious diseases or the rising health impacts of climate change, global health will continue to shape the human condition

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across the planet in hugely consequential ways. It is highly likely that global health will continue to feature as a major area in IR for the foreseeable future, and indeed, IR and the politics inherent to any transnational issues will be a fault line within the practice and programs of global health. We hope that scholarship on both sides will reflect the richness that each can bring to the other.

DISCLOSURE STATEMENT

C.W. sits on the World Health Organization International Health Regulations Review Committee on the Proposed Amendments to International Health Regulations and the Technical Advisory Group for the Universal Health Preparedness Review.

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