

Global Health Governance and the State: Premature Claims of A Post-International Framework

James Ricci

Since the SARS outbreak of 2003, the Global Health Governance literature has challenged state-based frameworks in the provision of health. With the increased participation by a range of nonstate and transnational actors as primarily driven by globalization, the international has become the global. However, this article argues that this literature has overemphasised globalization and its ability to wrest health authority away from the state and diffuse it to a range of competing and interacting actors. In fact, the state remains at the centre of an international system. This, though, is not a retreat into neorealist and neoliberal orthodoxy and the article offers an alternative to these frameworks in the description of state cooperation in the context of infectious diseases.

INTRODUCTION

The first decade of the twenty-first century has witnessed health, and particularly infectious diseases, emerge as a central political consideration for actors on various levels around the world. From SARS to Andrew Speaker to the H1N1 pandemic, infectious diseases are no longer confined to specific geographical areas and through the machinery of globalization impact peoples separated by vast distances within short periods of time. In the Speaker example, an individual with a rare form of tuberculosis criss-crossed the Atlantic Ocean via intercontinental air travel, coming into contact with thousands of individuals in six countries who were completely unaware of the disease carried in his lungs. For many Global Health Governance (GHG) scholars, this encapsulated the significant changes in how diseases spread, and, importantly, which actors participate in the creation and dissemination of global health policy. The World Health Organization (WHO), The Bill and Melinda Gates Foundation, and *The Global Fund to Fight AIDS, Tuberculosis and Malaria*, among others, demonstrate how transnational actors (TNAs), nonstate actors, and global public-private partnerships (GPPPs) are occupying territory either formerly controlled by the state or simply did not previously exist. Driven by globalization, the international has become the global.

However, while the GHG literature continues to develop and currently presents a more dynamic and nuanced conception of actors, issues, and the related interaction, a general and problematic theme continues to fester; namely, this literature displays an uncomfortable relationship with the state. Even as previous claims of a shift to a post-Westphalian framework in which the WHO assumed independent authority during the SARS outbreak have been refined¹, the more recent GHG literature still demonstrates a commitment to the concept of a post-international framework.² This is not a claim that GHG has attempted to make the state irrelevant. In fact, GHG scholars recognise the power of the state in many areas of health policy and continue to explore its relationship with other actors. In the move into the global, though, GHG continues to underemphasise the state and similarly

overemphasises the role of nonstate actors and TNAs. Accordingly, in an analytical capacity any claims of significant movement towards a post-international framework in the context of health are premature.

As GHG is an important framework within the international relations and public health literatures, the time is right to critically evaluate its conceptual assumptions and claims with particular attention given to the state and its place in the health research agenda. Through the lens of infectious diseases, this article argues that despite claims of globalization altering the political landscape such that nonstate actors and TNAs find themselves on more equal terms with the state, in fact the state remains the clear driver of international as opposed to global health policy. The article will proceed by first reviewing how GHG conceptualises globalization and the resulting impact on the emergence of a diverse governance structure. The second part will argue that despite these claims, a state driven, international framework persists. Finally, section three offers a state-based alternative to describe the current international system. While GHG offers great potential, it must more explicitly recognise the degree to which international health currently flows through the state and that this will likely remain for the short to medium term.

INTO THE GLOBAL: A REVIEW

Globalization

Any attempt to define a process or series of processes that explains various organizational mechanisms and levels of human interaction on a global scale will undoubtedly prove challenging. Health scholars, though, have increasingly sought to engage what many consider the critical force behind the emergence of a new form of health governance: globalization. While a complex concept with competing definitions, several overlapping themes exist with globalization generally recognised as the process of people, businesses, and nations becoming increasingly interconnected and interdependent through the vehicles of trade, communication, cultural, and trade, among others.³ Though globalization is not a recent phenomenon, what has changed in the second half of the twentieth century is the level and complexity of global interactions with significant participation by increasing numbers of diverse actors. In this context, Fidler argues that globalization ‘arises from the confluence of something old and something new in international relations’.⁴ Similarly, Lee suggests that while the historical process of globalization can be traced back millions of years, the current form is ‘distinctive in its unprecedented intensity and extent of change’.⁵ In particular, new technologies such as mass transportation and communication demonstrate the unique features of speed, distance, and complexity – the ‘death of distance’ – that dominate the twenty-first century.⁶

For many GHG scholars, the spread of infectious diseases has been undeniably aided by the mechanisms of globalization, with Lee and Dodgson arguing that ‘Cholera ... is a mirror for understanding the nature of globalization’.⁷ While the Andrew Speaker incident called attention to a particular strain of TB, globalization continues to drive all strains of TB and no country can fully protect itself.⁸ For Altman, the sudden and rapid emergence of HIV most likely occurred due to urbanisation and population

shifts associated with the global economy.⁹ Antimicrobial resistance across a range of diseases significantly has accelerated within the past twenty-five years only increasing the opportunities for these diseases to multiply and move across geographical locations.¹⁰ In the context of disease, the local almost inevitably becomes the global.

Importantly, globalization has fundamentally changed the perception of infectious diseases which impacts the actors that participate in the creation and dissemination of infectious diseases policy. Lee et al. claim that spatial, temporal, and cognitive process are rapidly evolving and forcing a wholesale re-evaluation of how the world is conceptualised and which actors are needed to confront these complex challenges.¹¹ Critically, Bettcher and Lee argue that while physical geography is important to how people interact, the state no longer defines these interactions and 'requires a rethinking of how we define and respond to the determinants of health'.¹² This reformulation of perspective is further expedited as globalization constricts the ability of the state to handle many emerging issues.¹³ From these conceptions of globalization emerges a shift away from a state-based approach to health as globalization 'clearly challenges national control of health policy'.¹⁴ These developments also demonstrate ineffective infectious diseases governance on both the national and international levels.¹⁵

This, though, is not a claim that GHG argues that the state is rendered irrelevant by globalization. Dodgson, Lee, and Drager argue that states will neither disappear nor become redundant and they will remain key actors.¹⁶ McInnes and Lee explore how infectious diseases have moved onto the foreign policy and security agendas of many states.¹⁷ Fidler argues that states are resisting some attempts to reform health governance structures.¹⁸ Even scholars who question the extent to which globalization has altered the political landscape, acknowledge that new methods of transportation, for example, have undoubtedly both aided in the spread of diseases and, importantly, challenged the manner in which the state confronts these pathogens.¹⁹ Accordingly, the speed and intensity of competing actors interacting, political globalization, has generated a new configuration of actors in which the state is one amongst many.²⁰ A new framework was needed. However, the extent to which globalization has created a new and more horizontally structured political environment has been overstated by GHG scholars.

Global Health Governance

Developed from the Global Governance literature, GHG claims that globalization has challenged the state and diffused authority to a range of actors. As Rosenau notes, the relocation of authority away from the state was hastened as the constraints of the bi-polar world were unshackled which allowed for better political structures to emerge, people to more clearly identify wants, and economic changes to develop as well as for the exploration of interdependence issues that generated new forms of transnational collaboration.²¹ These transnational collaborations are particularly accelerated by globalization which poses significant challenges to states which forces states and other actors to increasingly interact.²² This demonstrates the erosion of state sovereignty with globalization further exacerbating new challenges such as poverty, intrastate conflict, and population growth and has

increased the number of agents that are and will continue to affect the resulting move towards a more inclusive, holistic form of governance.²³ Linklater claims that the state is in fact challenged on two fronts: 'globalization has seriously reduced its scope for independent action and ... subnational groups demand greater representation and autonomy'.²⁴ Lawrence notes that the shift in authority emerges from 'relationships that transcend national frontiers'.²⁵

It is from this point of departure that GHG emerges and claims that the inclusion of a wide range of actors in the global health policy dialogue is both necessary and a reality. As Lee notes, for example, because 'cholera is a global [and globalising] story, one that requires going far beyond traditional approach to public health', GHG, with its variety of actors, is needed to tackle this threat.²⁶ Rather than passive observers commentating on state policy prescriptions, these actors are directly involved with global infectious disease policy. Further, Pereira notes that increasing numbers of nonstate governance actors have continued to reduce national sovereignty.²⁷ Despite no universally accepted definition of GHG, Dodgson, Lee, and Drager offer a point of departure:

GHG ... is distinguished [from International Health Governance] by the starting point that globalization is creating health needs and interests that increasingly cut across and, in some cases, are oblivious to state boundaries. To effectively address these global health challenges, there is a need to strengthen, supplement and even replace existing forms of IHG. ... [S]tate and nonstate actors have long interacted on health governance. The difference for GHG will lie in their degree of involvement and nature of their respective roles, varying with the health issue concerned.²⁸

Thus, GHG includes states and international institutions like the WHO, charitable foundations and individuals, with globalization drawing these actors closer together in an unprecedented manner.²⁹

This significant shift results in a more complex and holistic approach to health. GHG thus becomes a two-way process in which the sum of actors and subsequent policy demonstrates how globalization may impact health policy and what policies are needed.³⁰ It is in this evolving political environment, particularly within the last twenty-five years, that demonstrates the 'institutional change from a structure that consisted primarily of independent national health politics and some international efforts to control cross-border effects of ill health towards a system of global health governance'.³¹ This results in a global health system that is pluralistic and increasingly privatised with an array of GPPPs participating in the process.³² Even as the concept is still developing, it provides a framework in which to engage the incorporation of human rights, among others, as a critical element of global health.³³ Thomas and Weber suggest that the international relations literature has been slow to interpret and analyse GHG.³⁴ However, as Chan et al. develop in their analysis of infectious diseases and China, GHG perspectives have rapidly emerged in the wider literature.³⁵ Further, GHG has staked a clear position in respect to the location of health authority.

POST-INTERNATIONAL IS PREMATURE

While GHG and health globalization scholars recognise the longer historical narrative in which globalization operates, the relative changes in how states, nonstate actors, and TNAs interact on the global scale have not significantly changed. Navarro illustrates this in an analysis of health in that 'We need to demystify globalization and what it stands for. And we need to realize that it is not as new or as "unprecedented" or even as irreversible as some would claim'.³⁶ Hay and Marsh similarly suggest a need to more critically evaluate the sceptical and exaggerated claims made about globalization.³⁷ In particular, the decline and the 'hollowing out' of the state as the result of globalization cannot be substantiated.³⁸ The state is not merely an absent actor simply submitting to external forces in which it has no control. A more critical analysis of globalization would demonstrate how globalization proponents both overstate the novelty and extent of transnational movements as well as underrate the ability of the state to adapt.³⁹ The example of Indonesia and avian influenza samples highlights the ability of the state to resist the pressures of globalization.

Since 2006, Indonesia, through its Ministry of Health, has refused to share domestically acquired avian influenza (H5N1) samples with the world community. While the WHO-based influenza surveillance networks have been one of the most successful mechanisms of international cooperation since its inception in 1947, Indonesia claims that states have 'viral sovereignty' over infectious diseases and do not have to share them.⁴⁰ Despite being home to the largest concentration of avian influenza cases and even in the face of the swine influenza (H1N1) pandemic that first emerged in April 2009, Indonesia continues to resist international pressure in respect to the exchange of epidemiological information. Indonesia has been able to manage the political globalization of avian influenza and is willing to leverage its advantage; even in the midst of 'globalised era'.

Clearly, some *elements* of globalization are unique to the early twenty-first century with states having to respond to a new set of challenges. In this context, Bashford notes that, among others, the 'transborder nature of microbes and disease, has been, without question, augmented with the frequency of travel ... [and] there has been considerable use of supranational, fully global technologies and networks to track disease outbreaks'.⁴¹ The Andrew Speaker event of 2007 demonstrates the speed in which diseases can spread; something that could not have happened in the mid-1900s. Infectious diseases now have new mechanisms through which to interact with similarly new methods of social organization. Beyond issues of travel and communication, though, is the political effect of globalization and its ability to wrest traditional political functions away from the state. While SARS and H1N1 have been reported by twenty-four hour media, the evidence that this translates into a political shift is much more difficult to substantiate. The state can still manage globalization.

While this article is concerned with GHG and infectious diseases, a brief look at the 2008-09 global credit crisis does offer valuable insight into the centrality of the state in the context of globalization. China, for example, appears to have not only benefited from state control over the mechanisms of the national economy and its participation with international commerce, but, importantly, demonstrates that even as one of the largest markets in the world

it can regulate economic forces.⁴² The United States, with the world's largest economy, effectively nationalised the home mortgage industry, argued by many to be at the centre of the credit crisis and long believed to be a major contributor to the national and global economy.⁴³

Further, in October 2008 the United Kingdom, using established security legislation, froze Icelandic financial assets in order to protect British savers after Iceland nationalised its banking system.⁴⁴ The state is far from a passenger in the global economic environment, simply at the mercy of MNCs and other nonstate economic actors. Hurrell and Woods note that globalization is in fact an expression of political power in which the state chooses to regulate – or not – aspects of the international economy.⁴⁵ As Nobel Laureate in Economics Krugman argues, temporary nationalisation of certain key elements of the American economy is not only essential, but the United States does have the ability (political and economic) to conduct such policy.⁴⁶ At the height of this crisis, the inevitability of globalization in reshuffling the political deck and distributing power across a diverse set of actors is particularly overstated.

Overstated participation

Along the same lines, Elbe argues that international organizations like the WHO are limited by the resources provided by states and responses can be hampered, as SARS demonstrated, by an influential state not cooperating.⁴⁷ Elbe, though, does not suggest that the state is necessarily the best provider of infectious diseases services and remains concerned about the 'shambolic' condition of the international health infrastructure. GHG suggests that it can fill many of these gaps. However, Dingswerth and Pattberg acknowledge that even as global governance approaches have both an analytical and normative use, conceptual clarification is needed.⁴⁸ It is from this perspective that the GHG literature centrally suffers in description of the current state of international health and infectious disease policy; namely, an uncomfortable and unmanageable balance between what *is* and what *ought* to be.

GHG is in part driven by moral obligation and hope – demand – that states and other actors take responsibility on public health issues and that the WHO, GPPPs, and NGOs have filled the gap in this new political environment. As Lee notes with cholera, something must be done.⁴⁹ That infectious diseases and other health issues are critical for the development of safe, secure, and democratic societies is not in question. Yet, whatever challenges exist, however difficult they may be to overcome, and any justifiable sense of incredulity that billions of people, for example, lack access to clean drinking water, cannot obscure the fact that an international health framework persists and the state continues to allow nonstate actors and TNAs to participate in the provision of health. Even as the number of these actors increases, this has not translated into a significant shift in the organizational features of the international system. Suggestions of the emergence of a global framework are premature, regardless of absolute and relative changes in state authority.

Certainly, nonstate actors have contributed to the fight against infectious diseases with the Bill and Melinda Gates Foundation a prime example. As of 2008, the Foundation's endowment stands at just under US\$40 billion, with a 2006 contribution from fellow American capitalist

turned philanthropist Warren Buffet making it the largest private foundation in the world.⁵⁰ According to Cohen, the Gates Foundation has 'rearranged the public health universe'.⁵¹ Others such as Buse and Walt similarly acknowledge that contributions from the Gates Foundation, as well as other NGOs, provide critical resources to specific health challenges and play an important role in global health governance.⁵² However, the degree to which the Gates Foundation significantly changed the allocation of public health resources is overstated. Individuals have long participated in international health initiatives with the Rockefeller Foundation a key contributor to yellow fever eradication in Central America in the early twentieth century.⁵³

Additionally, whatever financial contributions are made by the Gates Foundation and other nonstate actors are dwarfed by resources, however lacking, from states. While the proposed 2010-11 WHO Budget is roughly US\$5 billion and is roughly similar in terms of the financial impact of the Gate Foundation⁵⁴, this masks other state-based contributions. For example, *The Global Fund to Fight AIDS, Tuberculosis and Malaria* has received US\$14.2 billion to date from states as compared to US\$0.8 billion from nonstate actors of which approximately 70% comes from the Gates Foundation.⁵⁵ Further, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was reauthorized in 2008 to provide up to US\$48 billion to combat HIV/AIDS, tuberculosis, and malaria. The CDC alone has a 2009 budget of more than US\$6 billion. Clearly the Gates Foundation and the increasing numbers of nonstate contributors have directed much needed resources towards critical health issues. However, these actors must be seen in a larger context in which the state and state-based institutions such as the G8 play the single greatest role in terms of financial contributions.⁵⁶

Further, even as the GHG discourse suggests that globalization continues to generate a whole new wave of nonstate health actors that have challenged the state, in fact much of this centres on only a handful of organizations, MNCs, and state-based institutions. Brugha and Walt note that the composition of the board members of the Global Alliance for Vaccines and Immunization (GAVI) includes one NGO representative.⁵⁷ Subsequent research by Buse and Walt similarly indicate that GAVI was launched by the executive heads of the WHO, UNICEF, the World Bank, and Merck & Co. along with Gates.⁵⁸ This does not represent a wave of NGO participation at the international level. Similarly, Drezner in an analysis of HIV acknowledges that in respect to Trade-Related Intellectual Property Rights (TRIPS) and patented antiretroviral research, global civil society (GCS) did have some causal effect on changing the TRIPS regimes.⁵⁹ However, the cumulative contributions from NGOs and other nonstate actors must be conceptualised through state-based frameworks and Drezner continues by arguing that the influence of GCS is overstated and the key to a shift in US policy was viewing HIV through a security lens as opposed to the GCS campaign. States, particularly strong ones, still drive the infectious disease agenda, allowing other actors to participate.

SARS and WHO

While the GHG literature has developed greatly since the SARS outbreak, this event does offer an important window into some of its deeper conceptual problems. Of particular note, is whether the WHO has levelled – or is levelling – the playing field and removed the state from its position of

supreme dominance. For many GHG scholars, the WHO remains a critical, though not the only vehicle in the movement towards a stronger health framework, and as such pay particular attention to its role with SARS continuing to remain an important case study within the literature. As argued by Fidler, the WHO assumed independent authority during the outbreak, dictated policy to states, and ushered in a new post-Westphalian era.⁶⁰ Cortell and Peterson suggest a similar description and as noted in the conclusion, this idea, even modified, continues to hold strong sway with GHG scholars.⁶¹

However, Davies questions whether international organizations can ever conduct policy without state authority and suggests that the WHO authority during SARS was delegated by states to serve particular interests.⁶² Similarly critical, Guilloux argues that it is not credible that the United States simply submitted to the will of the WHO.⁶³ The SARS outbreak, however dramatic the events and outcome, was driven through states not contesting WHO actions and whatever delegated authority was granted remained in state control. Yoon even suggests that the openness demonstrated by China during the outbreak did not appear genuine and argues that GHG scholars have paid little attention to Chinese policy in the subsequent months and years.⁶⁴ While undoubtedly an important event, many GHG claims overstate the role of the WHO during SARS.

Much like the relationship between states and MNCs, the one between states and TNAs such as the WHO is dictated by the former. While Abbott and Snidal note that states can and do grant TNAs authority and independence, independence is constrained and states – particularly the powerful – can limit authority, ignore dictates, and interfere with operations.⁶⁵ This does not suggest that particular institutional elements or agents always operate in line with the exact interests of states.⁶⁶ Further, the WHO undoubtedly became more heavily involved with infectious disease prevention since the 1990s. Rather, TNAs are primarily driven by state interests. Kelle argues the central role of the state in international public health is reaffirmed by the International Health Regulations in which states – as opposed to nonstate actors – provide the focal point for the implementation of the Regulations as well as the management of disease surveillance and reporting, with the WHO and nonstate actor providing a supporting role.⁶⁷

Calain similarly argues that even with the enhanced provisions of the Regulations, there is no sanctions regime for states that do not comply.⁶⁸ The state continues to play the defining role, both as an actor as well as the foundation of an organizational framework in the fight against infectious diseases. While MNCs, TNAs, and a range of nonstate actors have increasingly participated in infectious disease policy, this reflects the state allowing – or choosing not to challenge – these actors to participate. GHG scholars mistake the inability of the state to respond to a wide range of normative challenges with the emergence of a post-international framework. The state, despite the pressures of globalization, still dictates infectious disease policy through an international system.

Wendt concisely sums up the reality of the state and the international system by arguing the 'transition to new structures of global political authority and identity ... will be mediated by and path dependent on the particular institutional resolution of the tension between unity and diversity ... that is the sovereign state'.⁶⁹ Even in an era of instantaneous communication, jet-powered commercial air travel, and twenty-four hour news, the state remains

the central actor in the provision of health and protection against infectious diseases. It also defines both the framework through which these challenges are addressed as well as how other actors participate. While the threat of infectious diseases and problems of global health will undoubtedly remain, so too will the state remain the principle driving force in tackling these challenges. Despite picking up the gauntlet, GHG continues to fall short in describing how international health is currently provided.

INTERNATIONAL PUBLIC HEALTH SOCIETY

Even as the state remains the organizational principle through which infectious diseases are confronted, this does not represent a retreat into neorealist or neoliberal orthodoxy. In this context, GHG scholars are correct; namely, the political priority afforded to infectious diseases in the early twenty-first century has resulted in new levels of cooperation amongst states. This also includes the increased participation of nonstate actors and TNAs. While traditional elements of self-interest still exist and remain quite powerful, the presence and recognition of common interests and values has provided the opportunity for states to move beyond the narrow boundaries of national defence into the arena of collaboration. Further, this qualitatively new level of interaction changes the very nature of how states conceive each other, infectious diseases, and nonstate as well as transnational actors. The emergence of *international public health society* describes the new era of infectious disease cooperation.

International public health society and its analytical tools are developed from the English School literature and the pioneering work of Hedley Bull. In particular, Bull was interested in the cultural context in which common interests amongst states were perceived at particular points in time.⁷⁰ So even as malaria, for example, is a pathogen that has remained biologically unchanged for thousands of years, how it has been perceived by the state has varied considerably. This shift in perception can also result in overlapping interests in which states refrain from pursuing traditional (narrow) agendas and generates opportunities for cooperation. For Bull, states are not myopic actors and recognise that threats can derive from many quarters with cooperation needed to achieve common goals. Further, and of particular importance, states also treat goals such as infectious diseases prevention as more than a means to an end; they are an expression of common values.⁷¹ Infectious disease prevention is more than simply protecting domestic populations. It is a reflection of public health representing a goal that transcends national borders and creates a particular international society.

From this point of departure the international society framework moves away from neorealist (and neoliberal) assumptions which Buzan and Little suggest argues for a timeless, ahistorical construction of threats and cooperation.⁷² The interaction between states represents more than billiard balls on a table governed by a fix set of rules. States can and do change the rules of interaction based on changes in perception. This does not have to be applied universally with infectious diseases providing an area for cooperation on one hand, while, on the other, the issue of climate change produces divergent policies.⁷³ These varying levels of interaction do produce environments in which states will refrain from pursuing self-interests at the

expense of other states. Specifically, Bull saw the emergence of a society of states when 'a group of states, conscious of certain common interests and common values, form a society in the sense that they conceive themselves to be bound by a common set of rules in their relations with one another, and share in the working of common institutions'.⁷⁴ While self-interest is still a powerful motivating factor, within a given society states rely on the society as oppose to traditional self-interest to pursue particular goals.

Upon recognition of these common interests and values, states form institutions as a more effective method to prevent the spread of infectious diseases. However, unlike neorealist and neoliberal claims of self-interests being the primary and perhaps only factor in the creation of these institutions, the international society framework recognises critical social elements.

[Institutions] are rather an expression of the element of collaboration among states in discharging their political functions – and at the same time a means of sustaining this collaboration. These institutions serve to symbolise the existence of an international society that is more than the sum of its members, to give substance and permanence to their collaboration in carrying out the political functions of international society, and to moderate their tendency to lose sight of common interests.⁷⁵

The overlapping self-interests between states in respect to infectious diseases drive states to create institutions like the WHO and surveillance networks such as the Global Outbreak and Alert Response Network (GOARN). In doing so, public health has emerged as a value in and of itself.

Accordingly, international public health society is defined as the political priority given to infectious diseases, which has generated a significantly new type of cooperation amongst states, and is reflected in the establishment and participation in shared institutions. Further, even as this approach argues that the state remains the central actor within an international framework, this is not a retreat to Westphalian conceptions of borders with states only pursuing narrow national goals. The international society framework introduces missing or ignored social elements which are essential to understand states interaction. By including these elements, state interaction is demonstrated as more than cold, calculated, rational choice politics. This does not imply that the state is the most efficient or appropriate agent for the prevention of outbreaks. As introduced in the conclusion, the state-based model may be under threat with the movement towards a *world society* in which nonstate actors, TNAs, and international law, for example, play a leading role in combating diseases may be underway. In fact, world society and GHG share many similarities, suggesting that at a future date GHG, in an analytical capacity, may explain the global framework of competing and interacting actors. However, as the later SARS example demonstrates, international public health society does provide a better understanding of how states *currently* interact.

Response to Neorealism and Neoliberalism

While this article is primarily a response to the analytical claims of GHG, international public health society is also a response to neorealism and

neoliberalism. The interaction between neorealism and neoliberalism in terms of describing how and why states participate in international institutions is one of the central dialogues that emerged in the post-Cold War literature. Mearsheimer's 'The False Promise of International Institutions' explored essence of the debate by claiming that neorealists and neoliberals (whom he calls institutionalists) 'particularly disagree whether institutions markedly affect the prospects for international stability. Realists say no; institutionalists say yes'.⁷⁶ While neither approach has directly tackled infectious diseases and health to the extent of GHG, they still dominate in terms of describing international cooperation and therefore warrant attention.⁷⁷

Despite important differences in terms of why states participate in the WHO, for example, both agree that states are self-interested actors. For neorealists, states participate in international institutions to achieve very narrow national goals. In the SARS example, a neorealist would likely claim that the threat of the microscopic pathogen was particularly acute such that almost all states similarly conceived the potential impact of a pandemic and the need for immediate action. This was achieved not through coordination, but rather by highly specific interests overlapping. Similarly, neoliberals may suggest that states participated in the WHO-based response because they understood that tackling infectious diseases would be difficult if not impossible without a coordinating mechanism. Accordingly, states gave up some element of sovereignty to achieve this self-interested goal.

While international public health society recognises the importance of self-interests, this is not the only factor in understanding state cooperation. Critically, as Checkel notes, both neoliberalism and neorealism ignore the 'content and sources of state interests and social fabric of world politics'.⁷⁸ Interests are constantly changing as is how they are perceived by states. Further, interaction between states changes how they perceive each and influences the extent to which they are willing (or not) to cooperate. As states recognise that interests are dependent on recognition by other states, they can 'afford to rely more on the institutional fabric of international society and less on individual national means'.⁷⁹ Additionally, states pursue infectious diseases for more than insuring economic growth and stability; they represent the shared interests and values among states. It is in these missing or downplayed social elements in which international public health society distinguishes itself from neorealism and neoliberalism.

SARS and International Public Health Society

As the SARS outbreak has been developed in depth throughout much of the GHG literature and this article does not challenge the related timeline, there is no need to repeat the story. This brief section will focus on the relationship between states and the WHO and will argue that WHO actions reflected states interests and demonstrate the existence of international public health society. Key to this are the events from November 2002 when SARS first emerged to March 2003 when the WHO called on states to collaborate in order to diagnosis SARS in a clinical capacity. While the GHG literature has not ignored these events, the primary focus on WHO actions during the outbreak distorts the path through which the WHO was delegated authority. The shared interests and values of states in these earlier periods provided the

foundation through which the WHO emerged as an expression of collaboration amongst states.

While the initial SARS cases appeared in the southern Chinese province of Guangdong in November, it was not until February that states began to take particular notice. The combination of relatively few cases coupled with China failing to report actual cases kept this a local issue. Canada, though, was one of the first countries to recognise a developing health problem and the federal government recommended that all provinces be vigilant for illnesses in travellers returning from China.⁸⁰ Similarly, Singapore, Thailand, and Vietnam started to experience increased cases of what was labelled atypical pneumonia and reported these to the WHO.⁸¹ Vietnam was particularly aware of this emerging threat, communicating some of the earliest 'SARS cases' to the international community through GOARN at the end of February.⁸² To be sure, the WHO participated in these initial diagnosis when, for example, a WHO official in Vietnam notified the Singapore regional office of possible avian influenza symptoms in some of his patients.⁸³ However, states provided most of this information to the WHO.

Throughout February and into March an increasing number of atypical pneumonia cases were being reported across Southeast Asia. States, particularly those in Southeast Asia, took an active interest in what look like the possible emergence of a new strain of influenza with recent history serving as a guide. While these cases were reported to the WHO, states were doing so voluntarily. This is particularly important as even before the WHO issued travel warnings and restrictions of March, states were aware of an impending problem (though not necessarily exactly sure of the specifics) and started to take action. The foundation of the political environment in which WHO 'leadership' emerged was laid by states conceptualising this disease through a shared social lens and recognising the need for cooperation.

This, though, does not mean that all states shared a similar conception of SARS. China's refusal to acknowledge the extent to which SARS had spread domestically does demonstrate that a common response amongst states was not universal. Even between countries such as Canada and the United States who shared a similar conception of the threat as well as the need to develop immediate responses, political disagreements emerged.⁸⁴ However, international public health society makes no claim that all states shared an identical opinion of how to engage SARS. The overlapping interests and values of *many* states, though, did create a political environment in which states delegated authority to the WHO. Accordingly, this leadership was a reflection of these shared interests and values which generated a qualitatively new level of cooperation.

By the end of February, researchers around the world quickly started to recognise that this unknown virus, while similar to influenza, was constructed differently and took immediate action. It is here that states recognised not only overlapping interests, but also the need for a common, coordinated response. The United Kingdom acknowledged that 'strenuous international efforts are being undertaken co-ordinated by the WHO to identify the cause of this condition'.⁸⁵ Similarly, other states followed suit and for the first time in the twenty-first century, a series of states bonded together to tackle an emerging infectious disease. Never previously had states shared information so quickly and with such detail.⁸⁶ However and as noted in the previous

section, this was not the result of the WHO taking authority. Instead, states delegated authority in order to pursue a common goal.

Further, and of particular importance, this also reflected the pursuit of SARS as more than a means to an end. Self-interest was undoubtedly part of many of the decisions made by states. In fact, China's refusal to participate in any form of international coordination until April demonstrates that states prioritize interests differently. However, as then-CDC director Gerberding noted in April 2003, 'the most remarkable aspect of this entire SARS response has been the ongoing, high-caliber collaboration among all partners'.⁸⁷ This collaboration included participation from states with high numbers of SARS cases to those with none. While this does not imply the conquest of traditional notions of self-interest, this interaction did reinforce the idea that public health represented more than protection of domestic constituents and very much linked the national with the international. As opposed to a shift to a post-international environment, international public health society is an expression of infectious diseases engagement amongst states as an issue that transcends national boundaries and interests.

CONCLUSION

The GHG framework has clearly developed over the past decade, offering both a more nuanced conception of actors as well as tackling an impressive range of health threats. In particular, this second wave of literature demonstrates a keen awareness of the challenges in establishing a more efficient and equitable system of global health and displays no illusion about the difficulties in achieving these goals. Research on tobacco control, for example, demonstrates that GHG scholars are developing increasingly sophisticated analytical tools and approaches to exploring fundamentally complex issues that draw states, TNAs, civil society, and other actors together on multiple levels.⁸⁸

Despite attempts to free itself from earlier claims of a post-Westphalian environment, though, GHG still remains tethered to this concept. As Kirton and Cooper claim, the mounting evidence demonstrates that the world is moving away from the Westphalian model with the state as the dominant pillar.⁸⁹ While this may be true, GHG fails to fully describe the current system in which the state, despite absolute or relative losses of sovereignty, still towers over all other actors and provides the framework through which infectious diseases and health are engaged. The international has not become the global. In fact, international public health society provides a more accurate representation of how states cooperate in the context of infectious diseases.

This, though, is not a defence of the state nor a claim that a post-Westphalian (or even anti-Westphalian) model cannot emerge. In fact, Buzan and Little suggest that the 'Westphalian mode is already under question, and may be entering into a significant change'.⁹⁰ One such post-Westphalian approach is the concept of world society that follows from the international (public health) society framework. Within this approach, geography would not inherently limit transnational relations with the values, interests, and rules attributed to individuals, non-governmental organizations, and states.⁹¹ As Buzan notes, world society is associated with idealist thinking and antagonistic to the primacy of the state.⁹²

Despite significant and fundamental disagreement in the description of the *current* role of states, Fidler is correct in that the challenges posed by

infectious diseases will continue to grow and require the engagement of a host of public health and political concerns that extend beyond the development of better drugs.⁹³ This also includes other areas of health in which the solutions of tomorrow will require radically new methods of conceptualisation as well as vehicles to deliver healthcare. With its impressive range of contributors and flexible approach, GHG is well positioned to embrace these challenges, develop a richer research agenda, and offer practical policy recommendations.

Yet, a central problem remains. GHG has yet to resolve the inherent tension between its normative and analytical aspirations. That health, which includes infectious diseases, obesity, and cancer, among others, represents a critical issue within the discourses at the local, regional, national, international, and perhaps global levels is not in question. The fact that the income gap, for example, is closely related to life expectancy should cause great alarm and signal the need for the integration of disciplines as well as a fundamental questioning of the current (Westphalian) model in terms of its ability – or not – to deliver healthcare.

Whatever challenges exist, though, and however great they are should not obscure that fact that the state, irrespective of practical, ethical, or moral failings, still remains the organising principle to which individuals and social units aspire and, importantly, through which international health issues are addressed. Any claims of the emergence a significantly more globally and horizontally configured framework are premature. GHG must go beyond the exploration of important normative challenges and tackle the reality of the sovereign state and its ability to allow nonstate actors and TNAs to participate in international health policy. Until this is more directly engaged, GHG will be unable to fully recognise its potential in shaping the global health discourse.

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