Global health: an order struggling to keep up with globalization

By Markus Kornprobst and Stephanie Strobl

Abstract. Do global health institutions keep up with globalization forces? We contend that they seriously lag behind. While medical knowledge becomes more and more refined in showing how diseases spread globally, the political order meant to address this problem is barely global. It is global in terms of the promises it makes in declarations and even legally binding instruments (institutional foreground). But many entrenched political practices of interaction do not keep these promises (institutional background). We explain this with the dominance of a traditional diplomatic 'feel of the game' in which often narrowly defined national interests, positioning battles among states, and a subordination of global health under considerations of international security and economics prevail. Based on this diagnosis, we discuss three scenarios for the further evolution of the global health order: (1) the persistence of current institutions, (2) revisions of the institutional foreground and persistence of the background, and (3) a qualitative break that makes amendments to both. While the COVID crisis provides openings for the third and, even more so, the second one, the current upheavals in the liberal constellation of orders makes the first scenario the most likely one.

Keywords: globalization, global health, health institutions, COVID, politics, order, organization

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Introduction

On the one hand, scholars, pundits and experts widely agree upon labels such as 'global health', 'global health politics', 'global health diplomacy', and 'global health governance' when they describe their area of expertise. Indeed, there are few, if any, issue areas studied within the discipline of international relations and related fields in which the consensus on the adjective 'global' is stronger. The dominant narrative is about how the field transitioned from international health to global health.[1] On the other hand, globalization scholars point out again and again that globalization and deglobalization processes are multidimensional.[2] Even if we look only at a single issue area, some aspects of it may come to be further and further globalized while others lag behind or even come to be more deglobalized.[3] Does this apply to global health, too? If so, what explains why some dimensions are more global than others?

We, an international relations scholar and a medical professional, argue that medical dimensions of global health are ever more globalizing. This applies to norms and knowledge constituting a global medical community of practice as much as to the trans-boundary spread of diseases that we can make intelligible thanks to these norms and knowledge. The

[1] For an excellent overview of the state of the art, see Colin McInnes, Kelley Lee and Jeremy Youde, 'An introduction', in Colin McInnes, Kelley Lee and Jeremy Youde, eds., *Oxford handbook of global health politics* (Oxford: Oxford University Press, 2021), pp. 1-18.

[2] For this terminology, see the introduction to this special issue.

[3] Almas Heshmati, 'Measurement of a multidimensional index of globalization', *Global Economy Journal* 6: 2, 2006, pp. 1-28; Markus A. Höllerer, Peter Walgenbach and Gili S. Drori, 'The consequences of globalization for institutions and organizations', in Royston Greenwood, Christine Oliver, Thomas Lawrence and Renate Meyer, eds., *The SAGE handbook of organizational institutionalism* (London: Sage, 2017), pp. 214-242.

globalization of the political dimensions, however, lags severely behind. On the surface, a lot of progress seems to have been made over the last decades. Declarations and legally binding instruments have become more global in terms of how they conceptualize health and how they distribute agency across state and non-state actors (institutional foreground). Digging a bit deeper, however, yields a different picture. Prevailing practices are often incompatible with the promises made by the institutional foreground. There are deeply entrenched interaction patterns that, far from fostering global health, primarily revolve around the health of wealthier nations, and agency, far from meaningfully distributed across state and non-state actors around the globe, primarily resides with these nations, too (institutional background).

Having found that the political dimensions lag behind the medical ones, this article then proceeds to explaining this gap. We contend that the diplomatic community of practice, revolving around deeply entrenched norms and knowledge for how to assert national interests and a nation's positioning vis-à-vis other nations, dominates the medical community of practice (intra-order relations). Diplomacy's prevailing normative and epistemic underpinnings have always sat uneasily with global understandings of health. Furthermore, diplomatic know-how arranges relations between health, human rights and development horizontally but subordinates health to security and economics. The latter makes for a persistent challenge for the global health order.

To be sure, things do not always stay the same. At the height of liberalism's influence on global health, diplomacy moved towards re-interpreting the rules of its game in light of the specific requirements of ordering health and, partly borrowing from the human rights and development orders, helped make the institutional foreground more global. With liberalism

becoming more and more beleaguered in world politics, and great powers playing hard ball to the extent that it is at times barely within the rules of the diplomatic game, the dominance of the diplomatic community of practice has become a more pronounced challenge again, and all of this in the midst of the COVID-19 pandemic.

This study makes two key contributions. First, it broadens our grasp of how globalization and health hang together, finding evidence for how the globalization of medical dimensions far outpaces political ones, and, when it comes to the latter, how the institutional background stands in the way of keeping promises made in the institutional foreground. Second, this study highlights that there is an added heuristic value in disaggregating what usually passes as the overarching 'liberal international order' into its constitutive functional orders. Most debates about what we refer to as the liberal constellation of orders focus squarely on security and economics, neglecting other functional orders such as health. Past epidemics, however, played their parts in bringing down empires, great powers, and re-configuring world politics fundamentally. Vice versa, changes in functional orders such as security and economics are very much felt in global health.

This article is organized into four sections. We start with discussing the globalization of medical dimensions of global health, moving from intersubjective to pathological dimensions. We continue by describing the evolution of the global health order, focusing on what is being ordered and how those who order are positioned vis-à-vis one another. Then, we fine tune our analysis and, examining intra-order relations among communities within the global health order as well as inter-order relations with other orders within the liberal constellation, explain why the global health order lags behind medical dimensions of globalization. Finally, our

conclusion summarizes our findings and discusses future scenarios of the (co-)evolution of the global health order within the liberal – or no longer that liberal – constellation of orders.

Medical dimensions: ever more globalizing

This section first identifies key normative commitments and practices of knowledge production widely put to use by medical professionals and then describes the pathological patterns that become intelligible in light of this intersubjective compass. We contend that both dimensions – the intersubjective and the pathological ones – are ever more globalizing.

The intersubjective dimension

Medical professionals form an increasingly global community of practice with a distinctly global outlook on health. There is plenty of convergence on 'normative and epistemic ground for action'[4] upon which this community rests. On the normative side, the medical community subscribes to variants of the Hippocratic Oath. In the past, these variants applied key aspects of the oath very selectively. Colonial medicine, for example, drew a major distinction between colonial subjects not entitled to full health and colonial masters who were. Robert Koch, for example, will feature prominently below for his ground-breaking research findings, but the field work he did in Africa served the interests of British and German colonial administrations. The health of Africans mattered in as far as diseases were not to decimate the African workforce to the extent that this would hurt the colonial economy. Furthermore, Koch used

[4] Emanuel Adler, *World ordering: a social theory of cognitive evolution* (Cambridge: Cambridge University Press, 2019), p. 112.

Africans for human experiments that were outlawed in Europe at the time. This applies especially to his attempts to find a cure against trypanosomiasis (sleeping sickness).[5]

To be sure, even in our days, the medical profession still has a way to go[6] but, overall, the deeply ingrained normative commitments of the medical community of practice have moved further and further from such a selective towards a much more inclusive and global understanding of health. The latest version of the Physician's Pledge, adapted by the 68th World Medical Association General Assembly in October 2017, reads as follows: 'As a member of the medical profession: I solemnly pledge to dedicate my life to the service of humanity; the health and well-being of my patient will be my first consideration.'[7] Documents of national medical associations echo these formulations across world regions and domestic regime type. It does not matter whether these are based in, say, the United States, China or Russia, or Australia, Brazil, Germany, India or South Africa, they revolve around the normative

[5] Wolfgang U. Eckart, 'The colony as laboratory: German sleeping sickness campaigns in German East Africa and in Togo, 1900-1914', *History and Philosophy of the Life Sciences* 24, 2002, pp. 69-89.

[6] Vaidehi Nafade, Paulami Sen and Madhukar Pai, 'Global health journals need to address equity, diversity and inclusion', *BMJ Global Health* 4: 5, 2019, e002018; Seye Abimbola, Joel Negin, Stephen Jan and Alexandra Martiniuk, 'Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low-and middle-income countries', *Health Policy and Planning* 29.suppl_2, 2014, pp. ii29-ii39.

[7] World Medical Association, 'WMA Declaration of Geneva', 2017, available at https://www.wma.net/policies-post/wma-declaration-of-geneva/, accessed 2 December 2020.

commitment to serve humanity and human beings in general (and not just citizens, or certain citizens, of these states).[8]

On the epistemic side, the medical community subscribes to what the virologist and philosopher of science Ludwik Fleck referred to as thought styles and what came to be known as paradigms when Kuhn developed Fleck's ideas further.[9] Many of these (at times competing) paradigms are global in character, and none more so than epidemiology. It highlights that diseases do not simply stop at the border of a state. Although some of the basic terms such as epidemic and endemic appear to have been coined by Hippocrates, it was not before the 18th

[8] Brazilian Federal Council of Medicine, *'Code of medical ethics, Brazil'*, 2017, available at https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/code-medical-ethics-brazil, accessed 1 October 2020; Larisa Podovalenko Yurievna and Chris Speckhard, 'Solemn oath of a physician of Russia', *Kennedy Institute of Ethics Journal* 3: 4, 1993, pp. 419-419; Bundesärztekammer, '*Professional code for physicians in Germany*', 2011, available at https://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/MBOen2012.pdf, accessed 2 December 2020; American Medical Association, '*AMA code of medical ethics*', 2016, available at https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview, accessed 2 December 2020; Australian Medical Association, '*Code of ethics*', 2016, available at https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016, accessed 2 December 2020; Chinese Medical Doctors Association, '*Charter*', 2020, available at http://www.cmdae.org/?page_id=25, accessed 1 October 2020; Indian Medical Association, '*IMA pledge*', 2020, available at https://www.ima-india.org/ima/free-way-page.php?pid=18, accessed 23 December 2020; South African Medical Association, '*Doctors and patients rights and responsibilities*', 2020, available at https://www.samedical.org/for-our-doctors/ethics, accessed 16 October 2020.

[9] Ludwik Fleck, *Entstehung und Entwicklung einer wissenschaftlichen Tatsache* (Basel: Schwabe, 1935); Thomas Kuhn, *The structure of scientific revolutions* (Chicago: University of Chicago Press, 1962).

century that medical studies slowly started to move away from a focus on preconditions of individuals to researching the spread of diseases within and across populations. James Lind's research on scurvy and John Snow's investigations into cholera were early proponents of this medical turn.[10]

The break-through finding preparing the path for a theory of germs happened at the beginning of the 20th century. Louis Pasteur and Robert Koch presented compelling evidence that microorganisms can lead to infectious diseases.[11] While European scholars found it easier to make themselves heard internationally, medical professionals from elsewhere also made important discoveries. The Cuban Carlos Finlay, for instance, found out that mosquitos (more precisely *aedis aegypt*) transmit yellow fever to human beings. He made this discovery in 1886, but it was only two decades later that a wider audience believed him.[12]

In 1941, Wade Hampton Frost published a collection of papers, which amounts to something akin to the first textbook on the matter.[13] From the mid-20th century, epidemiology became such a widely recognized medical paradigm that it came to be its own discipline within the medical sciences.[14] Since then, mathematical models used by epidemiologists have

[10] Kuhn, *The structure of scientific revolution*, pp. 26-29.

[11] National Research Council Committee to Update Science, *A theory of germs: science, medicine, and animals* (Washington DC: National Academies Press, 2004).

[12] Marcos Cueto, 'The history of international health: medicine, politics, and two socio-medical perspectives', in Colin McInnes, Kelley Lee and Jeremy Youde, eds., *The Oxford handbook of global health politics* (Oxford: Oxford University Press, 2020), p. 20.

[13] Wade Hampton Frost, *Papers of Wade Hampton Frost: a contribution to epidemiological method* (New York: Commonwealth Fund, 1941).

[14] Centers for Disease Control and Prevention, *Principles of epidemiology in public health practice* (Atlanta: U.S. Department of Health and Human Services, 2012), pp. 1-2.

become increasingly advanced and research designs ever more sophisticated. More recently, the paradigm has been broadened. It is more and more applied to non-communicable diseases as well. With chronic diseases, it is not pathogens and the diseases they cause that spread globally but patterns of unhealthy nutrition and lifestyles and how they relate to illnesses such as diabetes and diseases of the cardiovascular system. Zimmet, referring to these as 'epidemic of Western lifestyle diseases'[15], has a point. The increasingly global spread of more and more non-communicable diseases is associated with the globalization of this lifestyle.[16]

The pathological dimension

The medical community's epistemic understandings enable us to make sense of ever more globalizing pathological patterns. Seen through the prism of epidemiology, the globalization of the spread of diseases has gained momentum for centuries. This has been closely linked to colonization, warfare and commerce.

Early epidemics did not span the entire globe but much of what to people constituted the then known world. Yet from the early 16th century onwards, microbial globalization gained more and more momentum.[17] Only twelve years after Christopher Columbus's death, the spread of diseases from Europe to the Americas started. This included the plague, leprosy,

[15] Paul Zimmet, 'Globalization, coca-colonization and the chronic disease epidemic: can the doomsday scenario be averted?', *Journal of Internal Medicine* 249: 741, 2001, pp. 17-26.

[16] Karl-Heinz Wagner and Helmut Brath, 'A global view on the development of non-communicable diseases', *Preventive Medicine* 54, 2012, pp. 38-41; Sheikh Mohammed Shariful Islam et al., 'Non-communicable diseases (NCDs) in developing countries: a symposium report', *Globalization and Health* 10: 1, 2014, pp. 1-8.

[17] Kelley Lee, *Globalization and health: an introduction* (Basingstoke: Palgrave, 2003), pp. 40-47.

smallpox, cholera, malaria, yellow fever and venereal syphilis. Of these, smallpox was the worst killer. It is estimated that up to 80-90 per cent of the local population in what would later be baptized Latin America died when smallpox first made it across the Atlantic.[18]

Since the 19th century, the globalization of communicable diseases gained further momentum. To mention only the most devastating pandemics, the Third Plague Pandemic started in China in the mid-19th century and then spread via the port cities of Canton and Hongkong to other places in Asia, Africa, North America and Australia. It claimed 13 million lives. The influenza pandemic of 1889/90 spread from Central Asia via railway connections and steamships to Europe, Far-East Asia, the Middle East and the Americas. As much as half of the world's population may have been infected by the influenza virus. In Europe, about 300,000 people died. The influenza pandemic of 1918/19 killed at least 50 million people worldwide. In absolute numbers, India was affected the most. It cost 20 million people their lives. HIV/AIDS peaked in 2000, killing almost three million people worldwide. From 1981 to 1995, it is estimated that 20 million people died, with Southern Africa being the worst affected region. Tuberculosis and malaria also claimed millions of lives worldwide.[19] In 2020, COVID-19 was a major global killer. There were 1,791,246 confirmed deaths.[20] The figure for 2021 could end up being even higher.

[18] Sheldon Watts, *Epidemics and history: disease, power and imperialism* (New Haven: Yale University Press, 1999), p. xiv.

[19] All figures taken from J. N. Hays, *Epidemics and pandemics: their impacts on human history* (Santa Barbara: ABC-Clio Inc), pp. 331-456.

[20] WHO, '*WHO coronavirus disease (COVID-19) dashboard*', available at https://covid19.who.int/, accessed 31 December 2020.

Yet, in today's world, the globalization of non-communicable diseases costs even more lives than the globalization of communicable ones. Ischemic heart disease and stroke are the number 1 and 2 causes of death, respectively. In 2019, they accounted for over 15 million deaths. Other non-communicable diseases causing over a million deaths a year include lung cancer and diabetes.[21] These kinds of epidemics are closely linked to the global spread of an unhealthy lifestyle.[22] While job characteristics and leisure time activities are part and parcel of this lifestyle, it is also affected by food processing and global trade. A recent study, for example, provides strong evidence that the increase of food exports from the United States to Mexico caused a significant increase in obesity in Mexico.[23] With obesity being a risk factor for type 2 diabetes, hypertension and coronary heart disease,[24] current trends (and vicious cycles) are becoming evident.

Having analyzed the medical dimensions, i.e. the shared normative and epistemic understandings that constitute a medical community of practice as well as the pathological patterns that become visible in light of these understandings, it is easy to sum up this section:

[21] In lower income countries, non-communicable diseases are also on the rise but communicable diseases continue to be major killers. See WHO, '*The top 10 causes of death*', 9 December 2020, available at https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death, accessed 2 February 2021.

[22] Peter L. Schnall, Marnie Dobson and Paul Landsbergis, 'Work and cardiovascular disease', *International Journal of Health Services* 46: 4, 2016, pp. 656–692.

[23] Osea Giuntella, Matthias Rieger and Lorenzo Rotunno, 'Weight gains from trade in foods: evidence from Mexico', *Journal of International Economics* 122, 2020, 103277.

[24] Chryski Koliaki, Stavros Liatis and Alexander Kokkino, 'Obesity and cardiovascular disease: revisiting an old relationship', *Metabolism* 92, 2019, pp. 98-107.

There is a medical community of practice that very much understands health as global health and there are ever more globalizing patterns of the spread of diseases. What about the political dimensions? Is there an equivalent globalizing trend?

Political dimensions: a pattern of lagging behind

This section aims at sketching a bird's eye view of the political dimensions. In doing so, it draws from latest research on the evolution of international political orders. It conceptualizes global health as functional order that is constituted by an institutional foreground and background, addressing what is to be ordered (ordering object) and how actors are positioned to do the ordering (ordering relations).[25] We contend that there is a (not all that) global health order but it lags severely behind the degree of globalization of the medical dimensions observed above. Legal documents such as the WHO Constitution and the International Health Regulations (IHR) have, on balance, made the foreground more global but the background's deeply seated practices of how to do health politics beyond the nation-state have not followed suit.

[25] On the ordering object, see Bentley B. Allen, 'Producing the climate: states, scientists, and the constitution of global governance objects', *International Organization* 71: 1, 2017, pp. 131-162. On ordering relations, see Iver B. Neumann, 'Returning practice to the linguistic turn: the case of diplomacy', *Millennium* 31: 3, 2002, pp. 627-651; Vincent Pouliot, *International pecking orders: the politics and practice of multilateral diplomacy* (Cambridge: Cambridge University Press, 2016). We borrow the distinction of foreground and background from Adler, *World ordering*.

Ordering object

For an order to qualify as 'global', the object to be ordered should be widely understood in global terms. When the international health order developed from the mid-19th to the mid-20th century, this was clearly not the case. There were at least two important limitations: First, the institutional foreground did not deal with health as such but only with a narrow list of communicable diseases. The twenty international sanitary conferences that took place within this time span were meant to curb the cross-border spread of cholera and plague.[26] A similar focus applied, to the *Office international d'hygiène publique*, which was created in 1907, and even to the League of Nations Health Organization, founded after the First World War.[27] Second, the institutional background sharply distinguished between those human beings entitled to health and those who were not. Practices of stigmatization and neglect were widespread, especially in colonial health. To give just two examples, colonial administrations did little to try to protect and cure African children from malaria. Instead, they stigmatized them for allegedly spreading the disease.[28] In India, 25 million people died of cholera between 1817 and 1920. The British colonial administration did not apply newly developing medical knowledge to prevent the epidemic to spread among its colonial subjects. Instead, it made them gather at small locales, far away from the homes of the colonial masters, with no access to safe drinking water.[29]

[26] This also pertained to the 1903 International Sanitary Convention, available at https://www.loc.gov/law/help/us-treaties/bevans/m-ust000001-0359.pdf, accessed on 2 February 2021.
[27] Martin Dubin, 'The League of Nations Health Organisation', in Paul Weindling, ed., *International health organisations and movements, 1918-1939* (Cambridge: Cambridge University Press, 1995), pp. 56-80.
[28] Watts, *Epidemics and history*, p. 224.
[29] Hays, *Epidemics and pandemics*, p. 397.

It was only after the end of the Second World War that the order came to be built upon principles that move closer to global understandings of health. This is very pronounced with regard to the institutional foreground. The first principle listed in the WHO Constitution is a very broad definition of health: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' And the second principle follows up by emphasizing that '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[30] A number of legal instruments seek to follow up on these promises, especially when it comes to non-communicable diseases. The 1969 IHR enlarged the list of diseases to be covered by the document. The 2005 IHR no longer confine instruments to be used, such as the global health emergency of international concern (PHEIC), to an *a priori* list of diseases. Aside from listing some diseases, it uses the broad term 'extraordinary event' (Art 1).[31] Moving beyond communicable diseases, the 1978 Alma-Ata Declaration and the 2018 Astana Declaration formulate ambitious aims for strengthening primary health care around the world. The Millennium Development Goals formulate three goals pertaining to health broadly understood[32] and the Sustainable Developments Goals do so explicitly and implicitly in even more comprehensive fashion.[33] The foreword of the 2003 WHO Framework Convention on Tobacco Control (FCTC) describes the purpose of the

[30] Preamble, WHO Constitution. Article 1, too, postulates these principles.
[31] Note that the foreword of the IHR postulates to apply this new body of law to diseases in general. There is no distinction made between, say, communicable and non-communicable ones: WHO, *International Health Regulations* (Geneva: WHO, 2005).
[32] A/RES/55/2 (2000).
[33] A/RES/70/1 (2015).

document as 'response to the globalization of the tobacco epidemic'.[34] Hence, by the early 2000s, the broadening of the epidemiology paradigm beyond communicable diseases started to become visible in global health documents.

Yet this global turn of the ordering object is much less clear-cut when it comes to the institutional background. Authors such as White and King may overdo their criticisms when they trace back today's institutional background to colonial health,[35] but political interaction in the global health order remains patterned in 'distinctly inequitable'[36] fashion. Determined action is more forthcoming when communicable diseases (threaten to) spread to higher than to lower income countries.[37] Not even PHEICs are an exception. They are more likely to be determined when high income countries feel threatened that they themselves will be directly

[34] WHO, *WHO framework convention on the tobacco control* (WHO: Geneva, 2003), available at https://www.who.int/tobacco/framework/WHO_FCTC_english.pdf.

[35] Nicholas B. King, 'Security, disease, commerce: ideologies of postcolonial global health', *Social Studies of Science* 32: 5/6, pp. 763-789; Alexandre White, 'Historical linkages: epidemic threat, economic risk, and xenophobia', *Lancet* 395: 10232, 2020, pp. 1250-1251.

[36] Kabir Sheikh et al, 'Boundary-spanning: reflections on the practices and principles of global health', *BMJ Global Health* 1: 1, 2016, pp. 1-5 (3).

[37] Paul Farmer, *Infections and inequalities: the modern plagues* (Berkeley: University of California Press, 2001); David Fidler, 'Germs, norms, and power: global health's political revolution', *Law, Social Justice & Global Development Journal* 1, 2004, pp. 799-804; Michael Marmot, 'Social determinants of health inequalities', *Lancet* 365: 9464, 2005, pp. 1099-1104; Kate E. Jones et al., 'Global trends in emerging infectious diseases', *Nature* 451: 7181, 2008, pp. 990-993. Thana Cristina de Campos, *The global health crisis: ethical responsibilities* (Cambridge: Cambridge University Press, 2017); Jennifer Prah Rueger, *Global health justice and governance* (Oxford: Oxford University Press, 2018).

affected by it.[38] There is a pattern of insufficient follow-up with implementing the SDGs. This pattern ranges from missing 'standardised metrics regarding progress and implementation' to necessary funding.[39] While the FCTC is a landmark document, underpinned by looking at the spread of non-communicable diseases through the lens of epidemiology, there is a pattern of neglect in implementing it. In many parts of the global south, therefore, tobacco consumption and with it the chronic diseases that it causes are on the rise.[40]

Ordering relations

Procedurally speaking, an order is global if agency is distributed globally. This should not only apply to the representation of states – then the labels international or inter-state would suffice – but also to non-state actors such as experts and civil society organizations. Prior to the mid-20th century, these conditions were clearly not met. The institutional foreground distributed agency very unevenly. At the first sanitary conference, representatives of only eleven European states attended.[41] By the time the thirteenth conference was organized in 1926, fifty states attended, half of them European and half from the rest of the world.[42] The

[38] Sara E. Davies, 'Securitizing infectious disease', *International Affairs* 84: 2, 2008, pp. 295-313; David Fidler, 'Africa, COVID-19, and international law: from hegemonic priority to the geopolitical periphery?', in Zeray Yihdego, Melaku Geboye Desta and Martha Belete Hailu, eds., *Ethiopian Yearbook of International Law 2019* (Cham: Springer, 2020), pp. 31-48.

[39] Zulfiqar Ahmed Bhutta et al., 'What will it take to implement health and health-related sustainable development goals?', *BMJ Global Health* 5: 9, 2020, pp. e002963.

[40] Amy S. Patterson and Elizabeth Gill, 'Up in smoke? Global tobacco control advocacy and local mobilization in Africa', *International Affairs* 95: 5, 2019, pp. 1111-1130.

[41] Norman Howard-Jones and WHO, *The scientific background of the International Sanitary Conferences, 1851-1938* (Geneva: World Health Organization, 1975), p. 12.

[42] Ibid*,* p. 85.

membership composition in the *Office international d'hygiène publique* and the League of Nations Health Organization was similar. Thus membership broadened somewhat but, given the persistence of colonial rule, many Asian and most African peoples remained unrepresented. Except for the short-lived experience of including medical experts with voting rights at the first sanitary conference,[43] states tried their very best to sideline non-state actors. Most notably, reporting and implementing measures remained very much within the hands of states.[44] Although the institutional background, too, came down heavily on the side of state agency, medical experts at times succeeded to assert themselves *qua* their expertise. Jean-Henri Dunant, for example, left a major mark on the order, among other things by co-founding what is now the International Committee of the Red Cross and building foundations for today's international humanitarian law.

Since the end of the Second World War, the institutional foreground, all in all, moved towards more inclusion. Procedurally speaking, it became more global. 194 member states regulate their interaction through the WHO Constitution. When the IHR were thoroughly revised in 2005, 196 states ratified the document. Together, the WHO member states pay assessed contributions to the organization. Since these have hardly changed in recent decades and at the same time WHO tasks have multiplied, voluntary contributions have become increasingly important. By now, these make for more than three quarters of WHO's overall budget.[45]

[43] Ibid, p. 12.
[44] *International Sanitary Convention*, available at https://www.loc.gov/law/help/us-treaties/bevans/m-ust000001-0359.pdf, accessed on 2 February 2021 (signed at Paris, 3 December 1903).
[45] Randall M. Packard, *A history of global health: interventions in lives of other peoples* (Baltimore: Johns Hopkins University Press, 2016), p. 269.

The WHO Constitution and the IHR entitle non-state actors to participate in co-managing global health affairs. Perhaps most notably, a public health emergency of international concern (PHEIC) is not determined by states but by the WHO Director-General after having heard the affected state(s) and consulted with an expert panel, i.e. the Emergency Committee (Articles 12, 49, IHR), and it is the WHO Director-General who is entitled to issue recommendations about how to counter such an emergency situation (Articles 1, 15, 16 IHR). Yet there are also plenty of provisions through which states assert their sovereignty, thus making sure that non-state actors cannot overpower them. Again, the PHEIC is a good example for this. The reporting of a disease outbreak is the prerogative of the affected state (Article 5, IHR). If there is no or only piecemeal reporting, the Emergency Committee has nothing or too little to work with. States' economic interests are enshrined in the IHR. Decisions made under the IHR are to balance health and economic concerns (Art 2 IHR). Last but not least, the recommendations issued by the Director-General are 'non-binding advice' (Art 1 IHR). They are, in contrast to many other provisions in the IHR, not legally binding.

While there are already these hints in the institutional foreground that the health order is not all that inclusive, the institutional background does much worse in terms of inclusivity. WHO may have near universal state membership, but power within the system resides with a small number of (groupings of) states. When we interviewed representatives of states situated in the global south, they repeatedly pointed the United States, the 'West', the European Union and China (in this order).[46] Note that some of this power is linked to the

[46] Representatives of a Latin American state and Central Asian state, both interviewed on 26 February 2020; Representative of a South Asian state, interviewed on 28 February 2020, all in Geneva.

foreground's financing mechanism. Since the above mentioned actors pay much of the bill – not only in terms of assessed but, even more so, even in terms of voluntary contributions – they have a tool in their hands to pursue their interests and they put it to use to exert influence.[47] This is not without problems. WHO, for example, finds it very difficult to implement long-term comprehensive plans to improve primary health care in the global south. States frequently re-direct their funding from one cause to the next, and powerful states have a strong tendency to do so in line with what they define as their – often short-term – interests. Among these, security and economic interests persistently rank highly.[48] Health interests hardly ever make it as high up in this hierarchy unless they come to be coupled to national security concerns. Once securitized, states can come to be very determined to curb the spread of diseases.[49]

[47] The Bill & Melinda Gates Foundation is an exception in this regard. It is a major donor (voluntary contributions) even though it is a non-state actor.

[48] Harley Feldbaum and Joshua Michaud, 'Health diplomacy and the enduring relevance of foreign policy interests', *PLoS Med* 7: 4, 2010: e1000226; Ilona Kickbusch, 'Global health diplomacy: how foreign policy can influence health', *BMJ* 342: 7811, 2011, pp. 3154-3162; Akram Khazatzadeh-Mahani, Arne Ruckert and Ronald Labonté, 'Global health diplomacy', in Colin McInnes, Kelley Lee, and Jeremy Youde, eds., The Oxford Handbook of Global Health Politics (Oxford: Oxford University Press, 2020), pp. 103-122.

[49] For recent contributions to this securitization debate, see Clare Wenham, 'The oversecuritization of global health: changing the terms of debate', *International Affairs* 95: 5, 2019, pp. 1092-1110; Colin McInnes and Anne Roemer-Mahler, 'From security to risk: reframing global health threats', *International Affairs* 93: 6, 2017, pp. 1313-1337; Christian Enemark, 'Ebola, disease-control, and the Security Council: from securitization to securing circulation', *Journal of Global Security Studies* 2: 2, 2017, pp. 137-149.

Non-state actors have carved out roles for themselves. This applies to organizations as varied as, say, WHO experts, the International Committee of the Red Cross, *Médecins Sans Frontières*, the Bill & Melinda Gates Foundation, the vaccine alliance Gavi and, of course, also to for-profit organizations, most notably multinational pharmaceutical companies. Their expertise endows them with a considerable amount of actorness. Yet when push comes to shove, states assert themselves strongly. The PHEIC makes again for an illustrative example. Late and incomplete reporting of disease outbreaks – and even a lack of reporting altogether – amounts to a widely used state practice that has troubled every PHEIC thus far.[50] Even when the evidence calls for determining a PHEIC, the Director-General cannot stand simply stand aloof of the power struggles within the order. As one of our interviewees put it, commenting on the late PHEIC determination with regard to SARS-CoV-2: 'China, we are talking about China here! On the one hand, there is China and on the other WHO. How are you going to do this? Determine a PHEIC straight away? What does China do then? There is a political dimension here!'[51] The institutional background, in other words, undermines the role of the Director-General (and also the experts of the Emergency Committee), which is so prominent in the institutional foreground. Add to this that the background very much downplays the role of the Director-General's recommendations, once he or she has declared a PHEIC. This is how another interviewee put it: 'It's only recommendations. So it's not too bad when you don't do it.'[52]

[50] Catherine Z. Worsnop, 'Concealing disease: trade and travel barriers and the timeliness of outbreak reporting', *International Studies Perspectives* 20: 4, 2019, pp. 344-372; David N. Durrheim, Laurence O. Gostin and Keymanthri Moodley, 'When does a major outbreak become a public health emergency of international concern?', *Lancet Infectious Diseases* 20: 8, 2020, pp. 887-889.
[51] Representative of a large EU member state, 20 February 2020, interviewed in Geneva.
[52] Representative of a Latin American state, 26 February 2020, interviewed in Geneva.

Overall, this discussion of the evolving global health order shows a nuanced picture. Judging by the institutional foreground, it has become a global order. The ordering object is health for everyone. Agency is, in principle, extended globally to state and non-state actors although there are a number of provisions that enshrine privileges of states, especially powerful states. The institutional background, however, is ill-suited to keep these promises. Prevailing practices ensure a greater standard of health for citizens of high-income countries, leave non-state actors often struggling to do their part in co-managing global health, and revolve around powerful states asserting their interests and influence. In sum, the health order, barely qualifying as global, severely lags behind the medical norms and knowledge about global health as well as the global spread of diseases that becomes intelligible in light of them. What explains this wide gap?

Why thus far and not further? Intra- and inter-order relations

Explaining the gap between medical dimensions and political dimensions, this section returns to the concept of communities of practice. There is not just a medical community of practice but also a diplomatic one. This diplomatic community of practice dominates the global health order, which has repercussions for relations within this order (medical and diplomatic communities) as well as the relations of the health order with other functional orders (horizontal and vertical). Deeply entrenched diplomatic how-to-do knowledge on pursuing the national interest, engaging in positioning games, and subordinating health under security as well as economic considerations makes it difficult for the political dimensions of global health to catch up with the medical ones.

Intra-order relations

The normative and epistemic constituents of the diplomatic community of practice are very different from the medical one. Normatively, diplomats, first and foremost, are to pursue the national interest. As literature on diplomacy has often put it since Richelieu, they are practitioners of *raison d'État*. This pursuit of the national interest is to be tamed by also taking the *raison de système* into account, i.e. the maintenance of the current diplomatic system.[53] Diplomats ought to try to get as much for the state they represent and, at the same time, make sure to keep 'the whole [diplomatic] show going'.[54] Diplomats, too, have something akin to what Fleck calls a thought style. Their how-to-do knowledge is a 'feel for the game' about how to assert the states they represent in the hierarchy of standing among international actors.[55]

The medical and diplomatic communities put very different lenses to use to make sense of global health. On the one hand, there is a normative commitment to the health of human beings, and on the other hand the national interest. The latter may, of course, include the health of the own citizens but the formulation of a cosmopolitan interest in the global

[53] Paul Sharp, *Diplomatic theory of international relations* (Cambridge: Cambridge University Press, 2009); Corneliu Bjola, 'Diplomatic ethics', in Costas M. Constantinou, Pauline Kerr and Paul Sharp, eds., *The Sage handbook of diplomacy* (London: Sage, 2016), pp. 123-146 (here: p. 126).
[54] Sharp, *Diplomatic theory of international relations*, p. 10.
[55] Iver B. Neumann, 'Returning practice to the linguistic turn'; Ole Jacob Sending, 'United by difference: diplomacy as a thin culture', *International Journal* 66: 3, 2011, pp. 643-659; Rebecca Adler-Nissen, *Opting out of the European Union: diplomacy, sovereignty and European integration* (Cambridge: Cambridge University Press, 2014); Vincent Pouliot, *International pecking orders*.

health of human beings, no matter where they are situated on the globe, is anything but easily accomplished. It goes against the habitual grain of putting the own nation first. Equally important, on the one hand there is a scientific epistemology and methodology to prevent the spread of diseases and cure human beings. On the other hand, there is the deeply internalized know-how of standing as tall as possible in encounters with representatives of other international actors.[56]

Global heath politics requires bridging this gap and, indeed, attempts to do so have happened ever since the advent of an international health order in the 19th century. It is just that the one pillar of the bridge is much weaker than the other. The diplomatic community is hegemonic. To be sure, input by global health experts has been very important to make the institutional foreground more global. The post-Second World War evolution of the foreground is best understood as grand compromise between the two communities. In this regard, the ordering object has moved considerably towards understandings of the medical community and even the positioning has come to strike more of a balance between experts and state representatives.

The institutional background, however, is dominated by the normative and epistemic understandings of the diplomatic community. The deeply taken-for-granted normative compass makes a major difference between the health of one's nationals and the rest. The neologism of vaccine diplomacy (although a century-old practice) shows this all too clearly.

[56] Similar points are made by Andrew Lakoff, 'Two regimes of global health', *Humanity* 1: 1, 2010, pp. 59-79, and Ilona Kickbusch and Austin Liu, 'Global health governance', in Hertie School of Governance, ed., *The Governance Report 2019* (Oxford: Oxford University Press, 2019) pp. 83-102.

Today, the term is used to describe state attempts to get as many doses of COVID-19 vaccinations for the own population as quickly as possible.[57] As a result, high-income states secure the lion's share and the rest receives very little. The WHO Director-General, a trained physician, may then chastise this selfishness as 'catastrophic moral failure'[58] but does not have the political efficacy to do much beyond making such desperate public appeals. The spread of SARS-CoV-2 also illustrates all too well how pervasive positioning games are in the global health field. Eager not to blamed as the country from which a deadly disease spreads, China was weeks late in reporting what was then still a pneumonia of unknown cause, and, once it finally started reporting, did so only 'piecemeal'.[59] Even more than a year later, Chinese co-operation with a WHO team mandated to investigate the origins of the SARS-CoV-2 outbreak was not forthcoming. As a result, 'major stones' remained 'unturned' as a report in *Nature* put it.[60] To be fair to China, it is not the first (and unlikely to be the last) state that insufficiently co-operates with WHO during an epidemic. It is not only China that is very sensitive when it comes to its standing in the world.

While the diplomatic background hegemony – and with it considerations of national interest and national standing – is a persistent phenomenon in global health, diplomatic interaction does not always stay exactly the same. Interpretations of interest and standing are subject to change and these changes are very much felt in the global health order. The

[57] Additionally, vaccine-exporting states use these exports to pursue their geopolitical goals.

[58] WHO Director-General, 'Opening remarks at 148th session of the Executive Board', 18 January 2021, available at https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board, accessed 2 February 2021.

[59] Representative of a Central European state, 18 February 2020, interviewed in Geneva.

[60] Smriti Mallapaty, Amy Maxmen and Ewen Callaway, '"Major stones unturned": COVID origin search must continue after WHO report, say scientists', *Nature*, 10 February 2021, available at https://www.nature.com/articles/d41586-021-00375-7.

decolonization of the late 1950s and early 1960s was the prerequisite for state representation to become global in the health order. Diplomacy increasingly opened up to non-state actors in the 1990s. Revising the International Health Regulations became possible due to rather co-operative relations among major states in the aftermath of the SARS-CoV-1 outbreak about two decades ago. By the same token, the co-management of the SARS-CoV-2 crisis has been severely hampered by antagonistic relations among some of the major states, especially China and the United States.

Inter-order relations

The post-Second World War making of the global health order happened within the context of what this special issue refers to as the rise of the liberal world order. In order to explain further why the global health order has evolved thus far and not further, we use a heuristic device that has come to be employed recently by several international relations theorists.[61] We, so to say, disaggregate the liberal world order into its functional orders. In this reading, there is a liberal constellation of functional orders and how these relate to one another has crucial repercussions for how they evolve. Global health is anything but an exception in this regard.

[61] Janice B. Mattern and Ayşe Zarakol, 'Hierarchies in world politics', *International Organization* 70: 3, 2016, pp. 623-654; Amitav Acharya, *Constructing global order: agency and change in world politics* (Cambridge: Cambridge University Press, 2018); Adler, *World ordering: a social theory of cognitive evolution*. See also Batora in this special issue.

Within the liberal constellation, the human rights and global health orders have been related to one another horizontally. They co-evolved in an almost symbiotic relationship. Thus, for as long as the human rights order came to elaborate on principles of human rights, the global health order did the same with principles pertaining to the ordering object of global health. Foundational human rights documents, formulating general principles (most notably in the Universal Declaration of Human Rights) as well as more and more specific and legally binding instruments, ranging from the anti-genocide convention to the elimination of racial discrimination and from the elimination of discrimination against women to the convention on the rights of the child, explicitly and implicitly have always included various aspects of health.[62] Vice versa, human rights are deeply woven into principles and instruments of global health. This started with the Preamble of the WHO Constitution, continued with the 1978 Alma Ata Declaration and its motto of 'heath for all' to the IHR (2005), which list human rights – ahead of state sovereignty – among its key principles (Art 3). From the 1990s onwards, the development field increasingly joined the human rights-global health tandem of orders.[63] The Millennium Development Goals constituted a first very tangible outcome of this development and the Sustainable Development Goals followed suit. Development is at times defined by linking human rights and health together, for example with formulations such as 'the human

[62] Paul Farmer, 'Pathologies of power: rethinking health and human rights', *American Journal of Public Health* 89: 10, 1999, pp. 1486-1496; Lawrence O. Gostin and Benjamin Mason Meier, eds., *Foundations of global health & human rights* (Oxford: Oxford University Press, 2020).

[63] This also had repercussions for funding: From 1990 to 2005, the World Bank funding for global health increased from 2.5 billion to 14 billion. See World Bank, 'Healthy development: the World Bank strategy for health, nutrition, and population results' (Washington DC: The World Bank, 2007). Yet via the World Bank, neoliberalism came to exert influence in the global health order and this is not easily reconciled with either a global understanding of the ordering object nor the ordering relations. See Matthew Sparke, 'Globalisation and the politics of global health', in Colin McInnes, Kelley Lee and Jeremy Youde, eds., *Oxford handbook of global health politics* (Oxford: Oxford University Press, 2018), pp. 37-58.

right to safe drinking water and sanitation'[64] and 'to protect labour rights and promote safe and secure working environments for all workers'.[65]

Recently, the co-evolution of development, human rights and global health has been characterized by ruptures in all three orders (and, indeed, the entire liberal constellation). Implementing the Sustainable Development Goals proves to be a very difficult process. A recent UN report finds that of twenty-one targets to be met by 2020, only three were actually 'achieved or on track of being achieved'.[66] None of these was about health but prospects for health-related Sustainable Development Goals are dire. The Report predicts, for example, that 'illness and deaths from communicable diseases will spike. Service cancellations will lead to a 100% increase in malaria deaths in sub-Saharan Africa.'[67] The human rights order has turned into a battle ground among great and middle powers. As a result, this order no longer exports ideas to the global health order.[68]

While the current state of the horizontally related human rights and global health orders poses new challenges, another set of even more severe problems has been very

[64] A/RES/70/1, 21 October 2015, §7.
[65] A/RES/70/1, 21 October 2015, §8.8.
[66] United Nations, *The Sustainable Development Goals Report* 2020 (New York: United Nations, 2020), p. 60.
[67] United Nations, *The Sustainable Development Goals Report* 2020, p. 8. States are, unfortunately, not all that committed to provide funds sufficient to implement these ambitious goals. In 2016, for example, 0.4% of global health spending happened in low-income countries even though these states comprise about 10% of the world population (Global Burden of Disease Health Financing Collaborator Network, 'Past, present, and future of global health financing', *Lancet* 393: 10187, June 2019, pp. 2233-2260).

[68] Representative of a P-5 state and representative of a Northern European state, both interviewed in Geneva, 20 February 2020. This contestation is, of course, embedded in a broader context of rising tensions among great powers: representative a South-Asian state, 28 February 2020, interviewed in Geneva and representative of a Latin American state, 26 February 2020, both interviewed in Geneva.

enduring. The dominant diplomatic community of practice subordinates the global health order under other functional orders, most notably security and economics. It is no coincidence that studies comparing grand strategies remain silent on global health but have a lot to say about security and economics. The documents that they look at – grand strategies of states – focus very much on the latter two. Global health, by contrast, hardly amounts to a matter of priority for states in their external relations.[69] In the words of Youde (2016), security and economics are 'high politics' whereas global health is relegated to 'low politics'.[70] This means that diplomacy routinely puts security and economic interests ahead of health-related ones. Uranium mining, for example, makes for a major health hazard. Being used for nuclear weapons and nuclear power stations, however, these health impacts hardly make it onto the diplomatic agenda.[71] Security and economic considerations even feature very prominently in emergency situations on the ground, for example in measures taken to curb the 2015 Ebola outbreak in West Africa.[72] Securitizing health during a health crisis can help push a certain global health issue temporarily even up towards the top of this agenda but the possibility of an ensuing militarization of instruments to deal with the crisis, along with treating sick people

[69] Thierry Balzacq, Peter Dombrowski and Simon Reich, eds., *Comparative grand strategy: a framework and cases* (Oxford: Oxford University Press, 2019).

[70] Jeremy Youde, 'High politics, low politics, and global health', *Journal of Global Security Studies* 1: 2, 2016, pp. 157-170.

[71] Atanu Sarkar, 'Nuclear power and uranium mining: current global perspectives and emerging public health risks', *Journal of Public Health Policy* 40: 4, 2019, pp. 383-392.

[72] Adia Benton and Kim Yi Dionne, 'International political economy and the 2014 West African Ebola outbreak', *African Studies Review* 58: 1, 2015, pp. 223-236.

as security threats and even enemies, is likely to cause all kinds of new problems. This is one of the lessons from countering Ebola in Africa.[73]

Conclusion

Researching how health and globalization hang together, this article cast its net widely. It researched medical and political dimensions of this relationship, finding that the former are much more globalized than the latter and, when it comes to the latter, that the institutional background holds on to old orthodoxies that some provisions of the institutional foreground promise to leave behind. As a result, the global health order is not as fit for purpose as it ought to be. On the one hand, diseases spread more and more globally and medical knowledge for how to counter this trend becomes increasingly refined. On the other hand, diplomatic rules of the political game, deeply rooted in national interest, positioning and the primacy of security and economics over health, make prospects for 'true global collaboration'[74], badly needed to cope with the global spread of diseases, rather elusive.

In the last decade, pressures on the liberal constellation of orders have made things even worse. While its horizontal relations with the human rights and development orders helped the global health order's foreground institutions progress in the 1990s and early 2000s, all of these orders are now under pressure. At the same time, great powers, playing more and

[73] Joanne Liu, 'We need a change of gear for Ebola outbreak in DRC', *Médecins Sans Frontières,* 18 July 2019, available at https://msf-seasia.org/news/18686, accessed 20 October 2020; Ben Parker, 'From Ebola to Kunduz: MSF head Joanne Liu looks back', *New Humanitarian*, 12 September 2019, available at https://www.thenewhumanitarian.org/interview/2019/09/12/ebola-kunduz-msf-head-joanne-liu-looks-back, accessed 15 October 2020.

[74] Brian McCloskey et al., 'Emerging infectious diseases and pandemic potential: status quo and reducing risk to global spread', *Lancet* 14: 10, pp. 1001-1010.

more hard ball on the diplomatic stage, move increasingly towards short-term understandings of *Realpolitik*. Given the persistent problems of the global health order, it was already structurally ill-equipped to deal with the COVID-pandemic but deteriorating relations among major states have complicated matters even further.

How are things likely to proceed from here? After all, we are in the midst of a global pandemic and actors at times do learn from catastrophes. These may deliver a 'cognitive punch' that drives it home to actors that the old ways of doings things cannot simply go on.[75] We would submit that there are three ideal-typical future scenarios. First, there is no learning. The current gap between medical and political dimensions of global health persists. Second, there is simple learning from the COVID-pandemic. New foreground institutions formulate new promises and perhaps also ways of curbing how states play by the diplomatic rules of the game. Third, there is complex learning from the COVID-pandemic. States even revisit the institutional background. Metaphorically put, they do not simply add new software (foreground) but install a new operating system (background). Once this is done, more far-reaching foreground changes become possible, too.[76]

Judging by our findings, we would submit that the first scenario is the most likely one, closely followed by the second and, at a distance, the third one. The current diplomatic climate makes it very difficult to engage in multilateral negotiations. Debates about overhauling the IHR started in the mid-1990s and the outbreak of SARS-CoV-1 provided further momentum

[75] Emanuel Adler, 'Cognitive evolution: a dynamic approach for the study of International relations and their progress', in Emanuel Adler and Beverly Crawford, eds., *Progress in postwar international relations* (New York: Columbia University Press, 1991), pp. 128-173 (155).
[76] On simple and complex learning in international relations, see, for example, Jeffrey W. Knopf, 'The importance of international learning', *Review of International Studies* 29: 2, April 2003, pp. 185-207.

for the revisions. In the case of SARS-CoV-2, it took well over a year for 26 state leaders and the WTO Director-General to call for an international pandemic treaty and this call was published in selected newspapers around the world and not made, say, at a global health summit.[77] This is a far cry from the kind of momentum gathered in the mid-2000s for revising the IHR.

Since the COVID-pandemic makes for a major crisis, however, there is a chance that states, taking the advice of medical experts into account, add to institutional foreground institutions. Here, it would be of crucial importance to ensure that national health systems around the world become capable of performing effective monitoring functions, to give WHO authority to investigate into disease outbreaks without state approval, and to make (some kinds of) recommendations issued by the Director-General under the IHR legally binding. Strengthening capacity would have major financial implications for many years to come and strengthening the role of WHO on reporting and recommendations would conflict with state sovereignty. Such results would not come easy in multilateral negotiations under any circumstances and given the current political climate they are especially difficult to attain.[78]

If such (far-reaching) amendments would be made to the institutional foreground, the gap between the medical and political dimensions would close somewhat. The result would be comparable to the revision of the IHR in the mid-2000s. It would not, however, do away with the underlying problem that the institutional background looms large over the

[77] WHO Press Release, 'Global leaders unite in urgent call for international pandemic treaty', 30 March 2021. Available at https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty, accessed on 17 April 2021.

[78] We are rather sceptical whether non-communicable diseases would be addressed, too. The 'cognitive punch' that COVID delivers is about communicable diseases.

foreground. Deeply seated understandings of security and economics as high politics and health as low politics, for example, are highly damaging for global health. In principle, the COVID-pandemic provides an opening to revisit these orthodoxies and build foundations of a political order that are no longer out of sync with the ever more globalizing spread of diseases. Yet such a re-institutionalization of global health makes for an uphill battle. Old habits die hard, especially in a political climate in which diplomatic communication resorts to blame games as opposed to finding out together what the enlightened common interest is.