Global health: an order struggling to keep up with globalization

MARKUS KORNPROBST AND STEPHANIE STROBL*

On the one hand, health scholars, pundits and experts widely agree upon the validity of 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 (IR) and related fields in which the consensus on the adjective ‘global’ is stronger. The dominant narrative is about how the field made the transition 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 IR scholar and a medical professional, argue that the medical dimensions of global health are globalizing to an ever greater degree. This applies to norms and knowledge constituting a global medical community of practice as much as to the transboundary spread of diseases that these norms and knowledge enable us to understand. The globalization of the political dimensions of global health, however, lags severely behind. On the surface, a lot of progress seems to have been made over recent decades. Declarations and legally binding instruments have become more global in terms of how they conceptualize health and how they distribute agency among state and non-state actors (the institutional foreground). Digging a bit deeper, however, yields a different picture (the institutional background).

* This article is part of the September 2021 special issue of International Affairs on ‘Deglobalization? The Future of the Liberal International Order’, guest-edited by T. V. Paul and Markus Kornprobst. The authors would like to thank Katharina Coleman, Jeanette Money, T. V. Paul, Aseema Sinha, Katja Weber and three anonymous reviewers for their very helpful comments. The authors’ names are listed alphabetically. They contributed equally to this article.

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, The Oxford handbook of global health politics (Oxford: Oxford University Press, 2021), pp. 1–18.

2 On this terminology, see Markus Kornprobst and T. V. Paul, ‘Globalization, de-globalization and the liberal international order’, International Affairs 97: 5, 2021, pp. 1505–16.

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. 214–42.
Prevailing practices are often incompatible with the promises made in the institutional foreground. There are deeply entrenched patterns of interaction that, far from fostering global health, primarily revolve around the health of wealthier nations; and agency, far from being meaningfully distributed among state and non-state actors around the globe, primarily resides with these nations, too.

Having found that the political dimensions lag behind the medical ones, this article then proceeds to explain the gap. We contend that the diplomatic community of practice, revolving around deeply entrenched norms and knowledge on 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 knowhow arranges relations between health, human rights and development horizontally but subordinates health to security and economics. This positioning poses 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 reinterpreting the rules of its game in view of the specific requirements of the health field and, partly borrowing from the human rights and development orders, helped make the institutional foreground more global. Today, with liberalism increasingly beleaguered in world politics, and Great Powers playing hardball to an extent that at times is barely within the rules of the diplomatic game, the dominance of the diplomatic community of practice has once again become a more pronounced challenge—and all 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 far the globalization of the medical dimensions outpaces that of the political dimensions—and, in respect of the latter, how the institutional background poses obstacles to the keeping of promises made in the institutional foreground. Second, it highlights that there is an added heuristic value in disaggregating what usually passes as an 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 and Great Powers, and fundamentally reconfiguring world politics. Conversely, changes in functional orders such as those of security and economics are very much felt in global health.

This article is organized in four sections. We start by discussing the globalization of the 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 do the ordering are positioned in relation to one another. Then we fine-tune our analysis

---

4 Sara E. Davies and Clare Wenham, ‘Why the COVID-19 response needs International Relations’, *International Affairs* 96: 5, 2020, pp. 1227–51.
Global health: an order struggling to keep up with globalization

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 for 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 the light of this intersubjective compass. We contend that both dimensions—the intersubjective and the pathological—are globalizing to an ever greater degree.

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 the ‘normative and epistemic ground for action’ 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 instance, drew a major distinction between colonial subjects, who were not entitled to full health, and colonial masters, who were. To take just one example, Robert Koch, who will feature prominently below for his ground-breaking research findings, conducted his fieldwork in Africa in service of the interests of the British and German colonial administrations. The health of Africans mattered only in so far as diseases were not to be allowed to decimate the African workforce to the detriment of the colonial economy. Furthermore, Koch used Africans for human experiments that were outlawed in Europe at the time—especially in the course of his attempts to find a cure for trypanosomiasis (sleeping sickness).

To be sure, even in our days the medical profession still has a way to go; but overall, the deeply ingrained normative commitments of the medical community of practice have moved further and further from such a selective approach towards a much more inclusive and global understanding of health. The latest version of the Physician’s Pledge, adopted by the 68th World Medical Association

5 Emanuel Adler, World ordering: a social theory of cognitive evolution (Cambridge: Cambridge University Press, 2019), p. 112.
6 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: 1, 2002, pp. 69–89.
7 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. ii20–ii39.
Markus Kornprobst and Stephanie Strobl

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.’

Documents of national medical associations echo these formulations across world regions and domestic regime types. It does not matter whether they are based in, say, the United States, China or Russia, in Australia or Brazil, in Germany, India or South Africa; their pledges revolve around the normative commitment to serve humanity and human beings in general (and not just citizens, or certain citizens, of the respective state).

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. Many of these (at times competing) paradigms are global in character—and none more so than epidemiology, which highlights the fact that diseases do not stop at state borders. Although some of the basic terms such as ‘epidemic’ and ‘endemic’ appear to have been coined by Hippocrates, it was not until the eighteenth 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.

The breakthrough finding preparing the path for a theory of germs came about at the beginning of the twentieth century, when Louis Pasteur and Robert Koch presented compelling evidence that micro-organisms can lead to infectious diseases. 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 mosquitoes (more precisely, *Aedes aegypti* mosquitoes) transmit yellow fever to human beings. He made this discovery in 1886, but it was not until two decades later that a wider audience believed him.

---

8 World Medical Association, *WMA Declaration of Geneva*, 2017 (Geneva, 9 July 2018), https://www.wma.net/policies-post/wma-declaration-of-geneva/. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 26 May 2021.)

9 Brazilian Federal Council of Medicine, *Code of medical ethics*, Brazil (Brasília: Federal Council of Medicine, 1988), https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/code-medical-ethics-brazil; Larisa Podovalenko Yurievna and Chris Speckhard, ‘Solemn oath of a physician of Russia’, *Kennedy Institute of Ethics Journal* 3: 4, 1993, pp. 419; Bundesärztekammer, *Professional code for physicians in Germany* (Kiel: German Medical Assembly, 2011), https://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/MBOen2012.pdf; American Medical Association, *AMA code of medical ethics* (Chicago, 2016), https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview (accessed 2 December 2020); Australian Medical Association, *Code of ethics* (Barton, ACT, 2016), https://www ama.com.au/position-statement/code-ethics-2004-editiorially-revised-2006-revised-2016; Chinese Medical Doctors Association, *Charter* (Beijing, 2020), http://www.cmdae.org/?page_id=25; Indian Medical Association, *IMA pledge* (New Delhi, 2020), https://www ima-india.org/ima/free-way-page.php?pid=18; South African Medical Association, *Doctors and patients rights and responsibilities* (Pretoria, 2020), https://www samedical.org/for-our-doctors/ethics.

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

11 Kuhn, *The structure of scientific revolutions*, pp. 26–9.

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

13 Marcos Cueto, ‘The history of international health: medicine, politics, and two socio-medical perspectives’, in McInnes et al., eds, *The Oxford handbook of global health politics*, p. 20.
Global health: an order struggling to keep up with globalization

In 1941, Wade Hampton Frost published a collection of papers that amounts to something akin to the first textbook on the matter. From the mid-twentieth century, epidemiology became such a widely recognized medical paradigm that it came to be a distinct discipline within the medical sciences. Since then, mathematical models used by epidemiologists have become increasingly advanced and research designs ever more sophisticated. More recently, the paradigm has been broadened to be applied more and more 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 lifestyle, which relate to illnesses such as diabetes and diseases of the cardiovascular system. Zimmet, referring to these as ‘epidemic of Western lifestyle diseases’, has a point. The increasingly global spread of more and more non-communicable diseases is associated with the globalization of these unhealthy lifestyle patterns.

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 been gaining momentum for centuries. This process has been closely linked to colonization, warfare and commerce.

Early epidemics did not span the entire globe, but much of what to people at the time constituted the known world. However, from the early sixteenth century onwards, microbial globalization gained more and more momentum. Only twelve years after Christopher Columbus’s death, the spread of diseases from Europe to the Americas started. These included bubonic plague, leprosy, 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.

In the nineteenth 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-nineteenth century and then spread, via the port cities of Canton and Hong Kong, to other places in Asia.

14 Wade Hampton Frost, Papers of Wade Hampton Frost: a contribution to epidemiological method (New York: Commonwealth Fund, 1941).
15 Centers for Disease Control and Prevention, Principles of epidemiology in public health practice (Atlanta: US Department of Health and Human Services, 2012), pp. 1–2.
16 Paul Zimmer, ‘Globalization, coca-colonization and the chronic disease epidemic: can the doomsday scenario be averted?’, Journal of Internal Medicine 249: 741, 2001, pp. 17–26.
17 Karl-Heinz Wagner and Helmut Brath, ‘A global view on the development of non-communicable diseases’, Preventive Medicine 54: suppl., 2012, pp. 38–41; Sheikh Mohammed Shariful Islam, Tina Dannemann Purnat, Nguyen Thi Anh Phuong, Upendo Mwingira, Karsten Schacht and Günter Fröschl, ‘Non-communicable diseases (NCDs) in developing countries: a symposium report’, Globalization and Health 10: 1, 2014, pp. 1–8.
18 Kelley Lee, Globalization and health: an introduction (Basingstoke: Palgrave, 2003), pp. 40–47.
19 Sheldon Watts, Epidemics and history: disease, power and imperialism (New Haven, CT: Yale University Press, 1999), p. xiv.
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, 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 this episode. 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 the worst affected, with 20 million deaths. HIV/AIDS peaked in 2000, killing almost 3 million people worldwide; in all, between 1981 and 1995, it is estimated that 20 million people died from this disease, southern Africa being the worst-affected region. Tuberculosis and malaria also claimed millions of lives across the globe. In 2020, COVID-19 was a major global killer, responsible for 1,791,246 confirmed deaths. The situation even worsened in 2021, with more than two million deaths recorded in the first half of that year.

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 one and two 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. These kinds of epidemics are closely linked to the global spread of unhealthy lifestyles. While job characteristics and leisure activities are part and parcel of these lifestyles, food processing and global trade also contribute to them. 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. With obesity being a risk factor for type 2 diabetes, hypertension and coronary heart disease, current trends (and vicious circles) are becoming evident.

Having analysed the medical dimensions of global health—that is, the shared normative and epistemic understandings that constitute a medical community of practice, along with the pathological patterns that become visible in the light of these understandings—it is easy to sum up this section. There is a medical community of practice that very much understands health as a global issue, and there are ever more globalizing patterns of the spread of diseases. What about the political dimensions? Is there an equivalent globalizing trend here?

---

20 All figures taken from J. N. Hays, *Epidemics and pandemics: their impacts on human history* (Santa Barbara: ABC-Clio, 2005), pp. 331–456.
21 WHO, *WHO coronavirus disease (COVID-19) dashboard*, https://covid19.who.int/.
22 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* (Geneva, 9 Dec. 2020), https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death.
23 Peter L. Schnall, Marnie Dobson and Paul Landsbergis, ‘Work and cardiovascular disease’, *International Journal of Health Services* 46: 4, 2016, pp. 656–92.
24 Osea Giuntella, Matthias Rieger and Lorenzo Rotunno, ‘Weight gains from trade in foods: evidence from Mexico’, *Journal of International Economics*, vol. 122, 2020, art. 103277.
25 Chryski Kolaki, Stavros Liatis and Alexander Kokkino, ‘Obesity and cardiovascular disease: revisiting an old relationship’, *Metabolism*, vol. 92, 2019, pp. 98–107.
Global health: an order struggling to keep up with globalization

**Political dimensions: a pattern of lagging behind**

This section aims at sketching a bird’s-eye view of the political dimensions of global health. In doing so, it draws on recent research on the evolution of international political orders. It conceptualizes global health as a 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). We contend that there is a (not all that) global health order, but this political order lags far 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 institutional foreground more global; but the institutional background’s deep-seated practices of how to do health politics beyond the nation-state have not followed suit.

**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 between the mid-nineteenth century and the mid-twentieth, this was clearly not the case. During this period, the order was subject to at least two important limitations. First, the institutional foreground did not deal with health as such, but only with a short list of communicable diseases. The 20 international sanitary conferences that took place within this period were intended to curb the cross-border spread of cholera and bubonic plague. 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. Second, the institutional background sharply distinguished between those human beings who were considered 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 African children from malaria, or cure them of the disease, but instead, they stigmatized them for allegedly spreading the sickness; and in India, where 25 million people died of cholera between 1817 and 1920, the British colonial administration did not apply its newly developing medical knowledge to prevent the illness from spreading.

---

26 This section draws from conceptual language developed in Markus Kornprobst and Martin Senn, ‘A rhetorical field theory: background, communication and change’, *British Journal of Politics and International Relations* 18: 2, pp. 300–17. 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. 131–62. On ordering relations, see Iver B. Neumann, ‘Returning practice to the linguistic turn: the case of diplomacy’, *Millennium* 31: 3, 2002, pp. 627–51; Vincent Pouliot, *International pecking orders: the politics and practice of multilateral diplomacy* (Cambridge: Cambridge University Press, 2016). On foreground and background, see Adler, *World ordering*.

27 For an example, see the 1903 International Sanitary Convention, https://www.loc.gov/law/help/us-treaties/bevans/m-ust000001-0359.pdf.

28 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.

29 Watts, *Epidemics and history*, p. 224.
Markus Kornprobst and Stephanie Strobl

among its colonial subjects, but rather made them gather far away from the homes of their colonial masters at places with no access to safe drinking water.30

It was only after the end of the Second World War that the order came to be built upon principles that approached global understandings of health. This trend is very pronounced with regard to the institutional foreground. The first principle listed in the constitution of the WHO, founded in 1948, presents 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 ‘the 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’.31 A number of legal instruments seek to follow up on these assertions, especially when it comes to non-communicable diseases. The 1969 IHR enlarged the list of diseases covered by the document, and the 2005 IHR no longer confine the use of mechanisms such as the declaration of a public health emergency of international concern (PHEIC) to a specified list of diseases; while they do list some, they also use the broader term ‘extraordinary event’ (article 1).32 Moving beyond communicable diseases, the 1978 Alma-Ata Declaration and the 2018 Astana Declaration formulated ambitious aims for strengthening primary health care around the world. The Millennium Development Goals (MDGs) included three goals pertaining to health broadly understood,33 and the Sustainable Development Goals (SDGs) do so, explicitly and implicitly, in even more comprehensive fashion.34 The foreword of the 2003 WHO Framework Convention on Tobacco Control (FCTC) describes the document as a ‘response to the globalization of the tobacco epidemic’.35 Hence, by the early 2000s, the broadening of the epidemiology paradigm beyond communicable diseases had 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 overstate their criticisms when they trace today’s institutional background back to the health practices of colonial times,36 but political interaction in the global health order remains patterned in a ‘distinctly inequitable’ fashion.37 Determined action is more forthcoming when communicable diseases (threaten to) spread to higher-income countries than when they endanger lower-income countries.38 Not even PHEICs

30 Hays, Epidemics and pandemics, p. 397.
31 Preamble, WHO constitution. Art. 1, too, enunciates these principles.
32 Note that the foreword of the 2005 IHR proposes that this new body of law should be applied to diseases in general, making no distinction between, say, communicable and non-communicable ones: WHO, International Health Regulations (Geneva: WHO, 2005).
33 UN General Assembly, A/Res/55/2 (2000).
34 UN General Assembly, A/Res/70/1 (2015).
35 WHO, WHO Framework Convention on Tobacco Control (Geneva, 2003), https://www.who.int/tobacco/framework/WHO_FCTC_english.pdf.
36 Nicholas B. King, ‘Security, disease, commerce: ideologies of postcolonial global health’, Social Studies of Science 32: 5–6, 2002, pp. 765–89; Alexandre White, ‘Historical linkages: epidemic threat, economic risk, and xenophobia’, Lancet 395: 10232, 2020, pp. 1250–51.
37 Kabir Sheikh, Helen Schneider, Irene Akua Agyepong, Uta Lehmann and Lucy Gilson, ‘Boundary-spanning: reflections on the practices and principles of global health’, BMJ Global Health 1: 1, 2016, pp. 1–5 at p. 3.
38 Paul Farmer, Infections and inequalities: the modern plagues (Berkeley: University of California Press, 2001); David
Global health: an order struggling to keep up with globalization

are an exception: they are more likely to be determined when high-income countries feel that they themselves will be directly affected. As for the SDGs, there is a pattern of insufficient follow-up, which ranges from missing ‘standardised metrics regarding progress and implementation’ to failure to provide necessary funding. While the FCTC is a landmark document, underpinned by seeing 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.

Ordering relations

Procedurally speaking, an order is global if agency is distributed globally. This should apply not only to the representation of states—in which case the labels ‘international’ or ‘interstate’ would suffice—but also to non-state actors such as experts and civil society organizations. Prior to the mid-twentieth century, this condition was clearly not met. The institutional foreground distributed agency very unevenly. At the first sanitary conference, representatives of only eleven European states attended. By the time the 13th conference was held in 1926, 50 states attended, half of them European and half from the rest of the world. The composition of membership in the Office international d’hygiène publique and the League of Nations Health Organization was similar. Thus, while membership broadened somewhat, 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, states tried their very best to sideline non-state actors. Most notably, measures on reporting disease outbreaks and implementing counter-measures remained very much within the hands of states. Although the institutional background, too, was weighted heavily on the side of state agency, medical experts at times succeeded in asserting themselves by virtue of their specialist knowledge.

Fidler, ‘Germs, norms, and power: global health’s political revolution’, Law, Social Justice and Global Development Journal, vol. 1, 2004, pp. 799–804; Michael Marmot, ‘Social determinants of health inequalities’, Lancet 365: 9484, 2005, pp. 1099–1104; Kate E. Jones, Nikkita G. Patel, Marc A. Levy, Adam Storeygard, Deborah Balk, John L. Gittleman and Peter Daszak, ‘Global trends in emerging infectious diseases’, Nature 451: 7181, 2008, pp. 990–93; 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).

39 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 Hallu, eds, Ethiopian Yearbook of International Law 2019 (Cham: Springer, 2020), pp. 31–48.

40 Zulfiqar Ahmed Bhutta, Sameen Siddiqi, Wafa Afzal, Fahad Javid Siddiqui, Luis Huicho, Roman Mogilevski, Qmarr Mahmood, Peter Friberg and Fawad Akbari, ‘What will it take to implement health and health-related sustainable development goals?’, BMJ Global Health 5: 9, 2020, e002965.

41 Amy S. Patterson and Elizabeth Gill, ‘Up in smoke? Global tobacco control advocacy and local mobilization in Africa’, International Affairs 95: 5, 2019, pp. 1111–30.

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

43 Howard-Jones and WHO, The scientific background of the International Sanitary Conferences, p. 85.

44 Howard-Jones and WHO, The scientific background of the International Sanitary Conferences, p. 12.

45 1903 International Sanitary Convention.
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 the foundations of today’s international humanitarian law.

Since the end of the Second World War, the institutional foreground has, overall, moved towards more inclusion. Procedurally speaking, it became more global. Today, the WHO Constitution regulates the health-related relations of 194 member states. 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 up more than three-quarters of the WHO’s overall budget.\(^4^6\)

The WHO constitution and the IHR entitle non-state actors to participate in co-managing global health affairs. Perhaps most notably, declaration of a PHEIC is determined not by states but by the WHO director-general, after having heard from the affected state(s) and consulted with an expert panel, 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 overrule them. Again, the PHEIC provides a good example. 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 also protected in the IHR, which state (article 2) that decisions made under the regulations must balance health and economic concerns. Last but not least, the recommendations issued by the director-general are ‘non-binding advice’ (article 1, IHR); that is, in contrast to many other provisions in the IHR, they do not have legal force.

While there are, then, indications in the institutional foreground that the health order is not all that inclusive, in the institutional background the picture is even worse in terms of inclusivity. The 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 on this question, they repeatedly pointed at the United States, the ‘West’, the EU and China (in that order).\(^4^7\) It should be noted that some of this power is linked to the financing mechanism, part of the institutional foreground. Since the above-mentioned actors pay much of the bill—in terms not only of assessed but also, to an even greater extent, of voluntary contributions—they have a tool in their hands to pursue their interests, and they use it to exert influence.\(^4^8\) This situation raises

---

\(^4^6\) Randall M. Packard, *A history of global health: interventions in lives of other peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), p. 269.

\(^4^7\) Author interviews with representatives of a Latin American state and a central Asian state, Geneva, 26 Feb. 2020; with representative of a South Asian state, Geneva, 28 Feb. 2020.

\(^4^8\) The Bill & Melinda Gates Foundation is an exception in this respect, being a major donor (via voluntary contributions) even though it is a non-state actor.
problems: for example, the WHO finds it very difficult to implement long-term comprehensive plans to improve primary health care in the global South. States frequently redirect their funding from one cause to another, and powerful states have a strong tendency to do so in line with what they define as their own—often short-term—interests. Among these, security and economic interests persistently rank highly.\footnote{Harley Feldbaum and Joshua Michaud, ‘Health diplomacy and the enduring relevance of foreign policy interests’, \textit{PLoS Med} 7: 4, 2010, e1000226; Ilona Kickbusch, ‘Global health diplomacy: how foreign policy can influence health’, \textit{British Medical Journal} 342: 7811, 2011, pp. 3154–62; Akram Khazatzadeh-Mahani, Arne Ruckert and Ronald Labonté, ‘Global health diplomacy’, in McInnes et al., eds, \textit{The Oxford handbook of global health politics}, pp. 103–22.} Health interests are hardly ever accorded similar priority unless they come to be coupled to national security concerns. Once disease is securitized, states can become highly motivated to curb its spread.\footnote{For recent contributions to this securitization debate, see Clare Wenham, ‘The oversecuritization of global health: changing the terms of debate’, \textit{International Affairs} 95: 5, 2019, pp. 1092–1110; Colin McInnes and Anne Roemer-Mahler, ‘From security to risk: reframing global health threats’, \textit{International Affairs} 93: 6, 2017, pp. 1313–37; Christian Enemark, ‘Ebola, disease-control, and the Security Council: from securitization to securitising circulation’, \textit{Journal of Global Security Studies} 2: 2, 2017, pp. 137–49.}

Non-state actors have, it is true, 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, for-profit organizations as well, most notably multinational pharmaceutical companies, whose expertise endows them with a considerable degree of agency. 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—even a complete failure to report—is a widely used state practice that has troubled every PHEIC to date.\footnote{Catherine Z. Worsnop, ‘Concealing disease: trade and travel barriers and the timeliness of outbreak reporting’, \textit{International Studies Perspectives} 20: 4, 2019, pp. 344–72; David N. Durrheim, Laurence O. Gostin and Keymanthri Moodley, ‘When does a major outbreak become a Public Health Emergency of International Concern?’, \textit{Lancet Infectious Diseases} 20: 8, 2020, pp. 887–9.} Even when the evidence calls for declaration of a PHEIC, the WHO director-general cannot simply stand aloof from 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, the virus that causes COVID-19:

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!\footnote{Author interview with representative of a large EU member state, Geneva, 20 Feb. 2020.}

The institutional background, in other words, undermines the role of the director-general (and also that of the experts on the Emergency Committee), which is so prominent in the institutional foreground. To this we must add that the background very much downplays the role of the director-general’s recommendations, once he or she has declared a PHEIC. As another interviewee put it: ‘It’s only recommendations. So it’s not too bad when you don’t do it [follow the recommendations].’\footnote{Author interview with representative of a Latin American state, Geneva, 26 Feb. 2020.}
Overall, this discussion of the evolving global health order shows a complex 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 the privileges of states, especially powerful states. The institutional background, however, is ill suited to delivering the object. Prevailing practices ensure a higher 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 they render intelligible. What explains this wide gap?

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

To explain the gap between the medical dimensions and political dimensions of the global health order, 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 (between the medical and diplomatic communities) as well as the relations of the health order with other functional orders (both horizontal and vertical). Deeply entrenched diplomatic knowledge on how to pursue national interests, on engaging in positioning games, and on subordinating health to 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 those of the medical one. Normatively, diplomats, first and foremost, are expected to pursue the national interest. As the literature on diplomacy has often put it since Richelieu, they are practitioners of *raison d’État*. This pursuit of the national interest is tempered by also taking into account the *raison de système*, i.e. the maintenance of the current diplomatic system. Diplomats try to get as much as they can for the state they represent and, at the same time, keep ‘the whole [diplomatic] show going’. Diplomats also have something akin to what Fleck calls a thought style: their professional knowledge incorporates a ‘feel for the game’ of how to assert the states they represent in the hierarchy of standing among international actors.

54 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. 123–46 at p. 126.
55 Sharp, *Diplomatic theory of international relations*, p. 10.
56 Neumann, ‘Returning practice to the linguistic turn’; Ole Jacob Sending, ‘United by difference: diplomacy

International Affairs 97: 5, 2021
Global health: an order struggling to keep up with globalization

The medical and diplomatic communities use very different lenses 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 there is the national interest. The latter may, of course, include the health of the state’s own citizens; but the formulation of a cosmopolitan interest in the global 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 one’s own nation first. Equally important, on the one hand there are the scientific epistemology and methodology to prevent the spread of diseases and cure human beings; and on the other hand, there is the deeply internalized imperative of standing as tall as possible in encounters with representatives of other international actors.\(^{57}\)

Global health politics requires this gap to be bridged; and, indeed, attempts to do so have been made ever since the advent of an international health order in the nineteenth century. It is just that 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 in making the institutional foreground more global. The post–Second World War evolution of the foreground is best understood as a grand compromise between the two communities. Viewed in this light, the understandings of the medical community have become considerably more prominent in respect of the ordering object, and even the positioning of actors 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 indicates a major difference between the health of one’s own nationals and the rest. The neologism of ‘vaccine diplomacy’ (although the practice is not new) shows this all too clearly. Today, the term is used to describe states’ attempts to get as many doses of COVID-19 vaccinations for their own populations as quickly as possible.\(^{58}\) As a result, high-income states secure the lion’s share and others receive very little. The WHO director-general, a trained physician, may chastise this selfishness as a ‘catastrophic moral failure’,\(^{59}\) but does not have the political power to do much beyond making such desperate public appeals. The spread of the SARS-CoV-2 virus also illustrates all too well how pervasive positioning games are in the global health field. Eager not to be 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

---

\(^{57}\) 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.

\(^{58}\) Also, vaccine-exporting states use these exports to pursue their geopolitical goals.

\(^{59}\) WHO director-general, ‘Opening remarks at 148th session of the Executive Board’, 18 Jan. 2021, https://www.who.int/Director-General/speeches/detail/who-Director-General-s-opening-remarks-at-148th-session-of-the-executive-board.
started reporting, it did so in a ‘piecemeal’ fashion.\textsuperscript{60} Even more than a year later, Chinese cooperation with a WHO team mandated to investigate the origins of the outbreak was not forthcoming. As a result, ‘major stones’ remained ‘unturned’, as a report in \textit{Nature} put it.\textsuperscript{61} To be fair to China, it is not the first (and is unlikely to be the last) state that cooperates insufficiently with the WHO during an epidemic. Nor is it only China that is very sensitive about 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 itself does not remain 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 decolonization of the late 1950s and early 1960s was the prerequisite for global state representation in the health order; and in the 1990s, diplomacy increasingly opened up to non-state actors. Revising the IHR became possible owing to the more cooperative relations among major states prevailing 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 between some of the major states, especially China and the United States.

\textit{Inter-order relations}

The post-Second World War making of the global health order came about 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 IR theorists.\textsuperscript{62} That is, we disaggregate the liberal world order into its component 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.

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 elaborated 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 that on the elimination of racial discrimination, and from the convention on the elimination of discrimina-

\textsuperscript{60} Author interview with representative of a central European state, Geneva, 18 Feb. 2020.

\textsuperscript{61} Smriti Mallapaty, Amy Maxmen and Ewen Callaway, ‘“Major stones unturned”: COVID origin search must continue after WHO report, say scientists’, \textit{Nature}, 10 Feb. 2021, https://www.nature.com/articles/d41586-021-00375-7.

\textsuperscript{62} Janice B. Mattern and Ayşe Zarakol, ‘Hierarchies in world politics’, \textit{International Organization} 70: 3, 2016, pp. 643–54; Amitav Acharya, \textit{Constructing global order: agency and change in world politics} (Cambridge: Cambridge University Press, 2018); Adler, \textit{World ordering}. See also Jozef Bátora, ‘States, interstitial organizations and the prospects for liberal international order’, \textit{International Affairs} 97: 5, Sept. 2021, pp. 1433–50.
Global health: an order struggling to keep up with globalization

tion against women to that on the rights of the child, have all, explicitly and implicitly, included various aspects of health.\(^6^3\) Equally, human rights are deeply woven into the principles and instruments of global health, from the preamble of the WHO constitution through the 1978 Alma-Ata Declaration with its motto of ‘health for all’ to the 2005 IHR, which list human rights—ahead of state sovereignty—among the key principles (article 3). From the 1990s onwards, the development field increasingly joined the human rights–global health duo of orders.\(^6^4\) The MDGs constituted a first very tangible outcome of this development, and the SDGs followed suit. Development is at times defined by linking human rights and health together, for example with formulations such as ‘the human right to safe drinking water and sanitation’,\(^6^5\) and the goal of ‘protect[ing] labour rights and promot[ing] safe and secure working environments for all workers’.\(^6^6\)

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 SDGs proves to be a very difficult process. A recent UN report finds that of 21 targets to be met by 2020, only three were actually ‘achieved or on track of being achieved’\(^6^7\) None of these was about health; indeed, the prospects for health-related SDGs are dire. The 2020 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.’\(^6^8\) The human rights order has turned into a battleground fought over by Great Powers and middle powers. As a result, this order no longer exports ideas to the global health order.\(^6^9\)

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 proved persistent. The dominant diplomatic community of practice subordinates the global health order under other functional orders, most notably those of 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

\(^6^3\) Paul Farmer, ‘Pathologies of power: rethinking health and human rights’, *American Journal of Public Health* 89 (10, 1999, pp. 1486–96; Lawrence O. Gostin and Benjamin Mason Meier, eds, *Foundations of global health and human rights* (Oxford: Oxford University Press, 2020).
\(^6^4\) This also had repercussions for funding: from 1990 to 2005, World Bank funding for global health increased from US$2.3 billion to US$14 billion. See World Bank, *Healthy development: the World Bank strategy for health, nutrition, and population results* (Washington DC: World Bank, 2007). Yet via the World Bank, neo-liberalism came to exert influence in the global health order, and this is not easily reconciled with a global understanding of either the ordering object or ordering relations. See Matthew Sparke, ‘Globalisation and the politics of global health’, in McInnes et al., eds, *Oxford handbook of global health politics*, pp. 37–58.
\(^6^5\) UN General Assembly, A/Res/70/1, 21 Oct. 2015, sec. 7.
\(^6^6\) UN General Assembly, A/Res/70/1, 21 Oct. 2015, sec. 8.8.
\(^6^7\) UN, *The Sustainable Development Goals Report 2020* (New York, 2020), p. 60.
\(^6^8\) UN, *The Sustainable Development Goals Report 2020*, p. 8. States are, unfortunately, not strongly committed to providing funds sufficient to implement these ambitious goals. In 2016, for example, 0.4% of global health spending was disbursed 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. 2233–60).
\(^6^9\) Author interviews with representatives of a P5 state and a northern European state, Geneva, 20 Feb. 2020. This contestation is, of course, embedded in a broader context of rising tensions among Great Powers: author interviews with representatives of a south Asian state, Geneva, 28 Feb. 2020, and a Latin American state, Geneva, 26 Feb. 2020.
Markus Kornprobst and Stephanie Strobl

economics. The documents that they look at—grand strategies of states—focus very much on the latter two areas. Global health, by contrast, hardly amounts to a matter of priority for states in their external relations. 70 In the words of Jeremy Youde, security and economics are ‘high politics’, whereas global health is relegated to ‘low politics’. 71 This means that diplomacy routinely puts security and economic interests ahead of health-related ones. Uranium mining, for example, involves major health hazards. As uranium is used for nuclear weapons and nuclear power stations, however, these health impacts hardly make it onto the diplomatic agenda. 72 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. 73 Securitizing health during a health crisis can help push a certain global health issue temporarily 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 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. 74

Conclusion

In researching how health and globalization hang together, this article has cast its net widely. It has investigated both the medical and the 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 onto 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 are spreading more and more globally, and medical knowledge on how to counter this trend is becoming increasingly refined. On the other hand, the diplomatic rules of the political game, deeply rooted in national interest, positioning, and the primacy of security and economics over health, inhibit the prospects for the ‘true global collaboration’ that is so badly needed to cope with the global spread of diseases. 75

In the past decade, pressures on the liberal constellation of orders have only exacerbated these problems. While the horizontal relations of the global health order with the human rights and development orders helped its foreground insti-

---

70 Thierry Balzacq, Peter Dombrowski and Simon Reich, eds, Comparative grand strategy: a framework and cases (Oxford: Oxford University Press, 2019).
71 Jeremy Youde, ‘High politics, low politics, and global health’, Journal of Global Security Studies 1: 2, 2016, pp. 157–70.
72 Atanu Sarkar, ‘Nuclear power and uranium mining: current global perspectives and emerging public health risks’, Journal of Public Health Policy 40: 4, 2019, pp. 383–92.
73 Adia Benton and Kim Yi Dionne, ‘International political economy and the 2014 west African Ebola outbreak’, African Studies Review 58: 1, 2015, pp. 223–16.
74 Joanne Liu, We need a change of gear for Ebola outbreak in DRC (Geneva: Médecins sans frontières, 18 July 2019), https://msf-seasia.org/news/18686; Ben Parker, ‘From Ebola to Kunduz: MSF head Joanne Liu looks back’, New Humanitarian, 12 Sept. 2019, https://www.thenewhumanitarian.org/interview/2019/09/12/ebola-kunduz-msf-head-joanne-liu-looks-back.
75 Brian McCloskey, Osman Dar, Alimuddin Zumla and David Heymann, ‘Emerging infectious diseases and pandemic potential: status quo and reducing risk to global spread’, Lancet 14: 10, pp. 1001–1010.
tutions to make progress in the 1990s and early 2000s, all of these orders are now under pressure. At the same time, Great Powers, increasingly playing hardball on the diplomatic stage, are moving increasingly towards short-term understandings based on realpolitik. Given the persistent problems of the global health order, it was already structurally ill-equipped to deal with the COVID-19 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’, driving home the point that the old ways of doing things cannot simply go on. 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; to use a technological metaphor, 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.

On the basis of our findings, we would submit that the first scenario is the most likely one, followed closely by the second and, at a distance, the third. 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 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 when this call was made, it was published in selected newspapers around the world and not at, say, a global health summit. This is a far cry from the kind of momentum that gathered in the mid-2000s for revising the IHR.

Since the COVID-19 pandemic constitutes a major crisis, however, there is a chance that states, taking the advice of medical experts into account, will add to the components of the institutional foreground. 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 the WHO authority to investigate 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. The achievement of such results would not

---

76 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. 128–73 at p. 155.

77 On simple and complex learning in IR, see e.g. Jeffrey W. Knopf, ‘The importance of international learning’, Review of International Studies 29: 2, 2003, pp. 185–207.

78 WHO, ‘Global leaders unite in urgent call for international pandemic treaty’, press release, 30 March 2021, https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty.
Markus Kornprobst and Stephanie Strobl

be easy in multilateral negotiations under any circumstances, and will be especially
difficult in the current political climate.\textsuperscript{79}

If such (far-reaching) amendments were 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 institu-
tional background looms large over the foreground. Deep-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-19 pandemic
provides an opportunity to revisit these orthodoxies and build a political order on
foundations that are no longer out of sync with the ever more globalizing spread
of diseases. Yet such a re-institutionalization of global health will be an uphill
struggle. Old habits die hard, especially in a political climate in which diplomatic
communication is more inclined to resort to blame games than to work together
towards an enlightened common interest.

\textsuperscript{79} We are rather sceptical about the potential inclusion of non-communicable diseases. The ‘cognitive punch’
that COVID-19 delivers is about communicable diseases.