Introduction

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What is global health? The term “suffers from imprecision”, it has been said.¹ In a thought-provoking paper published in *The Lancet* in 2010, Dr Linda Fried and colleagues made a bid to get a new understanding of what is exactly global health.² Global health, they deplore, is “still often perceived as international aid [...] flowing from the wealthier countries of the global north to the poorer countries of the global south”. They beg for a “more nuanced and contemporary perspective” that would emphasize interdependence and the common impact of many health problems conducive to solutions that would be multilateral or, at a minimum, bidirectional. Taking its cue from another paper, the Northwestern University’s Center for Global Health defines on its site global health as: first, a trans-disciplinary body of knowledge and expertise (more on this below); and, second, a form of public health that deals with issues transcending national boundaries.³

Trans-disciplinarity and cross-border approach are certainly promising avenues of research in global health.⁴ But, while global health supposedly concerns health outcomes that “are beyond the capacity of individual countries to address alone”,⁵ to construe global health pushing aside national boundaries from the picture would amount to misconstrue the notion for want of considering its genuine context. For, even though “economic globalization has been the driving force behind the overall process of globalization

1 Lee 2011, 9.

2 Fried 2010.

3 Kaplan 2009.

4 Wernli 2016.

5 Lee 2011, 9.

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over the last” four decades,⁶ the political fabric of the planet kept sticking to the nation-state. As Henry Kissinger recently said, “economic globalization, in its essence, ignores national frontiers. International policy emphasizes the importance of frontiers even as it seeks to reconcile conflicting national aims”.⁷ Social order is structured around the state, the market and civil society.⁸ Surely market or civil society may ignore borders (but not necessarily); the state never would. Any past suggestion to divorce international security from frontiers and national sovereignty, like the one put forth by the historian E. H. Carr in *Nationalism and After* (1945), was just a shot in the dark.⁹ Global health cannot therefore be defined using the economy as a template, disregarding the political organization of the world order. By implication, one cannot understand global health as indifferent to, or ignorant of national boundaries, but, quite the opposite, as a form of public health for which national boundaries are a problem. Pandemics resulting from globalization “pose a significant risk to security, economic stability, and development”; as a result, “political attention to global health security can no longer be episodic”, and “political leadership must be sustained by standing agendas on health security at the WHA, G7, G20, and Security Council”.¹⁰ While global health is made of issue-specific debates, such debates certainly beg political questions.¹¹ In the latest issue of *Foreign Affairs*, Tedros Adhanom Ghebreyesus, recently elected as the World Health Organization’s (WHO) general director, underlines for instance how contingent on political commitment is the apparently purely technical issue of expanding health universal coverage, a key issue in present global health beside emergency response, women and children in adolescence, or climate change and health. “Health for all”, Ghebreyesus insists, is political, and that is the reason why the WHO should work not only with the ministry of health but also with the ministry of finance or even with heads of state and government.¹² Incipient global health in the 1990s brought about a bundle of three political problems at least: a surge in funding unprecedented in international public health (but see below the financial role of the Rockefeller Foundation in relation to the League of Nations Health Organisation in the interwar period); the search for a new institutional architecture of foreign aid; and finally, trying to heal

6 Woodward 2001.

7 Kissinger 2014, 368.

8 Hurrell 2007, 116.

9 Carr 1945, 67–71; quoted in Rothschild 1995, 57.

10 Gostin 2016.

11 Hurrell 2007, 39–41, 52; Mazlish 1998, 392.

12 Reid 2017.

corruption in weak states, whose origins frequently lie in extreme social inequality.¹³ Political questions are not side-issues.

Such views draw from the new principles of security that come from the international politics of the post-Cold War period. They are an inspiration for contesting existing notions of global health security and promoting new conceptions of global health, solidarity, security and sustainability, which constitutes by the way a rediscovery of ideas peculiar to liberal political thought, from the seventeenth century to the late Enlightenment in the 1820s.¹⁴

The concept of global health security aims at providing a framework for better preparedness and fighting against the risk of transnational emerging and re-emerging infectious diseases. Although there have been recent attempts to better define and advocate global health security, the term remains unfortunately deeply connoted as an initiative to protect the global North against threats coming from the global South. There is no doubt that many health professionals, academics and politicians define current threats as those coming from the South, on the one hand (Ebola, Lassa, Marburg, Rift Valley Fever, Dengue, Chikungunya or Zika infections), while the 'Northern causality' is brought into the discussion in the areas of antibiotic resistance, on the other hand. It is only pandemic influenza, which, in nowadays narrative, has no geo-political 'origin', and is seen as a truly global health security threat, even though the pathways of the 'Spanish' pandemic, for instance, is still a burning historical issue. Geopolitical 'origins' and 'causalities' always create tensions at the level of priority setting and resource allocation as risks can be prioritized differently when assessing with a national or regional perspective. Hence, the challenge remains to reconcile these perspectives to reach a common understanding that allows for the development of both a national and global agenda for health security issues. Such an agenda must attract high level political attention so that health security is addressed in national and foreign policy agendas as well as national security funding (see below). Global health security tends to focus more on disease containment rather than prevention and this is particularly true in the control of emerging infectious diseases. However, in resource constraint countries most of the disease burden is currently due to the double burden of disease (communicable and non-communicable diseases), which calls for a system level approach for interventions and continuous surveillance.

13 Cohen 2006, 162–167.

14 Rothschild 1995, 62–63, 67.

The main problem associated with the use of the term ‘global health security’ includes the potential contradiction with national security, which is – understandably – the traditional highest political priority of states. Endorsing a national security perspective might first result in unilateral, neo-colonial or short-term solutions that are limited to protect national borders, which are exemplified by, for example, the imposition by many countries of flight restrictions during the 2014 Ebola outbreak in West Africa, against the WHO International Health Regulations recommendations. National security is ambivalent about two key global health values, equity and solidarity, as well as about human rights. This disparity may create a growing gap between policy makers and field practitioners providing health services in the global South, who are primarily motivated by solidarity and humanitarian values. It is important to note that the 2014 Ebola outbreak has been effectively managed by the involvement of volunteers and professionals from public hospitals and non-governmental organisations, such as *Médecins Sans Frontières* or *Save the Children*. Meanwhile, the policy community and international organizations – following the conventional pathway of national consolidation of official information—were delayed to launch an effective response particularly in the early stage, leading in each of the affected countries to an excessive disease burden, not only owing to Ebola but due to all conditions once the peripheral health services broke down.

The global community should not rely uniquely on solidarity to protect the world from infectious disease threats but needs to reconcile this noble aim with the self-interest of states to truly serve the people and communities most in need. Global health security calls for long-term solutions and is linked to sustainable development and global health solidarity. The connotation of the word ‘security’ which translates into a restrictive use of the term ‘global health security’ tends to mask these core assumptions and risks to perpetuate a state-centric approach focused on the viewpoint of the global North. To make clear our normative standpoint and assumptions, we propose to use the concept global health solidarity, security, and sustainability.¹⁵ Reconciliation through a process of mutual learning for change even in an emergency situation ought to remain the ultimate aim. It is this spirit and public health action that will generate better prevention and control, while identifying the type of approach that will lead from emergency global health action to health development grounded on the values of solidarity and sustainability. The challenge of integrating different perspectives into a

15 Flahault 2016.

comprehensive concept and public health action agenda defines the trans-disciplinary nature of global health.

Now, if WHO's programs are linked to political issues, then we have a real interest to look in a historical and critical perspective at erstwhile international health policies, whether transgovernmental bodies (LNHO, WHO,¹⁶ World Bank) or individual states (West and East Germany, the USSR are relevant examples). But then the question arises: What is global history? We have to define it. Historians are sometimes keen to posit global history as a form of history quite different from world history. To quote historian Bruce Mazlish, world history attempts "to treat historical phenomena that arise on a world scale". Former collaborator of Toynbee, William H. McNeill published in 1976 *Plagues and Peoples*, one of the most important books on the subject of the history of epidemics and infectious diseases. In France, one must cite Fernand Braudel, of course. Privileging *longue durée*, comparative perspective, and categories not too much time-specific and not too closely connected to national histories, these pioneers were accompanied by social disciplines like anthropology, geography, sociology or economics.¹⁷ Transcending monographic structural units, such as nation-state and political boundaries, world history sticks to whatever type of border-crossing, impact or linkage between units, to dissemination and migration from one unit to the others, and tries to connect places, time-periods and topics across the board.¹⁸

Like world history, global history is still more an aspiration than an established body of historical writings.¹⁹ History of global health could be viewed as history of globalization of values, norms, and institutions in public health²⁰. But when did globalization began? While the world was involved in many processes of globalizing before it became globalized,²¹ the way was definitely opened to global society thanks to the unprecedented increase in inter-connectivity through satellites and personal computers, and also because threats to national security, environment, and public health took off after both World Wars. Even if political developments were never out of the big

16 Borowy 2009; Cueto 2004.

17 Mazlish 1998, 387. We would like to thank the anonymous referees for this reference. McNeill 1998, 7, 11.

18 Christian 2004; Manning 2003.

19 Burrow 2007, 506.

20 Mazlish 1998, 389.

21 Medick 2016, 252. Berger 2003, describes the 'first' globalization of the Western world that was to fade away as a consequence of the First World War. True though it may seem, it is rather difficult to speak of globalization when the world lacked the hyper-connectivity that exists since the 1950s–1960s, and also in the absence of new global ways of governance, particularly in the domains of environment and health.

picture, global history is “heavily tinged by scientific, technological, and economic happenings of recent times”.²² Instances are numerous. Since a couple of decades, virologists and biologists, for example, harvested a great deal of historical data on the subject of plague, typhus²³ or influenza.²⁴ These new developments triggered an extension of the perimeter of historical studies of health, integrating data from environmental studies, medicine, evolution study, linguistic, archaeology, chemistry, giving substance to more intimate connections between cultural history and ecological history. Health was part of global history topics from the start, even though social history and dynamic epidemiological modelling rarely meet. This is probably, as Jim Webb recalls in a recent position paper, because “the disciplinary biases of many graduate programmes discourage multidisciplinary training”.²⁵ Except for Webb’s paper, which examines the changing patterns of helminthic infections and the cultural, biomedical, and public health perceptions and practices that have had powerful influences on the transmission of intestinal diseases, the following contributions keep close to the trail of social history. But at the end of the day, the difference between world and global histories appears rather scanty. World history is being anxious to reintegrate the “vision of the vanquished” (Nathan Wachtel) in the main narrative, and to put forth a ‘xenological’ in lieu of an ‘egological’ history, while global history, as it has been said before, is less interested in symmetry than in a cumulative narrative anxious to underscore as many connectivities as possible.²⁶

According to Kissinger, “every international order must sooner or later face the impact of two tendencies challenging its cohesion: either a redefinition of legitimacy or a significant shift in the balance of power”.²⁷ Such a structural alternative has been in the pipes for some time in relation to global health. Convened in Oslo on March 20, 2007, ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand issued a statement inviting governments to broaden the scope of foreign policy in an age of globalization and interdependence. “We believe that health is one of the most important, yet still broadly neglected, long-term policy issues of our time”, goes the Oslo Declaration. The Declaration links people’s health not only to economic growth and development, but also to stability and national security.²⁸ Foreign policy will be examined, the Decla-

22 Mazlish 1998, 396, 392.

23 Drancourt 1998; Tung 2010; Sallares 2007.

24 Morens 2009; Oxford 2002; Taubenberger 2006.

25 Webb 2015.

26 Subrahmanyam 2014.

27 Kissinger 2014, 365.

28 Oslo Ministerial Declaration, *Lancet* 2007.

ration states, using “impact on health as a point of departure and a defining lens”.²⁹ “Health-impact assessments of all foreign trade and defence policies” are called for advancing the cause of health “within all relevant international bodies”. Such extraordinary invitation comes directly from the new footing upon which health policy has been put within the European Union (EU) since the 1990s. For example, clause 152 (1) of the 1997 Amsterdam treaty asks every EU policy “to warrant the highest level possible for the protection of human health”.³⁰

No doubt, putting health under the aegis of economic growth coupled with stability, or development coupled with security was by no means new. In the aftermath of World War I, contemplating the widespread disorder and health threats pounding Eastern European and Russian-Ukrainian populations, one of the directors of the Rockefeller Foundation devised a very similar, two-pronged, action plan for the rescuing of these countries. In the aftermath of the war, the League of Nations Health Organization would combine health and peacemaking in Eastern Europe. The 1919 period has similarities to our own: the anarchy, violence, rampant conflicts, big epidemics, weak and drifting states, and a thirst for a new governance structure in order to reach stability and security are equally characteristic of both periods. Differences are also conspicuously visible, of course. Of prime significance is the fact that the Western powers are currently no more in an undisputed influential situation. Other players, such as India, China, or Brazil came to take their share of global influence.

Now, even if health is to be raised to high politics, why should it be conceived as a global interest, after all? Indeed, cross-border risks and threats are global by definition. No country, says the Declaration, can achieve to be proof against health threats on his own. Reminiscent of the now vanished notion of linear progress, the Declaration assumes that “the development of all nations is a prerequisite to ensure global health security”. Obviously, global health is here regarded as a win-win process. Is really health the very last shared value attached to the norms, rules, and institutions of a global order? The Oslo Declaration pleads for “closer links between global health and foreign policy”.³¹ Public health in an age of globalism can work on the side of security and stability in association with the fight against climate change, energy security, food production and the financial system, all of them being nonetheless “serious potential threats to global health’s place in inter-

29 Oslo Ministerial Declaration, *Lancet* 2007.

30 Zylberman 2004, 27.

31 Lee 2011, 7.

national politics”.³² Historians, sometimes, regard development and security less as harmonious goals than as a dichotomy similar to the 1950–60s alternative between social medicine and the “technocratic high modernism” (the vertical programs for the eradication of malaria and the use of DDT, to cite a notorious example).³³ According to this view, global health is appraised as if it was split down the middle, and more interested in national health security than in combating poverty. Some may even go as far as considering global health as more serviceable to security (that is to developed countries) than to development (that is to developing ones). In that sense, global health would stand contrary to humanitarian health.³⁴ An age of global health will succeed to an age of social medicine, but at the price of turning the emblematic 1978 Alma Ata Conference principles upside down.

But no matter how historians slice it, the Oslo Declaration squarely stated that, for the benefit to all nations, “powerful synergies arise when national interest coincides with the need for concerted regional and global action”. Historical precedents for such concerted regional or global action have not exactly been a roaring success, however. Facing epidemics in 1919, the Eastern European countries showed no solidarity: shared vulnerability didn’t step up common defence. Again, in 2003, just four years before the Oslo Declaration, the Severe Acute Respiratory Syndrome (SARS) episode would demonstrate that national interest and global action do not coincide at all automatically, when China, Canada and others, in the name of political or geopolitical interests, complained about the unwelcome intrusion of the WHO. Foreign policy initiatives involving health work are rather rare. More often than not, Non-governmental Organizations (NGOs), not the state, perform it, since they appear to be the embodiment of the values altogether opposed to the blights of cynicism, bureaucracy and corruption that stain the state’s credit.³⁵ Little wonder their number has skyrocketed since the 1990s. The real McCoy of such international venture, albeit in no ways a NGO, was the Allied Commission of the Epidemics, which tackled typhus, cholera and dysentery wreaking havoc from Ukraine and Belarus to Poland in 1919–1923. national public health organizations and institutions, the Commission’s works was straddling political boundaries in order to medically control flows of refugees roaming a no man’s land devastated by war, misery and disease, an early example of the progressive yet short-lived domination of functional geography over political geography in the history of interna-

32 Fidler 2008/2009; quoted in Lee 2011, 7.

33 Manela 2010, 261.

34 Peterson 2007.

35 Rothschild 1995, 77.

tional public health.³⁶ Signatories of the Oslo Declaration are thus trading in illusions when they jump from the fact that emerging infectious diseases “do not respect geographical borders” to the universal conclusion that those diseases “can be tackled successfully only if nations work together”.

Of course, NGOs taking precedence over public agencies such as WHO or UNICEF greatly changes the relationship between health care and people, which becomes one of goodwill rather than of contract.³⁷ In this perspective, it is perfectly understandable that health care people can feel fairly insecure about funding. By 2010, global funding accounted for only 0.3% of total expenditures on health globally. By all measures, still a modest amount. Yet sub-Saharan Africa absorbed 6.5% of this aid. And some countries are still donor-dependent: 66% of the Mozambique national health budget, for example, came from external resources. Tanzania, Kenya and Uganda reported almost similar proportion of their health budget coming from donors. According to WHO, more than 20 countries had over 30% of their health budget funded by donors.³⁸

Moreover, global donor strategies might weaken recipient countries. The current demise of the state is a significant development, another hot button issue that shows the crucial part played in global health by the political structure of the world order. It can be ascribed to several factors. First, to the private sector ascent to the top of various multilateral organizations through public-private partnerships such as Medicines for Malaria, Stop TB Alliance, and above all the Global Fund to Fight HIV/AIDS, TB and Malaria. Private actors, e.g. the Bill and Melinda Gates Foundation, nowadays are quite often in a very powerful situation within multilateral organizations. In the 1920's, the Rockefeller Foundation funded 65% of the League of Nations Health Organization budget and acted as one unofficial representative of the US government that was bound to stay outside the League by Congress' opposition to the 1919 Covenant. Still, the Rockefeller never featured a stakeholder of the direction of the League's Health Organization. Today, the Gates Foundation appears on a par with governments as the Global Fund trustees. On top of that, funding agencies like the Fund or the United States President's Emergency Plan for AIDS Relief (PEPFAR, launched in 2003) deal directly with NGOs. Implications are two. First, as much of the funds go to civil society, the state becomes but a marginal player, raising worrying questions about sustainability of national health strategies. Second, today nearly 80% of the WHO's budget comes from external donors rather than from

36 A much discussed topic: see Khanna 2016, 17–18.

37 Rothschild 1995, 82.

38 Sridhar 2010, 2, 6.

member-states, while it was just the reverse four decades ago. Instead of reinforcing Geneva, new initiatives are causing still more erosion to the WHO's authority as a leader in global health.

Obviously, the decline of the state in global health policy making and the erosion of the WHO's authority are narrowly associated developments. Indisputably correlated is the politicization of global health proposed by the Oslo Declaration with the political downgrading of the WHO that set in since the 1980's. Harsh criticisms towards Geneva during the 2009 flu pandemic must be viewed against the backdrop of this increasing WHO's political weakness. No doubt it explains why the Oslo Declaration was so keen to affirm the role of the WHO as one of "the main arenas for global health governance",³⁹ a capital understatement, with the word 'arenas' in a conspicuous plural. Deterioration of WHO's emergency response and governance has been worsened just before the Ebola outbreak in West Africa in 2013–15, in particular because of the cut of nearly two-thirds of its emergency response unit, resulting in a severe, permanent crisis of confidence. An array of global commissions is now proposing a bold new agenda for global health in the hope of getting the Organization on its feet again.⁴⁰

To make the history of global health a trans-disciplinary body of knowledge and expertise is only incipient at the moment. One example is James Gillespie's paper on global social insurance presented in the following pages. Here, history of public health meets history of global social security. From the end of the First World War to the 1970's Geneva based organizations explored the crossing points between health policy and social security. But the League of Nations Health Organisation had an uneasy dialogue with the social insurance and social security approaches. In sharp contrast, the International Social Security Association developed a sophisticated relationship with national social insurance administrators. Yet this model translated rather uneasily in health.

A new equilibrium between social and epidemiological sort of history must be reached. In the meantime, research programmes in critical topics like the history of global health professions rightly mobilize scholars. Also a piece of history of policy learning, diffusion and exchange within the framework of international institutions, Maria Eugenia Galiana Sanchez focuses on the development of public health nursing in Europe from the League of Nations to the World Health Organisation. Maternal and child care, as well as the primary health care are scrutinized.

39 Oslo Ministerial Declaration 2007, 1378: point for collaborative action 10.3.

40 Gostin 2016.

Many of our queries about global health are related to health governance. In spite of it, by the 1930's and again after the Second World War, global connection of experts suffered a series of setbacks. There remain 'outlier' countries unwilling to cooperate with international public health (China at the time of SARS), or lacking the infrastructural and professional capabilities to join cooperative global programs, or having populations with divergent approaches to health goals and practices. Susan Solomon and Lion Murard explore further two examples. First, Soviet Russia, of which the political system was judged 'inimical' to democracy and a backward country from the point of view of the health system, which international experts hoped to lift up and influence from the outside. Western experts try to engage the Soviets through hiving off the politics from public health. In short, though there were limits to the international society of health, there were also interactions 'across the divide'.⁴¹ Outliers showed up at the very origins of the international health organizations, for instance when post-imperial Germany and Soviet Russia signed the Treaty of Rapallo (16 April 1922) in parallel to the Warsaw Conference (20-28 March 1922), where, no matter their recalcitrance, the Soviets (and the Germans) discussed with others Europeans Powers the notion of the 'sanitary zone' straddling political boundaries. The USSR would drop off the WHO again in 1951-53 for a short while. Second, Greece, whose health 'civilization' was deemed to haven't progressed fully beyond nineteenth century public hygiene. The idea of "outlier" has the virtue to underscore the nature of international organizations as coalitions of insiders (France and Britain in the League of Nations Health Organization; the US, Britain and Scandinavia in the WHO),⁴² on whom veto players (Soviet Russia, China during the SARS pandemic, or even Indonesia at the time of avian flu) try to force sharing disease control and program policies.

Medical cooperation with low-income countries could have been a promising endeavor for East and West Germany after the Second World War. However, although central planning still appealed to Third World intellectuals in the 1960's, political developments after 1968 weakened East Germany's international position, and put medical cooperation almost to a halt. In fact, since the 1950's comparative records show a wide gap between the German Democratic Republic's and the Federal Republic of Germany's performance in this field. By 1963, forty-three countries had received a broad spectrum of staff aid and equipment from West Germany, whereas seventeen

41 For a more general point of view, cf. Hurrell 2007, 552-555.

42 Mazower 2009, 21.

doctors and twenty-one nurses had been sent by the GDR to low-income countries. Reforms launched in the East from 1963 proved to be short-lived,⁴³ while independent activities of non-governmental organizations would be rapidly ruled out, and governmental options seriously curtailed. According to Iris Borowy and Walter Bruchhausen, both countries conceived medical cooperation as a means to distance themselves from the time of National Socialism. In the East and the West alike, it was the Korean War that triggered collaboration in the field of health activities. For both countries the dominant rationale for deciding about new projects was not health-based but political. Cuba and Communist China would follow in the footsteps of the GDR international health policy, sending medical personnel and assisting in medical education to the developing world. Health was regarded as an ‘agent for good’ in foreign policy.⁴⁴ That is the reason why, notwithstanding the ideological display of the notion, American administration, Obama’s lately, would embrace of “global health as a core feature of its national security, diplomacy, and development work around the world”.⁴⁵

Would global health ever escaped from the political morass in which it has been trapped so far?

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43 Maier 1997, 81–96.

44 *Strategy for Global Health 2008–2013*, 2008; quoted in Lee 2011, 4.

45 US Government 2009; quoted by Lee 2011, 5.

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