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Between nation and empire: how the state matters in global health

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Abstract

The role of the state has been underplayed in scholarship on global health. Taking a historical view, this paper argues that state institutions, practices and ideologies have in fact been crucial to the realisation of contemporary global health governance and to its predecessor regimes. Drawing on state theory, work on governmentality, and Third World approaches to international law, it traces the origins of the 'health state' in late colonial developmentalism, which held out the prospect of conditional independence for the subjects of European empires. Progress in health was also a key goal for nationalist governments in the Global South, one which they sought to realise autonomously as part of a New International Economic Order. The defeat of that challenge to the dominance of the Global North in the 1980s led to the rise of 'global governance' in health. Far from rendering the state redundant, the latter was realised through the co-option and disciplining of institutions at national level. To that extent, the current order has an unmistakably imperial character, one which undercuts its declared cosmopolitan aspirations, as evidenced in the approach to vaccine distribution and travel bans during the Covid-19 pandemic.

Keywords: global health governance; nationalism; imperialism; states; Covid-19

Introduction: understanding the health state

The state matters in global health. In the context of transnational spread of disease, it may not be the sole organ of preventive and mitigation action, but worldwide experience during Covid-19 shows that it is the principal vehicle for developing and enforcing health-promoting policies. National authorities have been central to coercive disease control measures and public information campaigns, to vaccine production, procurement, and distribution. Political rhetoric concerning the pandemic indicates that the nation-state still forms the primary target of popular expectations and demands for accountability as regards health.[1] Lockdowns and curfews were justified in terms of national unity and sacrifice, directed to the population as a whole. Vaccine nationalism largely trumped global solidarity and international human rights when it came to allocating scarce resources. Scholars and policymakers were

[1]For representative studies in relation to the UK, see J Broadbent 'The response to Covid-19 in England: political accountability and loss of trust' (2020) 16 Journal of Accounting & Organizational Change 527; D Devine et al 'Trust and the coronavirus pandemic: what are the consequences of and for trust? An early review of the literature' (2021) 19 Political Studies Review 274.

surprised by all of these developments and shocked by some of them. This is because the era of global health, from the late 1990s to now, has been characterised by a post-Westphalian orthodoxy which overlooks or denies a leading role for the state.[2] That was taken instead by an ascendant cast of non-state actors: philanthropic organisations; multilateral bodies; and non-governmental organisations.[3] Networked governance would suffice to serve the ends of a universally-defined global health, with the state cast as a mere obstacle to the achievement of this normative goal.[4] Theoretically sophisticated work on the emergence of a transnational health law pays relatively less attention to the state.[5] But, as Schrecker has noted and as the pandemic has confirmed, 'reports of the death of the (nation) state have been exaggerated'.[6] As a result, there is a gap in our knowledge and theorisation leaving us ill-equipped to understand the broader field of global health and its likely mutation as a result of Covid-19. This paper offers an indication of how we might address that deficit.

'Bringing the state back in' is a familiar move from elsewhere in the social and political sciences.[7] But we must first ask what is the nature of the 'state' that we are looking to recover here. Our answer proceeds from the insight that the state is not a single thing. It has no fixed essence, whether that be a list of definitive structures or a set of indispensable powers.[8] It is better understood as the ensemble of material practices (eg law enforcement, measurement and licensing) and institutions (eg ministries and agencies) attributed to the state and legitimated by ideational forms (eg objectives, goals, and national myths).[9] Thus, for example, vaccine procurement would be a state task since it is pursued by a 'national health service' in fulfilment of constitutionally guaranteed rights to life and health. States vary over time and space, because the practices, institutions, and discourses which make them up vary. A state in western Europe will differ from a former settler colony in east Africa, and neither will be what they were half a century ago. This is not, it should be added, because one is a less fully realised version of the other, taken as an ideal, but because each has had a distinct historical trajectory. Imperial nostalgia and well-established institutions in one case, may be matched by anti-colonial nationalism and political rupture in the other. As these examples suggest, however, the state is not wholly self-created or self-sustaining. Trajectories are interconnected, ideologies and practices travel from state to state directly or through international bodies.[10] They often do so in the service of asymmetric power, as between regions of the globe. We need to attend, therefore, to context and history, to discourses and institutions, in accounting for the state in global health.

Of course, it will not be possible to render a comprehensive account of state practices, ideas and trajectories within the confines of the present piece. What we can do, however, is to pick out three key characteristics of states that are significant in this context. First, it is clear that health has long

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[2]For the purposes of this discussion, it is worth noting that global and public health are interrelated fields. Thus, global health law encloses all the legal instruments and norms aimed at securing the determinants of public health, with the aim of achieving the highest attainable standard of physical and mental health; see L Gostin and A Taylor 'Global health law: a definition and grand challenges' (2008) 1 Public Health Ethics 53.

[3]DP Fidler 'Constitutional outlines of public health's "new world order"' (2004) 77 Temple Law Review 247.

[4]See L Gostin *Global Health Law* (Cambridge, MA: Harvard University Press, 2014) and L Gostin and B Meier 'Introducing global health law' (2019) 47 The Journal of Law, Medicine & Ethics 788.

[5]See A Krajewska 'Transnational health law beyond the private/public divide: the case of reproductive rights' (2018) 45 Journal of Law and Society S220.

[6]T Schrecker 'The state and global health' in C McInnes and K Lee (eds) *The Oxford Handbook of Global Health Politics* (Oxford, Oxford University Press 2020) p 75.

[7]T Skocpol 'Bringing the state back in: strategies of analysis in current research' in PB Evans et al *Bringing the State Back In* (Cambridge: Cambridge University Press, 1985) p 3.

[8]MR Trouillot 'The anthropology of the state in the age of globalization: close encounters of the deceptive kind' (2001) 42 Current Anthropology 125 at 126.

[9]This view of the state draws on perspectives including T Lemke 'An indigestible meal? Foucault, governmentality and state theory' (2007) 8 Distinktion: Scandinavian Journal of Social Theory 43; K Jayasuriya 'Globalization, law and the transformation of sovereignty: the emergence of global regulatory governance' (1999) 6 Indiana Journal of Global Legal Studies 425; and C Death *The Green State in Africa* (New Haven: Yale University Press, 2016).

[10]See J Lander *Transnational Law and State Transformation. The Case of Extractive Development in Mongolia* (London: Routledge, 2020).

had an intimate connection with 'stateness'. The biopolitical task of tending to the welfare and growth of the population has been partly definitive of what it means to be a nation-state in Europe and its colonies since the eighteenth century.[11] At the most general level, state performance is measured against statistics for mortality, sickness, life expectancy and so on. More specifically, projects and institutions aimed at meeting these goals are developed under the auspices of the state on behalf of the people. We can talk meaningfully, then, about states as 'health states'. Secondly, in the present context it is important to recognise that global health has largely been practised in and imposed upon the post-colonial states of the Global South. The practices and discourses which make up the 'health state' in these countries are influenced by imperial precedents, by nationalist reaction to them after independence, and by their neo-imperial re-imposition more recently. Drawing on key commentary and illustrations of the post-imperial international economic order, we understand global health, therefore, with reference to empire, and its aftermath. Thirdly, states in the Global South have been tasked above all with achieving development. The latter variously formed the self-justification of colonialism, the promise of post-colonial regimes and, more recently, the object of foreign aid and global governance. We may speak of a 'developmental state' passing through these declensions, being modified by each as its practices are re-shaped and its ideologies re-oriented or overturned. Moreover, health improvement has been an aim, an index, and a means of development.[12] Infectious disease outbreaks and the inaccessibility of medicines, for example, matter for the state in and of themselves, but also because they will stop or reverse wider social progress.[13]

Thus, if we are to fill the descriptive and theoretical gap in research on global health we will have to take seriously the nature of Global South states as health and developmental states. That can only be done by taking seriously the trajectories of these states, and their changing relations of subordination, independence and mutual implication with other states, international organisations and non-state actors. History is essential to understanding here, not just as inert context, but as the ground worked-over in producing contemporary state forms.[14] The following sections build on these insights in providing an outline defence of our initial claim that the state matters in global health. The discussion is ordered chronologically, drawing on international legal and policy debates, as well as controversies and developments at national and regional levels. It is informed by scholarship in the history of public health, international relations, the history of empire and Third World approaches to international law.[15] Taken together, these will show the enduring influence of imperial forms of rule on global health governance. This influence is compatible with and, indeed, depends on the contemporary nation-state.

An interdisciplinary framing will allow us to identify distinct phases in the relationship between health and the state in the Global South. For each, we attend to the manner in which the state was constructed and reconstructed out of practices and discourses, themselves shaped by international and national politics. The first moves from imperial health, through late colonial developmentalism and anti-colonial nationalism. The second attends to the rise and fall of state-led development in the 1970s and its implications for health. The third tracks the emergence of global health governance out of structural adjustment and the so-called post-Washington consensus. We elaborate in more

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[11]W Walters *Governmentality: Critical Encounters* (London: Routledge, 2012) p 82 ff.

[12]M Woodling et al 'New life in old frames: HIV, development and the "AIDS plus MDGs" approach' (2012) 7 Global Public Health S148.

[13]The potential contribution of framing theory to an understanding of international health is showcased in C McInnes and K Lee (eds) 'Special supplement: framing global health governance' (2012) 7 Global Public Health S88 ff.

[14]T Mitchell 'Society, economy and the state effect' in G Steinmetz *State/Culture. State-Formation after the Cultural Turn* (Ithaca, NY: Cornell University Press 1999) p 76.

[15]For example F Cooper 'Modernising bureaucrats, backward Africans, and the development concept' in F Cooper and RM Packard (eds) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley, LA: University of California Press, 1996) p 64; A Anghie *Imperialism, Sovereignty and the Making of International Law* (Cambridge: Cambridge University Press, 2004) p 133; A Anghie 'Legal aspects of the new international economic order' (2015) 6 Humanity 145.

detail the imperial characteristics of this dispensation. In the penultimate section, we return to Covid-19, exploring the extent to which these characteristics marked the struggle for access to vaccines and the imposition of travel restrictions as between different regions. This review will confirm that the state is a key site for the practice of global health, which we need to take seriously if we are to avoid 'playing with abstractions' as Lander puts it.[16] In conclusion we shift to a more normative register, reflecting on the consequences for health and development of the neglect of the state in critical scholarship on global health. While abjuring any uncritical nationalism, we argue that the state remains a vital, if neglected, instance in the struggle against latter-day imperialism and for a fair international health order.

1. Segregation and security: imperial health

Overall, international health in the period before 1919 was characterised by sanitarian strategies focused on infectious disease control, realised by way of vertical interventions and co-ordinated through a fairly shallow system of inter-imperial governance.[17] Thus, while, early European travellers had been enthused by the fecundity of the tropics, the prevalent attitude changed considerably in the nineteenth century due to the high death rates of settlers and soldiers. What Arnold has called a 'discourse of tropicality' represented non-European terrains as inherently dangerous to white bodies, with 'disease, putrefaction and decay running rampant in the moist warm air'.[18] This fatalism was attenuated somewhat on the emergence of germ theory, pioneered in a spirit of inter-imperial competition, by Louis Pasteur and Robert Koch in the 1880s.[19] Supplied with suitable vaccines and medicines, and by following the correct hygienic and moral precautions, white Europeans might be able to protect themselves from contamination.[20] This was, in effect, 'an attempt to put a fence around Europe and around the European in the tropics'.[21] By contrast, there was little concern with the health of local peoples, who were rather presented as a source of risk and made the subject of police and zoning powers aimed at separation and control.[22] With British administrators 'lukewarm' about efforts to spread western medicine in India and Africa, for example, clinical work was largely left to Christian missionaries who saw it as valuable way of gaining new converts.[23]

Such pro-active public health initiatives as there were took the form of targeted and highly coercive 'disease campaigns' premised on the notion that indigenous communities were incapable of dealing with their own problems. For example, the American-led campaign against Yellow Fever in the Panama Canal zone before the First World War is a good example.[24] Supported by the International Health Board of the Rockefeller Foundation, guided by then newly opened public health institutes and schools of tropical medicine, and conducted by the US military and Centre for Disease Control, it also laid the foundations for subsequent public health governance in the field. While the substance of health law on the ground was largely at the discretion of the relevant colonial power, inter- and intra-imperial mobility was the subject of a series of International Sanitary Conferences

[16]See Lander, above n 10.

[17]N King 'Disease, commerce: ideologies of postcolonial global health' (2002) 32 Social Studies of Science 763.

[18]D Arnold '"Illusory riches". Representations of the tropical world 1840–1950' (2000) 21 Singapore Journal of Tropical Geography 6.

[19]WU Eckart 'The colony as laboratory: German sleeping sickness campaigns in German East Africa and in Togo, 1900–1914' (2002) 24 History and Philosophy of the Life Sciences 69.

[20]See G Bankoff 'Rendering the world unsafe: "vulnerability" as Western discourse' (2001) 25 Disasters 21.

[21]R Edmond 'Returning fears. Tropical disease and the metropolis' in F Driver and L Martins (eds) Tropical Visions in an Age of Empire (Chicago: University of Chicago Press, 2005) p 175 at p 184.

[22]The spatialisation of the three-way racial hierarchy in colonial Nairobi through public health zoning is a notable example: see GO Ndege Health, State and Society in Kenya (Rochester, NY: University of Rochester Press 2000) ch 2.

[23]D Arnold Colonising the Body: State, Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley, CA: University of California Press, 1993) p 244.

[24]RM Packard A History of Global Health. Interventions into the Lives of Other Peoples (Baltimore, MD: Johns Hopkins University Press, 2016) p 28.

inaugurated in 1851.[25] Concerned that the spread of 'Asiatic diseases' like plague and cholera would interrupt commercial and military flows, European powers agreed to standardise systems for reporting and responding to disease outbreaks. Thus, an 1892 convention specified quarantine arrangements in the Suez Canal. The annual pilgrimage to Mecca was also a constant object of anxiety and a focus for regulation. By contrast, infectious diseases particular to Europe were not addressed until 1926.[26]

The state that mattered in this period was the imperial state, whether formally in the case of the European powers or informally in the case of the US. It was made present in colonised territories through health-focused practices of monitoring and segregation, realised through a thin institutional network, and justified in terms of racially demarcated risk. This bare and often brutal regime was tempered only by the salvationist doctrines of non-state religious groups, who were as likely to be in conflict as in harmony with the colonial authorities.[27] There was little official international oversight of these states. To the extent that the interests of colonised peoples were articulated, this was done on their behalf by humanitarian organisations in the imperial metropoles. As Burbank and Cooper put it, 'empires maintain distinctions and hierarchy among people even as they incorporate them, forcefully or otherwise'.[28] Development played little role in this ensemble. Health – and, thus, the proper role of the state – was framed rather in terms of security and free trade.[29] We will see that, though complemented and sometimes eclipsed by other frames, these practices and ideologies haunt global health down to the present.

2. The League of Nations and late colonialism: health and development

Colonial sanitarianism was augmented by more ambitious strategies from the 1920s on, both at the level of international policy and within the European empires. Under the direction of Ludwik Rajchman, a Polish expert in social medicine, the League of Nations Health Organization (LNHO) delivered training and produced advice for member states on issues such as health sector reform and nutrition, well beyond simple vertical disease control.[30] Funded by Rockefeller, which had similarly widened its approach, the LNHO penetrated deeply into colonised societies. It prescribed health-promoting conduct for individuals and drew domestic agencies into an increasingly transnational network.[31] The League's structural and holistic approach was most prominently showcased in the Intergovernmental Conference of Far Eastern Countries on Rural Hygiene held at Bandoeng, Dutch East Indies (now Indonesia) in 1937, which was advised by agronomists, engineers and educationists, as well as health specialists.[32] The connection between health and development was made explicit for the first time in the conference report which argued inter alia for land reform in the service of rural reconstruction and health promotion. More generally, it stated that 'public health work in rural areas can often be used as the entering wedge for the development of a broader program embracing education, economics, sociology, engineering and agriculture'.[33] Bandoeng anticipated the more

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[25]O Aginam 'The nineteenth-century colonial fingerprints on public health diplomacy: a postcolonial view' (2003) 1 LGD: Journal of Law, Social Justice and Global Development 1.

[26]D Fidler 'From international sanitary conventions to global health security. The new International Health Regulations' (2005) 4 Chinese Journal of International Law 325 at 331.

[27]M Vaughan *Curing Their Ills: Colonial Power and African Illness* (Palo Alto, CA: Stanford University Press, 1991) p 288.

[28]J Burbank and F Cooper 'The empire effect' (2012) 24 Public Culture 239.

[29]C McInnes et al 'Framing global health: the governance challenge' (2012) 7 Global Public Health S83.

[30]T Brown and E Fee 'The Bandoeng Conference of 1937: a milestone in health and development' (2008) 98 American Journal of Public Health 42.

[31]MD Dubin 'The League of Nations Health Organization' in P Weindling (ed) *International Health Organizations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995) p 73. The functional agencies of the League, in health, economics and so on were considerably more successful and of longer term impact, than its failed diplomatic effort to preserve world peace: see M Mazower *Governing the World. The History of an Idea* (London: Penguin, 2012) p 143.

[32]S Litsios 'Revisiting Bandoeng' (2014) 8 Social Medicine 113.

[33]Report of the Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene held in Bandoeng, Java, 3–13 August 1937 reproduced in (2008) 98 American Journal of Public Health 40.

famous conference held in the same city (renamed Bandung) in 1955. Attended by representatives from colonised territories, as well as the European powers, its recognition of the specific role of women and its acknowledgment that the cultures, views and needs of colonised peoples were integral elements of public health work were novel to that point. It exercised considerable influence on the demands of independence movements at the time in India and elsewhere.[34]

The 1930s also saw a turn to development as a goal and source of legitimacy among the imperial powers. This was driven by local resistance, including a wave of industrial disputes across Africa during the Great Depression of the 1930s. As a result, Britain and France made unprecedented, though quite limited, efforts to promote the welfare of non-European populations in their territories. The UK's Colonial Development and Welfare Acts, for example, committed funds to services such as water, housing, education and health.[35] The scope and nature of these schemes was informed by the statistical methods of the newly emergent social sciences, which had been pioneered by LNHO. These allowed definition and quantification of need and of progress towards meeting it.[36] Intended as an 'antidote to disorder', they were also an early example of might be called 'trickle up': the hope that investment in welfare would boost productivity in the colonies.[37] Healthier workers would generate hard currency to the benefit of economically depressed metropoles. Ironically, perhaps, this revenue was indispensable to the foundation of Britain's own post-war National Health Service, which offered comprehensive care free at the point of use to all metropolitan citizens and was, thus, much more generous than its colonial equivalents.[38]

It is argued that colonial developmentalism hastened the end of colonial rule.[39] On the one hand, the effort to generate resources to fund welfare programmes imposed harsh new demands on subject peoples to contribute to projects, such as the ill-fated groundnut cultivation scheme in Tanganyika. On the other hand, expectations were created which colonial authorities were not willing to meet. Indeed, anti-colonial activists challenged the sincerity, effectiveness and scope of these imperial health projects as part of their campaigning. For example, in his trenchant critique, *How Britain Rules Africa* (1936), George Padmore noted that in Nigeria there was more 'money for police and prisons than for the health and education of 20,000,000 Africans' and pointed to the fact that healthcare services elsewhere still primarily served white settlers rather than the majority population.[40]

The 1920s and 30s can be seen as a period of transition, from the imperial order to the phase of decolonisation which followed the Second World War. Viewed from the latter vantage point, the idea of development functioned as a means of managing oncoming decolonisation and shaping successor states.[41] This effect was made visible with greatest clarity in the League of Nations' mandate system, under which formerly Turkish and German colonial possessions were taken over by Britain, France, Belgium and others.[42] Under the League Charter, these powers were subject to a 'sacred trust' to ensure the 'well-being and development' of the peoples under their control.[43] A Permanent Mandates Commission was established and received detailed reports on social matters, including health, which were used to monitor the situation of indigenous inhabitants. These colonial subjects were taken to be too backward to be capable of exercising sovereignty themselves. Rather, in an

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[34]S Amrith *Decolonizing International Health. India and Southeast Asia, 1930–1965* (Basingstoke: Palgrave Macmillan, 2006).

[35]Cooper, above n 15, p 64.

[36]A Escobar *Encountering Development: The Making and Unmaking of the Third World* (Princeton, NJ: Princeton University Press, 1995) p 21 ff.

[37]See further Cooper, above n 15, p 64.

[38]See AE Hinds 'Sterling and imperial policy, 1945–1951' (1987) 15 Journal of Imperial and Commonwealth History 148.

[39]F Cooper and AL Stoler 'Introduction – tensions of empire: colonial control and visions of rule' (1989) 16 American Ethnologist 609 at 619.

[40]G Padmore *How Britain Rules Africa* (New York: Lothrop, Lea and Shepart Company, 1936) p 224.

[41]Cooper, above n 15, p 64.

[42]See generally, S Pedersen *The Guardians. The League of Nations and the Crisis of Empire* (Oxford: Oxford University Press 2015).

[43]Covenant of the League of Nations, Art 22.

internationalised version of the imperial civilising mission, they could only become sovereign through achieving development under the tutelage of the mandate power, subject to ultimate supervision by the League of Nations.[44] Consequently, the sciences of development (within which we can include early forms of global health) would provide a warrant for 'native' self-determination, and also set the conditions on which it could be exercised in formally colonised regions, as well as mandate territories.[45] The League of Nations and late-stage European imperialism, thus, tended to create a proto-developmental state, through the incorporation of public health and other practices, realised by way of internationally networked institutions, all oriented to an ideology of economic growth and social progress. The state in this mode was subject to external invigilation, with only the prospect of conditional sovereignty in sight. While anti-colonial nationalists challenged the paternalistic and racist assumptions which delayed emancipation, as Bashford notes, they too 'saw a bright future in planned, hygienic post-colonial states'.[46]

3. Decolonisation and the new international economic order: national health

In 1948 the World Health Organization (WHO) replaced the LNHO. Its first two decades saw a turning away from the social medicine of the 1930s, in favour of vertical disease-focused strategies now driven by pharmaceutical breakthroughs.[47] Dominated by medical doctors, the WHO allied itself with capital-intensive biomedical science rather than more structural and participatory approaches to public health. This resonated with the style of Cold War politics internationally and within the US, the commodification of public health reproducing the pro-corporate stance of the Eisenhower administration. Ironically, it was also consistent with the hospital-based medicine favoured by the Soviet Union. Indeed, both sides funded discrete, health-related initiatives as part of their soft-power efforts, eg the US-led smallpox campaign in West Africa in the early 1960s, conceived as a response to the threat posed by Kwame Nkrumah and similar nationalist leaders.[48] The WHO's own campaign to eliminate smallpox worldwide, running from 1966 to 1980, remains its most notable achievement to date. However, a subsequent anti-malaria initiative based on the widespread use of chemical fumigation failed. Academics increasingly cast doubt on the 'wonder drug' narrative of progress which underlay the WHO's policies, pointing to the greater significance of less costly innovations, like sewage systems, nutrition, and the availability of clean water.[49]

Disenchantment with technocratic international health coincided with a changing geopolitical conjuncture as newly independent states became full members of the UN, the WHO, and other multilateral organisations. The New International Economic Order (NIEO) pursued by these states in the 1970s rested on the values of sovereignty and self-determination affirmed at the 1955 Bandung conference.[50] Although health as such had received little attention at Bandung, these values subsequently shaped the terms on which Third World states engaged with the WHO, pushing the Organization to recognise global economic injustice, and in particular the neo-colonial mode of value extraction, as a cause of poor health within countries and profound health inequalities between them. This was reflected in the WHO's increasingly critical focus on multinational companies and the negative health impacts of their operations.[51] The creation of an essential drugs list, in response to the overpromotion and dumping of expired products, is one notable example. The 1981 WHO/UNICEF Code to control

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[44]Pedersen, above n 42, p 203.

[45]Anghie (2004), above n 15, p 133. As Mazower notes, far from being the antithesis of imperialism, the League's internationalism is better seen as aiming to modernise and preserve it: see Mazower, above n 31, p 167.

[46]A Bashford 'Global biopolitics and the history of world health' (2006) 19 History of the Human Sciences 67 at 77.

[47]Packard, above n 24, p 89 ff.

[48]Ibid, p 150.

[49]For example T McKeown *The Role of Medicine: Dream, Mirage or Nemesis?* (Oxford: Blackwell, 1979).

[50]B Benjamin 'Bookend to Bandung. The new international economic order and the antinomies of the Bandung era' (2015) 6 Humanity 33.

[51]N Chorev *The World Health Organization Between North and South* (Ithaca, NY: Cornell University Press, 2012) p 86 ff.

the marketing of breastmilk substitutes is another. The spirit of the LNHO conference at Bandoeng, discussed above, was evident in the return to favour of a broad view of health and the factors which are imperative for good health. Article 12 of the International Covenant on Economic Social and Cultural Rights, which came into force in 1976, bound states to realise 'the highest attainable standard of health' for their populations, through securing its 'underlying determinants', including sanitation, food and education. In the Declaration of Alma Ata (1978), the WHO and its member states prioritised primary care accessible to rural populations, delivered by non-medical staff as well as communities themselves, over expensive, highly-commodified and donor-funded medicine, concentrated in relatively privileged urban areas.[52]

The WHO's turn to primary care was influenced by Chinese innovations, most famously the training of 'barefoot doctors', but also the valorisation of indigenous medicine and its inclusion in the formal health care system. National level policies were motivated by a similar combination of sovereignty, self-determination, and solidarity. In a departure from the inherited colonial model, the Indian Patent Act 1970 limited intellectual property rights to production processes rather than products themselves. This allowed cheaper copies to be made lawfully by other means, spurring the development of a substantial generic pharmaceuticals industry serving much of the Third World.[53] To take another example, Tanzania's 'Mtu ni Afya' (the person is health) programme formed an important part of President Julius Nyerere's strategy of 'kujitegemea' (self-sufficiency).[54] Like Nkrumah's Ghana and revolutionary Zimbabwe, it also established a traditional medicine research centre with Chinese assistance, aiming to develop what Langwick has memorably called 'non-aligned medicines'.[55] This then was an era of state-led development, including health as a key goal, with considerable policy discretion for Third World nations, aided by South-South cooperation and generally favourable multilateral institutions.

It is important to recognise that the foregoing is a necessarily foreshortened description of a considerably more varied global health scenario. The WHO never fully adopted the Third World argument that lopsided economic development needed to be addressed as such in order to secure better health, preferring to stay within its perceived areas of expertise and political room for action.[56] Even those progressive initiatives which it did promote were marked by a culturalist developmentalism which traded on the presumed backwardness of local people, itself a carryover from the colonial and League of Nations periods. For instance, the WHO/ UNICEF Code was justified on the basis that uneducated mothers in the Global South were misusing breastmilk substitutes to the detriment of their infant children, and thus in need of protection against the encroachment of modern consumerism.[57] Moreover, states which remained allies of the former colonial powers and the US, Kenya for example, tended to be less enthusiastic in their adoption of 'health for all' strategies.[58] In others, such as Chile, the socialisation of medicine was reversed as reforming governments were overthrown with Western help.[59]

Developmental states had political pathologies of their own which shaped the impact of health policies on their citizens. For example, in 1976, frustrated by the global economic crisis and by domestic

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[52]B Mason Meier 'The World Health Organization, the evolution of human rights and the failure to achieve health for all' in J Harrington and M Stuttaford (eds) *Global Health and Human Rights. Legal and Philosophical Perspectives* (London: Routledge, 2010) p 163.

[53]V Mahajan 'Structural changes and trade competitiveness in the Indian pharmaceutical industry in product patent regime' (2019) 13 International Journal of Pharmaceutical and Healthcare Marketing 21. The distinction between 'product' and 'process' was removed in 1995, in implementation of India's obligations under the World Trade Organization's TRIPS Agreement: see the discussion below.

[54]For an overview see O Gish *Planning the Health Sector: The Tanzanian Experience* (London: Croom Helm, 1976).

[55]S Langwick 'From non-aligned medicines to market-based herbals: China's relationship to the shifting politics of traditional medicine in Tanzania' (2010) 29 Medical Anthropology 15.

[56]Chorev, above n 51, ch 2.

[57]L Newton 'Truth is the daughter of time: the real story of the Nestle case' (1999) 104 Business and Society Review 367.

[58]Ndege, above n 22, ch 5.

[59]S Reichard 'Ideology drives health care reforms in Chile' (1996) 17 Public Health Policy 80.

opponents, Indian prime minister Indira Gandhi declared a state of emergency. This was continued after resistance had been crushed, in the name of stability and economic development and included a population policy which led to millions of forced sterilisations, particularly of minority groups.[60] The campaign proceeded from a union of demographic theory with national planning and the idea that a reduction of the birth rate was central to poverty reduction, itself intensively promoted by the UN and major aid donors throughout the period.[61] Similarly, African socialism in Tanzania took the form of villagisation in a manner reminiscent of counter-insurgency strategies deployed by Britain in Kenya and the US in Vietnam.[62] As in those cases, selective access to health care was used to coerce reluctant peasants into participating.

Decolonisation was predicated on subject peoples adopting the form of the nation-state.[63] Though the latter was pre-defined and underwritten by international law, it was also a key demand of anti-colonial leaders themselves. 'Seek ye first the political kingdom' as Nkrumah put it.[64] Accordingly, the collective right to self-determination was listed first in the UN covenants on civil and political rights, and on economic social and cultural rights which came into force in 1976.[65] The NIEO, adopted by the UN General Assembly in 1974 and referenced in the WHO's Declaration of Alma Ata in 1978, also elevated 'sovereign equality' and 'non-interference' as principles of international relations.[66] Third World countries would be free to choose the 'economic and social system', and the constitutional ordering, they considered 'most appropriate to their needs'.[67] According to the NIEO, global injustice manifested as underdevelopment, and resulted from the system of trade between states, itself a legacy of colonialism. Externally, states were thus cast as key actors in the quest for a fair economic order and for restorative justice.[68] Internally, they were permitted to define the scope of development and the means needed to achieve this. The practices and institutions which realised health promotion, as part of that developmental effort – teaching hospitals, research centres, nutrition programmes, and so on – were marked as national and justified in terms of a popular project for collective betterment.[69] Taken together, they helped to define the independent state in jurisdictional, spatio-temporal and normative terms, as an ideally sovereign, territorially-bounded entity, overcoming past disadvantage, and making process towards a shared national future.[70]

4. Roll-back and roll-out neoliberalism: global health

By the early 1980s the NIEO had foundered on the rocks of Third World indebtedness, worsening terms of trade, and concerted action by the Western powers. The influence of the WHO waned as its primary care strategy, giving states wide discretion, proved difficult to implement. In response,

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[60]RJ Williams 'Storming the citadels of poverty: family planning under the Emergency in India, 1975–1977' (2014) 73 Journal of Asian Studies 47.

[61]A Ahmed 'Bandung's legacy: solidarity and contestation in global women's rights' in L Eslava et al (eds) *Bandung, Global History and International Law. Critical Pasts and Pending Futures* (Cambridge: Cambridge University Press, 2017) p 450.

[62]P Lal *African Socialism in Postcolonial Tanzania: Between the Village and the World* (Cambridge: Cambridge University Press, 2015); C Elkins *Britain's Gulag. The Brutal End of Empire in Kenya* (London: Bodley Head, 2005) ch 4; M Latham *Modernization as Ideology: American Social Science and 'Nation Building' in the Kennedy Era* (Chapel Hill: University of North Carolina Press, 2000) ch 5.

[63]P Chatterjee 'The legacy of Bandung' in Eslava et al, above n 61, p 655 at p 658.

[64]K Nkrumah *Ghana: The Autobiography of Kwame Nkrumah* (Edinburgh: Nelson, 1957) p 112.

[65]S Moyn *The Last Utopia. Human Rights in History* (Cambridge, MA: Belknap, 2010) p 96.

[66]United Nations General Assembly *Declaration on the Establishment of a New International Economic Order* (1974) A/RES/3201(S-VI).

[67]O Gish 'The relation of the new international economic order to health' (1983) 4 Journal of Public Health Policy 207 at 218; G Rist *The History of Development. From Western Origins to Global Faith* (London: Zed, 5th edn, 2019) p 147.

[68]Anghie (2015), above n 15.

[69]See for example K Ombongi 'The historical interface between the state and medical science in Africa: Kenya's case' in P Wenzel Geissler and C Molyneux *Evidence, Ethos and Experiment. The Anthropology and History of Medical Research in Africa* (New York: Berghahn, 2011) p 353.

[70]L Eslava and S Pahuja 'The state and international law: a reading from the global south' (2019) Humanity 118.

targeted vertical approaches based on quantifiable goals, returned to favour (again) in international health, most notably UNICEFs Growth Oral Rehydration Breastfeeding and Immunization (GOBI) initiative.[71] More broadly, health issues were 'forum-shifted' away from the UN and the WHO where Third World influence had been strong, and into multilateral institutions, dominated by the US and its allies, particularly the World Bank, a move which was aided by the loan-dependency of Third World states.[72] Structural adjustment programmes mandated privatisation and the imposition of user fees for public services, including health care.[73] The accessibility of medical care was dramatically reduced as a result, confirming experience after the introduction of similar reforms in Chile after the Pinochet coup in 1973.[74] Women's health and their burden of care labour worsened dramatically. Gains in life expectancy made since the period of decolonisation were reversed. The austerity regime contributed to the spread of HIV/AIDS across the Third World and left governments and populations defenceless in its face.

Structural adjustment programmes were the sentinel of a new global economic order with profound implications for the content of health policies and the range of actors responsible for delivering them.[75] The reduction of barriers to capital movement and the 'implicit conditionalities' imposed by financial markets (eg low and regressive taxes) limited the state's fiscal capacity to lead on development and public health, as Schrecker has noted.[76] Treaties establishing the World Trade Organisation (WTO) in 1995 thickened out this normative regime, strengthening the relative power of private corporations based in the Global North. Tobacco companies, for example, were able to challenge domestic non-tariff measures aimed at the reduction of smoking in Thailand.[77] The WTO's Trade Related Intellectual Property Agreement (TRIPs) bound state parties to accord a high level of protection to corporate monopolies over knowledge, including a minimum 20-year patent duration with strict limitations on the power of governments to override them. Its requirement that patents be afforded over products, as well as production processes, led India to undo the pro-access to medicine provisions of its 1970 Patent Act discussed above, hobbling the capacity of its generic drugs industry to respond to the HIV/AIDS pandemic.[78]

The earlier phase of 'roll-back' neoliberalism ('the Washington Consensus'), was followed in the 1990s by a longer lasting 'roll-out programme ('the Post-Washington Consensus'), itself facilitated by a reordering of the nexus between health and development established during the NIEO period.[79] With its vastly greater resources and unique ability to make loans conditional on the local implementation of systemic reforms, the World Bank eclipsed the WHO as the key multilateral actor in health across the Third World. Its World Development Report of 1993, suggestively titled *Investing in Health*, was a landmark in this regard. Revising the orthodoxy of the 'roll-back' period, the Report argued that medical care and public health were best understood not as simple costs, but as a means to boost economic growth. The health sector, even in poor countries, now mattered because it furnished the prerequisites for increased productivity and provided opportunities for private accumulation.[80] *Investing in Health* launched the World Bank's wider and more active 'roll-out' intervention in the Third World, funding, guiding and monitoring health promotion, as well as promoting commercial activity in the sector.

[71]R Jolly *UNICEF. Global Governance that Works* (London: Routledge, 2014).

[72]DJ Sargeant 'North/south: the United States responds to the new international economic order' (2015) 6 Humanity 201.

[73]See for example the data presented in J Lennock *Paying for Health. Poverty and Structural Adjustment in Zimbabwe* (Oxford: Oxfam, 1994).

[74]Reichard, above n 59.

[75]S Gill 'Globalisation, market civilisation, and disciplinary neoliberalism' (1995) 24 Millennium 399.

[76]T Schrecker 'Globalization, austerity and health equity politics: taming the inequality machine, and why it matters' (2016) 26 Critical Public Health 4.

[77]SR Benatar et al 'Global health and the global economic crisis' (2011) 101 American Journal of Public Health 648.

[78]Mahajan, above n 53; T Amin 'Revisting the patents and access to medicines dilemma' in O Aginam et al (eds) *Global Governance of HIV/AIDS. Intellectual Property and Access to Essential Medicines* (Cheltenham: Edward Elgar, 2013) p 109.

[79]J Peck and A Tickell 'Neoliberalizing space' (2002) 34 Antipode 380.

[80]Woodling et al, above n 12.

Seeking to regain influence by adapting to the changed international environment, the WHO convened a Commission on Macroeconomics and Health which reported in 2001. It was led by US development economist, and sometime partisan of structural adjustment, Jeffrey Sachs, with other members drawn from academia and business, but significantly not public health. The Commission marshalled evidence to show that disease was a cause of poverty, and that 'investments to improve health should form a key strategy towards economic development'.[81] Sachs and colleagues represented private corporations as potentially benevolent actors in international health, needing only adequate incentives to contribute positively. In this spirit they defended the global intellectual property regime as a precondition for pharmaceutical innovation. Commentators criticised the Commission's revival of the 'trickle up' approach to health and development which had been a feature of colonial policy, as we noted above.[82] Rather, they argued that poverty, and indeed inequality per se, is a much more potent cause of ill health, than the other way around. Predicating development on health was counterproductive, according to Waitzkin, because it took attention away from the need for broader redistributive policies, nationally and globally, and encourages a focus on specific communicable diseases rather than the creation of integrated health systems.[83]

The nation-state was, thus, pegged back fiscally and discursively in this new regime, which has been characterised as shifting from international health law to global health governance.[84] The 1981 WHO/UNICEF code on the marketing of breastmilk substitutes, mentioned above, can itself be seen as a cusp moment between these two formations. On the one hand, it was aimed at the deleterious effects on Third World citizens of formula milk produced by commercial firms headquartered in the Global North. As such it was consistent with the campaign for a NIEO. On the other hand, it exemplified a form of Post-Westphalian governance beyond the state quite at odds with that earlier phase. As a 'soft law' instrument, rather than a binding treaty, its implementation depends on voluntary measures taken by states, and on NGO campaigns to 'name and shame' code violators.[85] Moreover, the Code originates in a consumer boycott campaign in Europe and the US, directed at food companies involved marketing formula milk in the Global South. This leveraged the workings of the market through influencing the choices of consumers, instead of seeking to outflank or confront it head-on.[86]

These features were taken up and expanded in the much-delayed response to HIV/AIDS, as well as the so-called 'neglected diseases', which saw a massive increase in global health funding from the late 1990s on. Much of this originated with the US government and philanthropies, most notably the Gates Foundation, and was channelled through dedicated agencies, such as the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Fund for AIDS Relief (PEPFAR).[87] Donor apprehension about the multilateral, state-centric governance structure of the WHO meant that the funding either bypassed the Organization completely or was earmarked for specific disease-focused programmes.[88] At national level, though the GFATM was committed to 'country ownership', this was realised through mechanisms which marginalised elected governments in favour of civil society and professional representation.[89] The proliferation of funders and agencies responding

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[81]Commission on Macroeconomics and Health *Report of the Commission on Macroeconomics and Health* (Geneva: WHO, 2001).

[82]D Banerji 'Report of the Commission on Macroeconomics and Health: a critique' (2002) 32 International Journal of Health Services 733.

[83]H Waitzkin 'Report of the WHO Commission on Macroeconomics and Health: a summary and critique' (2003) 361 The Lancet 523.

[84]D Fidler 'Germs, norms and power: global health's political revolution' (2004) 1 Law, Social Justice and Global Development Journal, https://warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/fidler/.

[85]SP Sethi *Multinational Corporations and the Impact of Public Advocacy on Corporate Strategy. Nestlé and the Infant Formula Controversy* (Dordrecht: Kluwer, 1994).

[86]T Sasson 'Milking the Third World? Humanitarianism, capitalism and the moral economy of the Nestlé boycott' (2016) 121 American Historical Review 1196.

[87]Packard, above n 24, p 289 ff.

[88]Chorev, above n 51, ch 4.

[89]See S Sekalala *Soft Law and Global Health Problems: Lessons from Responses to HIV/AIDS, Malaria and Tuberculosis* (Cambridge: Cambridge University Press, 2017).

to the AIDS pandemic and other 'global health challenges' has led to fragmentation in delivery and incoherence in policymaking. On the ground, an archipelago of 'international standard' facilities, focusing on problems favoured by donors and linked to Western institutions through research protocols and expatriate contracts, exists within a wider terrain of 'national standard' facilities depleted by structural adjustment and health worker migration.[90]

No longer the bearer of historic justice claims or the central agent of progress in health and development, the Third World state was now subject to formal constraint externally and substantive restructuring internally. The sovereign equality claimed at Bandung in 1955 and through the NIEO subsequently was undone by moving health and other issues out of fora where each counted equally (eg the UN General Assembly and the WHO), and into those where historic asymmetries of power between North and South were reflected in differential voting rights (eg the World Bank) or in the terms of founding treaties (eg the WTO).[91] This strategic defeat in international relations was underpinned by a problematisation of states themselves as the source of injustice and developmental failure. Allegedly endogenous tendencies, such as corruption, authoritarianism and inefficiency, were posited as the cause of inequality as between countries, not the world economic system or the legacy of colonialism. Development and better health thus depended on 're-engineering the institutional form of the state and its relation with the exterior'.[92] This took three related forms: transnationalisation; unbundling; and governmentalisation.[93] *Transnationalisation* of the state involved the intensification of links between specific ministries and agencies and their counterparts in multilateral institutions and donor countries.[94] Blood transfusion services, for example, might be wholly-funded and partly-staffed by US partners, and run in accordance with WHO guidelines.[95] *Unbundling*, a corollary of this, resulted from a weakening of horizontal links between state health bodies domestically, with each being sustained vertically by different external sponsors.[96] Thus, health facilities in various regions of a single country might be supported by a variety of European donors, each with different operational routines and strategic objectives. *Governmentalisation*, realised through both of the foregoing tendencies, saw multilateral institutions, donors and, ultimately, philanthropies shaping and monitoring the exercise of state functions in detail.[97] Sovereignty was no longer recognised as such, but would rather be conditional on the delivery of health and other developmental programmes.[98] Performance in that regard would be defined and measured through the pervasive and intensive deployment of 'governance technologies' such as indices, benchmarks, audits and league tables.[99] These allowed 'poor countries to be known, specified and intervened upon' as Escobar put it.[100] The jurisdictional unity and spatio-temporal coherence of the nation-state leading its people along a developmental trajectory which had marked the NIEO period was left behind.[101] No longer a national project, health was at one

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[90]See V-K Nguyen *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS* (Durham, NC: Duke University Press, 2011).

[91]S Grovogui 'Regimes of sovereignty: international morality and the African condition' (2002) 8 European Journal of International Relations 315.

[92]C Tan *Governance Through Development. Poverty Reduction Strategies, International Law and the Disciplining of Third World States* (London: Routledge, 2011) p 98.

[93]Eslava and Pahuja, above n 70.

[94]K Jayasuriya 'Globalisation, law, and the transformation of sovereignty: the emergence of global regulatory governance' (1999) 6 Indiana Journal of Global Legal Studies 425.

[95]See WH Schneider *The History of Blood Transfusion in Sub-Saharan Africa* (Athens, OH: University of Ohio Press, 2013).

[96]B de Sousa Santos 'The heterogeneous state and legal pluralism in Mozambique' (2006) 40 Law and Society Review 1.

[97]L Zanotti 'Governmentalizing the post-Cold War international regime: rhe UN debate on democratization and good governance' (2005) 30 Alternatives 461.

[98]Anghie (2004), above n 15, p 245.

[99]V Adams 'Metrics of the global sovereign: numbers and stories in global health' in V Adams (ed) *Metrics: What Counts in Global Health* (Durham, NC: Duke University Press, 2016) p 19.

[100]Escobar, above n 36.

[101]PW Geissler 'Introduction. A life science in its African para-state' in PW Geissler (ed) *Para-States and Medical Science. Making African Global Health* (Durham, NC: Duke University Press, 2015) p 1.

and the same time a matter of discrete initiatives and the object of universally-framed human rights enforced variously by domestic courts, international bodies and non-governmental actors. Health-related human rights provided a further normative basis for governing states, elevating the claims of individuals, and, thus, setting limits to collective self-determination.[102] From a historical point of view, it is worth recalling Moyn's persuasive claim that, far from being implicit in the anti-colonialism of Bandung and the NIEO, the rise to prominence of human rights, in health as elsewhere, was only possible with the defeat of these movements.[103]

5. The constitution of global health: cosmopolitan or Imperial?

The rise of global health has been underpinned ideationally by normative and scientific universalism. We have already noted the importance of human rights in this discursive formation. More fundamental still has been the image and self-image of the health professions. If 'pathogens carry no passports' (perhaps *the* motto of global health), then the medical sciences which study and respond to them must be equally unconstrained.[104] Unsurprisingly perhaps Médecins sans Frontières/ Doctors without Borders is the name of the leading global health-focused NGO, born out of a repudiation of the respect for national sovereignty traditionally practised by the Red Cross.[105] The epistemic undercore of a world-wide science sustains an ethical universalism intolerant of national peculiarities and shortcomings.[106] The power of this combination lies in its legitimacy among professionals and wider populations around the world, its outreach far greater than, say, the neo-classical economic doctrine which served to justify structural adjustment and the post-Washington consensus which followed it. The institutional and practical consequences of that process, discussed in the previous section – transnationalisation, unbundling, and governmentalisation – can be viewed together as creating the elements of a global health constitution, which aspires to condition and constrain the exercise of state sovereignty in the Third World.[107]

However, as Kornprobst and Strobl suggest, realisation of this cosmopolitan ideal has been frustrated by the workings of the broader international political order.[108] Whereas medicine itself has largely left behind the racially-defined segregation of late nineteenth and early twentieth century public health, high-level diplomacy remains concentrated on securing the strategic interests of Global North states and the welfare of their populations. Two equivalent, indeed rival constitutional orders are advanced thereby, both of which limit contemporary 'global health'. First, as Gill argues, a global economic constitution has entrenched the interests of investors and intellectual property holders by effectively limiting the policy and legislative competence of national governments and removing relevant dispute settlement to largely unaccountable, private fora.[109] Secondly, the security concerns of European and North American countries have also profoundly shaped the institutions and practices of global health as realised within and through Third World states, again with constitutional effects. Global North states acted in concert to reform the WHO's International Health Regulations (IHR) in 2005, which now impose obligations on states to maintain the capacity to identify and respond to epidemic outbreaks.[110] Non-governmental actors can now outflank the official sources by providing

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[102]Gostin, above n 4, ch 2.

[103]Moyn, above n 65, p 119.

[104]See for example O Aginam 'Between isolationism and mutual vulnerability. A south-north perspective on global governance of epidemics in an age of globalization' (2004) 77 Temple Law Review 297 at 303.

[105]P Redfield 'Doctors, borders and life in crisis' (2005) 20 Cultural Anthropology 328.

[106]M Kornprobst and S Strobl 'Global health: an order struggling to keep up with globalization' (2021) 97 International Affairs 1541.

[107]G Ooms and R Hammonds 'Global constitutionalism applied to global health governance: uncovering legitimacy deficits and suggesting remedies' (2016) 12 Globalization and Health 84.

[108]Kornprobst and Strobl, above n 106, at 1543.

[109]S Gill and I Bakker 'The global political economy and global dealth' in SR Benatar and G Brock (eds) *Global Health Ethics* (Cambridge: Cambridge University Press, 2011) p 221.

[110]D Fidler and L Gostin 'The new international health regulations: an historic development for international law and public health' (2006) 93 Journal of Law, Medicine and Ethics 8.

outbreak information directly to the WHO. In other words, the global health constitution partakes significantly of a combined economic and security ordering which limits sovereignty in the Global South and tends to advance the interests of Global North states. As such, it can be reproducing a set of unequal international relations sharing characteristics with earlier periods of formal imperialism.

The concept of 'imperialism' has analytical value here above and beyond its (wholly understandable) usage in polemics about global justice. It acknowledges that contemporary global health is inevitably done on 'terrain that various sorts of colonialism have worked over'.[111] While there can be no simple repetition of the historic practices, institutions and ideational forms discussed in earlier sections, these have provided an indispensable repertoire for the contemporary production and disciplining of health states. An open reckoning with imperialism also counters the tendency to neglect questions of power and conflict and instead to privilege a simple functionalism.[112] Rather than all of humanity facing a set of common health challenges in the here and now, ill-health and responses to it are produced by historically inflected relations of inequality which run through the state-system.[113] Recovery of imperialism as a category of analysis and critique has a re-territorialising effect, bringing us back to the concrete practices in specific locations, each with its distinct though interconnected trajectory, by which health law and policy is realised.

Given confines of space, we can do no more than signal the potential for further development of this analytic. To that end, four implications of the 'imperial' are offered here as an aid to understanding global health:

First, a *dynamic of inclusion and inequality* was common to formal empires, based as they often were on a graduated scale of citizens, semi-citizens, and subjects.[114] Like the British Empire with its enduring order of rank and preferment, global health is an enterprise all-encompassing in ambition and territorial reach, though stratified in operational practice. Resources are promised to 'all of humanity' but delivered on highly unequal terms.[115] (By contrast, national health policies up to the 1980s were addressed to all citizens within the territory equally, but only to them.) Thus, as noted above, drug and vaccine trials may provide access to care for patients and the experience of research-based medicine for professionals in Third World countries. But these opportunities are only available to select groups and only where the matter to be tested offers a likely return, whether reputational or financial. As Crane has shown, notwithstanding the good intentions of most Northern partners, the global health regime profits from the very inequality it aims at eliminating.[116] This tendency reaches its ultimate point in the humanitarian framing of emergency global health interventions, which presupposes a fundamental inequality between donor and recipient permitting exceptional action.[117]

Secondly, the *extraction of valuable resources on unequal terms* was an explicit feature and, indeed, purpose of imperial systems, one which has endured more covertly in the form of neo-colonial arrangements between independent states. (By contrast, under the NIEO the Global South asserted permanent sovereignty over its natural resources.) The so-called biopiracy of traditional remedies, as well as plant samples and genetic materials, is a high-profile example in this context, one which is facilitated at community and state level by a combination of bribery and the asymmetric operation of global intellectual property rules. Similar practices and institutions are needed to allow the smooth

[111]W Anderson 'Making global health history: the postcolonial worldliness of biomedicine' (2014) 27 Social History of Medicine 372 at 381.

[112]S Hodges 'The global menace' (2011) 25 Social History of Medicine 719 at 720.

[113]For a defence of the former perspective see MA Stevenson and AF Cooper 'Overcoming constraints of state sovereignty: global health governance in Asia' (2009) 30 Third World Quarterly 137.

[114]S Strange 'Towards a theory of transnational empire' in E-O Czempiel and J Rosenau (eds) *Global Changes and Theoretical Challenge. Approaches to World Politics for the 1990s* (Lexington, VA: Lexington Books, 1989) p 167.

[115]See F Cooper *Africa in the World. Capitalism, Empire, Nation-State* (Cambridge, MA: Harvard University Press, 2014) p 38 ff.

[116]JT Crane *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science* (Ithaca, NY: Cornell University Press, 2013).

[117]D Fassin *Humanitarian Reason. A Moral History of the Present* (Berkeley, CA: University of California Press, 2012) p 4.

transfer of reliable trial data from Third World sites to Global North institutions.[118] Labour has been another exploitable source of value, historically in agriculture, mining and domestic service, for example, and latterly through the recruitment of health professionals to meet staffing shortages in European and North American institutions.

Thirdly, imperial rule commonly depended on the *co-option, reconstruction, and invigilation of authorities 'on the ground'*. Colonised territories were rarely governed directly from the metropole, but more frequently by way of indirect rule, as practised in many British colonies, or the demarcation of *evolué* administrators from dominated *indigenes* in French territories.[119] Of course, the period of formal empire has long ended, replaced by the norm of sovereign equality. Nonetheless, as we have seen, the defeat of Third World nationalism and the NIEO led to the governmentalisation and trans-nationalisation of the state in a manner reminiscent of indirect rule, as Hindness has pointed out.[120] In an echo of the League of Nations' approach discussed above, the promise of full self-determination in the Global South is, thus, predicated on the demonstration of a certain collective maturity through complying with good governance conditionalities and meeting targets set by the economic, social and health sciences.[121]

Fourthly, *the national interests of a distinct metropolitan core predominated over those of the colonised periphery*. This is contrary to latter-day historiography, which proposes erroneously that territories and peoples were conquered in 'a fit of absent-mindedness', or even for their own good.[122] It equally challenges the claim of contemporary social theorists, such Hardt and Negri, that a smooth global order, with no core or periphery, emerged with economic globalisation and the rise of a truly transnational capitalist class in the 1990s.[123] Developments since then have confirmed the rival view of more perceptive critics who noted the persistently asymmetric and partial nature of international governance in finance, trade, military affairs, and – we can add in this context – health.[124] Thus, Weir and Mykhalovskiy have argued that developments in global health, including the passage of the IHR, were significantly motivated by a concern to protect the specific interests of Northern states.[125] As they note, American professionals, academics and institutions both civilian and military, have been active in domestic, bilateral and multilateral contexts, building the global health security order, for example. These interventions have been justified (no doubt in good faith) through an uneasy but necessary identification of public health universalism with the national interest.[126] The US matters as a state, like others, though in a manner specific to its relative size and power in the international order.[127] This perspective is shared by orthodox commentators who frankly declare that US is the 'indispensable nation', the hub of empire, promoting collective interests in security and the capitalist economy.[128] More precisely it reflects Ahmad's reading of American foreign policy post-World War II as one of supporting decolonisation, while promoting 'an imperialism of our time' that works through independent states.[129]

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[118]See Adams (ed), above n 99.

[119]M Mamdani *Citizen and Subject* (London: James Currey, 1997).

[120]B Hindness 'Liberalism – what's in a name?' in W Larner and W Walters (eds) *Global Governmentality. Governing International Spaces* (London: Routledge, 2004) p 34.

[121]Chatterjee, above n 63, p 655.

[122]See for example N Ferguson *Empire: How Britain Made the Modern World* (London: Penguin, 2004).

[123]M Hardt and A Negri *Empire* (Cambridge, MA: Harvard University Press, 2000) p xiii.

[124]AA Boron *Empire and Imperialism. A Critical Reading of Michael Hardt and Antonio Negri* (London: Zed, 2005) p 58 ff.

[125]L Weir and E Mykhalovskiy *Global Public Health Vigilance. Creating a World on Alert* (London: Routledge, 2010) p 51.

[126]P Calain 'From the field side of the binoculars: a different view on global public health surveillance' (2007) 22 Health Policy and Planning 13.

[127]L Panitch 'The new imperial state' (2000) 2 New Left Review (ns) 5; J Levich 'The Gates Foundation, ebola, and global health imperialism' (2015) 74 American Journal of Economics and Sociology 704.

[128]See references to Zbigniew Brzezinski, Thomas Friedman and Madeleine Albright in L Panitch and S Gindin 'Global capitalism and American empire' in L Panitch and C Leys (eds) *Socialist Register 2004* (London: Merlin Press, 2004) p 1 at p 1.

[129]A Ahmad 'Imperialism of our time' in Panitch and Leys (eds), above n 128, p 43.

6. 'Imperial continuities': Covid-19 and global health

Covid-19 moved global health to the centre of attention among practitioners and scholars of international relations, and indeed in the minds of the wider population around the world. International organisations, notably the UN and the WHO, affirmed that the pandemic was a challenge facing the whole of humanity.[130] Universal human rights should shape defensive responses, such as lockdowns and travel restrictions, permitted under the IHRs, requiring them to be scientifically based, non-discriminatory and proportionate to the ends sought.[131] Access to medicines and other positive measures to protect individuals should be predicated on need and sound infection-control strategies.[132] In practice, however, responses to the pandemic were marked by a failure to live up to this cosmopolitanism, and by a reassertion instead of the imperial dimensions of global health's constitution. Thus, in a reprise of the dynamic of inclusion and inequality, Global North states imposed severe and asymmetrical restrictions on travellers from the Global South. For example, in April 2021 the British authorities required travellers from states, mostly from Africa and Latin America, to spend two weeks in quarantine after landing in the UK.[133] This applied even where these travellers could show that they had been inoculated using the WHO-approved vaccines. At the same time, many of these countries had been effectively forced to permit the entry of travellers from Europe and North America in the interests of local tourism and other industries.[134] Ironically, samples of an emerging variant of the Coronavirus, discovered and shared as a valuable resource by scientists in the Global South, provided the basis for disproportionate restrictions in this way. Internally, most states implemented lockdowns, curfews and restrictions on movement in an attempt to check the spread of Covid-19.[135] Those imposed in many Global South states were qualitatively harsher, supported by military deployment and the application of indiscriminate and often lethal force, demolition of houses and arbitrary deprivation of livelihoods and access to nutrition. Commentators noted the continuity with colonial authoritarianism and with the coercive segregation strategies of imperial public health.[136]

It has been in relation to the procurement and distribution of vaccines and personal protective equipment that the privileging of the metropolitan core over the interests of the periphery has been most evident. Initially, at least, the fact that the virus spread across the northern hemisphere in early 2020, from China into Europe and North America, meant it was not possible to pursue a rhetorical strategy of 'extraversion', representing the Third World as a 'reservoir of infection' threatening the Global North unless aid was forthcoming.[137] On the contrary, formal multilateral initiatives, aimed at global fairness and an epidemiologically rational response, were bypassed by Western governments. Protective equipment was stockpiled and vaccines pre-emptively bought, marginalising the WHO's COVAX procurement system which had been intended to achieve global solidarity, pooling coverage and risk.[138] The iron lock of patent law over essential vaccines remained in place to the benefit of pharmaceutical companies based in the Global North. A campaign, ongoing at the time of writing, to introduce an appropriate waiver into the TRIPS Agreement has made limited progress to

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[130]See United Nations 'Human rights must guide COVID-19 recovery: Secretary-General', 24 April 2020, https://www.un.int/news/human-rights-must-guide-covid-19-recovery-secretary-general.

[131]See WHO 'Addressing human rights as key to the COVID-19 response', 21 April 2020, https://www.who.int/publications/i/item/addressing-human-rights-as-key-to-the-covid-19-response.

[132]UN Committee on Economic, Social and Cultural Rights (CESCR) 'Statement on the Coronavirus disease (COVID-19) pandemic and economic, social and cultural rights', 17 April 2020, E/C.12/2020/1.

[133]Department of Transport 'Countries added to red list to protect UK against variants of concern' 2 April 2021, https://www.gov.uk/government/news/countries-added-to-red-list-to-protect-uk-against-variants-of-concern.

[134]See for example S Dean 'Kenya warns of "vaccine apartheid" as it hits back at the UK over travel ban move' CNN, 7 April 2021, https://edition.cnn.com/2021/04/07/africa/kenya-vaccines-apartheid-uk-cmd-intl/index.html.

[135]A Harding 'New COVID variant: South Africa's pride and punishment', BBC 26 November 2021, https://www.bbc.com/news/world-africa-59432579.

[136]For examples see J Harrington and D Ngira 'Global health, COVID-19 and the state in East Africa' (2021) 32 Irish Studies in International Affairs 52.

[137]This strategy is explained in F Bayart 'Africa in the world: a history of extraversion' (2000) 99 African Affairs 217.

[138]AD Usher 'A beautiful idea: how COVAX has fallen short' (2021) 397 The Lancet 2322.

date.[139] Charitable donations of surplus vaccines were motivated not by humanitarian concern or the right to health, but by geopolitical anxiety at China's increased health diplomacy in the Global South.[140] Local interests trumped global health governance, at least as far as the states of Global North were concerned. Third World countries initially had fewer options.[141] Though these developments have been widely characterised (and condemned) as 'vaccine nationalism', this fails to capture their full import. Not all states are equal; some may deploy nationalist strategies in attempting to counter global injustice as they did during the period of the NIEO in the 1970s.[142] It needs to be recognised that the intellectual property regime which enabled a massively skewed distribution of essential medical resources during Covid-19 is firmly anchored in historic practices of extraction and exploitation at a world scale.[143] Vanni has formulated this precisely: the hoarding of vaccines and other needed materials can only be seen as 'imperial continuities manifesting in the present'.[144]

Conclusion: resistance and national futures

The state still matters. This is so even after globalisation, when de-territorialised governance was said to have superseded mechanisms of national control. It is so even in the Global South where the basic sovereignty obtained at independence was seen to have weakened or collapsed in many cases by the end of the 1980s. This paper has argued, rather, that the state, understood as a changing ensemble of institutions, routines and discourses, has been a fulcrum for relations between 'inside' and 'outside' in the world system. The precise way in which this fulcrum works has evolved over time: it is worth recalling our starting point, namely, that the state has no fixed essence. It is produced and reproduced through material practices and ideational forms which vary over time, under pressure of international law and governance, the capitalist world economy and security order, as well as developments within medicine and public health.[145] The outcome of contests between the peoples of the Global South and the interests of the Global North can be read-off from changes in the nature and functions of state institutions, eg new ministries, benchmarks and rights, patent laws and quarantine regulations, nationalisation or privatisation.[146] In so far as global health has imperial characteristics, these are fully compatible with, and indeed depend on, an enduring role for nation-states.

The picture to this point has been one of state co-option and transformation because of global/imperial initiatives in health, as well as economics and security. This emphasis is intended, as a corrective to the evacuation of historically conditioned relations of power and domination from accounts of global health. Nonetheless it is fitting to asking in conclusion: what scope has there been for challenging the depredations of the inequitable global order, discussed above, and who or what has been the bearer of this resistance? In response to these closing questions, we can identify 'counter-movements' challenging the constitutional ensemble sketched in the foregoing sections.[147] Given

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[139]WTO *Draft Ministerial Decision on the TRIPS Agreement* 17 June 2022, WT/MIN(22)/W/15/Rev.2; see also S Thambisetty et al 'The TRIPS intellectual property waiver proposal: creating the right incentives in patent law and politics to end the COVID-19 pandemic' (2021) LSE Law, Society and Economy Working Papers No 6.

[140]For an example of this anxiety see K Lancaster et al 'Mapping the health silk road' (2020) Council for Foreign Relations, 10 April 2020, https://www.cfr.org/blog/mapping-chinas-health-silk-road.

[141]Some of these states accepted Chinese aid; more trusted to COVAX and their traditional Western donors. See I Hill 'Russia and China's vaccine diplomacy: not quite the geopolitical slam dunk' Australian Institute of International Affairs 14 September 2021.

[142]CM Ho 'Confronting IP nationalism' (forthcoming) 100 Denver Law Review 35, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3910806.

[143]A Vats and DA Keller 'Critical race IP' (2018) 36 Cardozo Arts and Entertainment Law Journal 175.

[144]A Vanni 'On intellectual property rights, access to medicines and vaccine imperialism' (2021) 32 Third World Approaches to International Law Review, 23 March, https://twailr.com/on-intellectual-property-rights-access-to-medicines-and-vaccine-imperialism/.

[145]Death, above n 9, ch 2.

[146]See Lander, above n 10.

[147]GW Anderson 'Constitutionalism as critical project: the epistemological challenge' in S Gill and AC Cutler (eds) *New Constitutionalism and World Order* (Cambridge: Cambridge University Press, 2014) p 281.

the intense limitations on the contemporary state, it is perhaps unsurprising that non-governmental actors have provided conspicuous leadership in this regard.[148] The South African Treatment Action Campaign, in alliance with partners around Africa (eg CEHURD in Uganda) and globally (eg Médecins sans Frontières and Health Action International), resisted the patent lock-down on access to treatment for HIV/AIDS through litigation and on the streets. These struggles resulted in the WTO's Doha Declaration which endorsed a pro-access to medicines interpretation of TRIPs (2002). Senegalese trade unionists withheld patient information from the national ministry of health as part of industrial action against poor working conditions and unfair health care distribution between 2010 and 2013. Failing to provide this information was a novel and powerful form of political resistance, given the important role of data transfer in enabling countries to secure funding from international donors.[149]

Nonetheless, the state has remained a key focus for these counter-movements. National parliaments and courts were the main fora for the challenging of the harsh implementation of the WTO's TRIPS Agreement, discussed above. Within them, as the example of Kenya shows, arguments focused on the national interests and evoking the history of anti-colonialism justified the exploitation of flexibilities within the agreement in order to increase access to essential medicines.[150] As well as legal tools, the state also provides an ideational horizon for this resistance. Chatterjee has suggested that the developmental state, including its health components, mediated between abstract demands for independence and the concrete aspirations of the population in the Global South countries. Of course, as we discussed above, these aspirations were often bitterly disappointed in practice: there can be no grounds for uncritical 'national nostalgia' here.[151] Nonetheless, they have retained their mobilising force into the current, globalised era among citizens, activists and health professionals.[152]

It is too soon to say, as Eslava, Fakhri and Nesiah have suggested, that 'the progressive Third World project has unmoored itself from the state' and its goals of sovereignty, development and self-determination.[153] The most notable case in point is, perhaps, the refusal of Indonesia to share viral samples with the WHO during the H5N1 Avian Flu pandemic of 2005. This was in protest against the failure of manufacturers to make vaccines developed on the basis of such samples available in sufficient quantities to Third World states. Indonesia's invocation of 'viral sovereignty' as against the global health security regime was based on provisions of the Convention on Biological Diversity, which themselves articulated an NIEO-type preference for national control over valuable resources.[154] Of course, it is important not to over-state the effect of this resistance in its diverse forms. International measures to address the issues raised in these cases, like the WHO's scheme for vaccine sharing, or the Doha Declaration which followed the controversy over access to antiretrovirals, have been of limited practical utility to date.[155] Nonetheless, as Anderson has pointed out, such initiatives provide 'an important catalyst for political experimentation and transformation'.[156]

Covid-19 has seen a revival of these counterhegemonic efforts, in response to the indifference of the Global North and the failure of global health. Vaccine hoarding has directed attention to renewed South-South co-operation, including negotiating coalitions in international organisations, the creation

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[148]D Matthews *Intellectual Property, Human Rights and Development. The Role of NGOs and Social Movements* (Cheltenham: Edward Elgar, 2011).

[149]M Tichenor 'The power of data: global malaria governance and the Senegalese data retention strike' in Adams (ed), above n 99, p 105.

[150]J Harrington and A O'Hare 'Framing the national interest. Debating intellectual property and access to medicines in Kenya' (2014) 17 Journal of World Intellectual Property 16.

[151]P Chatterjee *Empire and Nation. Essential Writings 1985–2005* (Ranikett: Permanent Black, 2010) p 173.

[152]See for example N Toussignant 'Broken tempos: of means and memory in a Senegalese laboratory' (2013) 43 Social Studies of Science 729.

[153]L Eslava et al 'The Spirit of Bandung' in Eslava et al, above n 61, p 3.

[154]S Smallman 'Biopiracy and vaccines: Indonesia and the World Health Organization's new pandemic influenza plan' (2013) 4 Journal of International and Global Studies 20.

[155]See respectively Gostin, above n 4, chs 3 and 5.

[156]Anderson, above n 147, p 293.

of local vaccine manufacturing capacity, and the development of continental multilateralism in health, for example through the African Union.[157] India's 'Maitri programme' of vaccine donations to Global South states provides another example.[158] In spite of opposition from the EU, the UK and the International Federation of Pharmaceutical Manufacturers, the proposal for a waiver TRIPS obligations in relation to vaccines during the pandemic, discussed above, was proposed by India, South Africa, Kenya and Eswatini, with wide support from Global South states.[159] A health future beyond global health governance may be coming into view again, one which reconnects with the promise of broader, more structurally-focused public health, associated with the Bandoeng Conference on Rural Hygiene of the League of Nations Health Organization in 1937, and with the values of popular sovereignty and economic justice, associated with the Bandung conference of colonised nations and newly independent states in 1955.

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[157]See J Midega et al, 'African countries must muscle up their support and fill massive R&D gap' (2021) *The Conversation* 18 May, https://theconversation.com/african-countries-must-muscle-up-their-support-and-fill-massive-randd-gap-161024.

[158]It is worth noting, however, that this initiative was curtailed as Covid-19 infection rates rose in India itself: see G Steinhauser and N Bariyo 'Why Covid-19 vaccination in poorer nations has slowed, posing global risks', *Wall Street Journal*, 19 April 2021.

[159]For an overview see F Dos Santos et al 'Intellectual property framework responses to health emergencies – options for Africa' (2022) 118(5/6) South African Journal of Science 1.

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