The Need for a New Critical Framework for Global Health

https://www.e-ir.info/2015/11/29/the-need-for-a-new-critical-framework-for-global-health/

HETTIE O'BRIEN, NOV 29 2015

To find out more about E-IR essay awards, click here.

—

Interconnectedness in a globalised world brings with it the increased potential of disease transmission across borders. Global health has frequently been conceptualised as a security threat to states in accordance with this potential. Framing global health in terms of state security interests reifies the strategic interests of states, provoking a skewed prioritisation of health issues and leading to global health policies that are short-term and reactionary rather than long-term and preventative. This essay will argue that a cosmopolitan approach to global health could answer two shortcomings of the statist security framing, and in doing so will interrogate three related ideas. The first is why the shortcomings of a statist securitisation framing raise doubts as to its appropriateness as a framework for understanding global health. The second is how a normative cosmopolitan framework which prioritises the needs of individuals, and recognises the normative significance of health as a fundamental human right and a requisite to human wellbeing, could dispel these concerns. Thirdly, a broader question will be asked as to whether viewing global health as a security matter could ever be compatible with a framework that views humans as the ultimate referents of

moral concern. This will be explored with reference to the theory of human security, revealing a profound and perhaps irresolvable tension between viewing health as instrumental to security or as an intrinsically valuable requisite to human wellbeing.

In section I, I will argue that two shortcomings arise from securitisation framing. First, the skewed prioritisation of pandemic diseases, and second, an understanding of health in terms of 'survival', which overlooks the normative dimensions of health as an essential component human wellbeing, and fails to address the systemic causes of ill health. In section II, I will outline a cosmopolitan approach to global health, identifying three characteristics that will provide the basis for my argument in section III, that a cosmopolitan approach could answer the two shortcomings I direct at the securitisation framing. In section IV, I will raise the question of whether a cosmopolitan approach could ever be compatible with an understanding of health in terms of security, and will suggest that there is an irresolvable tension between understandings of health as an instrument to state security objectives and as something of intrinsic value that ought to be pursued as a fundamental human right and precondition of wellbeing.

SECTION I

The emergence of the concept of global health correlates with developments in the material world. Interconnectedness and globalisation have led to porous national borders where health issues are no longer confined to state boundaries and diseases have the potential to be transmitted globally (McInnes and Lee, 2012, O'Neill, 2002). In the field of foreign policy, the potential for global disease transmission has frequently led to an understanding of global health issues in terms of the threats they pose to state security. Davies (2010) articulates a divide in conceptualisations of global health security between what she terms statist and globalist perspectives. The fundamental contrast between these two positions lies between their normative prioritisation of the interests of individuals and states. The statist approach prioritises the interests of states and the pursuit of strategic state-focused objectives (Lencucha, 2013), while the globalist approach prioritises health equality, and prioritizes the rights and interests of individuals over the interests of states (Davies, 2010). While individual writers may espouse both statist and globalist tendencies, traditional security theories display a tendency towards a statist understanding of global health in terms of securitisation (Amon, 2014). This grounds health security in a national security paradigm, perceiving health issues as exogenous threats to states, and resulting in responses characteristic of this perception, such as emergency, quarantine and surveillance measures (DeLaet, 2014).

O'Neill (2002) has observed that poverty and ill health often occur within states as a mirror configuration of the power they wield internationally. If the international health agenda is shaped by the most powerful states that are comparatively free of noncommunicable diseases, the interests of those states and the health issues that constitute threats to their security will be continually reified, eclipsing the noncommunicable diseases plaguing poorer states. This casts doubt on the potential statist defence that states are composed of individuals and thus level individual interests. The continued prioritisation of global health issues that affect wealthy states contradicts the idea that health issues are attributed equal or proportional attention within the international health agenda (Lakoff, 2010), and refutes the notion that global health issues are addressed according to the effects they bear on individuals.

Framing health as a state security matter ties it into a broader ideography with normative and practical implications (Kamradt-Scott and McInnes, 2012). The securitisation framing prioritises the security of states and views global health policies as instrumental to this end (McInnes and Rushton, 2012). Both American and British governments have viewed overseas health engagement as a means to state security ends. The White House defended President Barack Obama's 2009 Global Health Initiative as an "important component of the national security 'smart power' strategy", while the British Government's 2008 Health is Global report echoed a similar tendency, viewing health as an instrument to the pursuit of national security (HM Government, 2008, the White House, 2009). This tendency frequently results in global health policies that display a greater concern for pragmatism rather than humanitarianism, as health policies become a means to realizing state ends rather than delivering effective health strategies concerned with human wellbeing (Mcinnes and Rushton 2012).

Two criticisms of this instrumental understanding of health raise questions about its conceptual and normative appropriateness. First, understanding health through the prism of state interests has resulted in a skewed

prioritisation of global health issues where pandemic and infectious diseases that pose potential threats to state security receive greater attention and resources than noncommunicable and chronic conditions (Davies, 2010, Rushton, 2014). Successful securitisation of a health issue elevates it beyond the realm of normal political discourse, positioning it at the top of a political agenda and affording it greater attention and resources (McInnes and Lee, 2014). Rushton (2011, 782) delineates common criteria by which health issues become securitised, describing infectious diseases, pathogens that may be weaponised, and diseases that pose a threat to the stability of states through their social, political, economic or military impacts, as indices in deciding whether a health issue poses a security threat. This criterion applies to limited health issues and excludes those which do not constitute a security threat to particular states, leading to the privileging of acute outbreaks and infectious over noncommunicable diseases (Dry, 2009). Simply put, noncommunicable diseases such as diarrheal diseases that do not fall within the category of health issues that pose a threat to state security receive less attention from the securitisation perspective, despite constituting critical health issues for a great many individuals.

Furthermore, there is a conceptual misalignment between the idea that health is a universal human right and the understanding of health as instrumental to state security objectives. The idea that health is a human right was first articulated in the preamble to the 1946 constitution of the World Health Organisation, and was subsequently included in the 1948 Universal Declaration of Human Rights. While there has been much disagreement surrounding the extent of obligations a 'right to health' confers, the idea that health is a human right is broadly noncontroversial, and reflects the fundamentality of health as an interest of intrinsic importance to all human beings. This fundamental aspect of health can be construed as what Shue (1980, 23) describes as a 'basic right', insofar as it is essential for the full enjoyment of subsequent human rights. The tendency of the securitisation framing to render health instrumental to the pursuit of state security highlights a conceptual disjunction between this framing and the idea that health is a universal human right. If health is understood as a universal human right, it is unclear how a perspective that prioritises the pursuit of national security objectives and consequently eclipses health issues that do not conform to this criterion, can align with this idea.

The second criticism I direct at the statist security framing arises from the predominantly negative conceptualisation of health security it adopts, which views health as a matter of negative security or survival (Brown and Stoeva 2014, 306). This somewhat reductive understanding of health has two troubling implications. First, it overlooks the important and normatively significant role that health plays in a broader picture of human wellbeing. Second, the conceptual separation of ill health from its systemic causes means that subsequent global health policies favour a reactive rather than preventative stance that often overlooks the systemic causes of ill health, such as poverty and a lack of domestic health capacity (Davies, 2015). This criticism can be traced to an evaluative distinction between negative and positive understandings of security and health. Global health security literature has tended to favour a version of 'negative' security, wherein security is understood as security from existential threat (Brown and Stoeva 2014, 306), aligning with a traditional view of security as survival (Booth, 2007). In contrast, a 'positive' version of security encompasses the pursuit of individual wellbeing as a means to achieving long-term stability and security (Gjørv, 2012). When applied to global health, security theories that defend a negative understanding of security frame health within this purview, resulting in a reductive understanding of health as survival and security from threat. The issue at stake here is that health is far more than freedom from disease or survival. It might be possible to survive free from the threat of disease, yet live in squalid conditions without adequate sanitation or nourishment: such an existence would not constitute a 'healthy' life. Health is an enabling requisite to human wellbeing that is affected by, and in turn affects, a more holistic picture of human wellbeing, a view echoed in the WHO's definition of health as a "State of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1946) . The predominantly negative conceptualisation of security within the global health security framework tends to isolate health from its systemic causes and favour responsive rather than preventative strategies, promoting "an ethos of negative security over an ethic of positive care" (Brown and Stoeva, 2014, 306). Subsequently, the constituents of broader human wellbeing and the systemic causes of ill health receive minimal attention.

Responses to the recent Ebola outbreak exemplified these characteristics. Attention paid to the virus was episodic and temporary, and arose from a concern with countering an outbreak that potentially constituted a threat to national security (Davies, 2015). The tendency to focus on quarantine and containment measures eclipsed long-term

background factors, such as a lack of adequate health infrastructure and domestic health workers which exacerbated the transmission of Ebola and ensured that the virus was not effectively identified in its early stages (Amon, 2014, Kaunakara, Klitzman and Myers, 2015). The long-term delivery of effective global health policies requires taking a preventative rather than reactive approach, with a focus on strengthening the domestic health capacities of states (Davies, 2015). Emergency responses may effectively contain disease outbreaks, but a preoccupation with quarantine and containment measures rather than building long-term domestic health capacity, means that global health strategies will continually be responding to disease outbreaks rather than preventing them.

SECTION II

In the previous section I outlined two shortcomings of a statist securitisation framing of global health, which were; a) that it privileges pandemic and acute outbreaks over noncommunicable diseases, and b) that the predominant understanding of health in terms of 'negative security' isolates health from a broader picture of human wellbeing, and that this in turn leads to global health policies that are reactive and tend to overlook the systemic causes of ill health. It will now be argued that a normative cosmopolitan framing could address these shortcomings.

Cosmopolitan approaches share three normative premises (Pogge, 1992). First, that the ultimate units of moral concern are human beings rather than particular communities or states. Second, this ultimate moral concern is attributed to each individual equally. Third, this ultimate moral concern is general and applies to all humans universally, no matter where they exist or the state or community to which they belong. My position is rooted in the idea that our current state system could adopt a normative cosmopolitan approach through which to frame global health. This would tie global health into a broader set of ideas and obligations and implicate global health policy making. Because of this, I am adopting a normative cosmopolitan approach intended to suggest how we might address current conceptualisations of global health within[1] the state system by acknowledging the equal worth and moral status of all humans.

We have seen that a statist securitisation of global health prioritises state interests. The most fundamental, and obvious, distinction between this understanding and cosmopolitanism is that the former prioritises the pursuit of state interests whereas the latter understands individuals as the ultimate referents of moral concern, and thus attributes them moral importance not afforded to states. An understanding of health as something of intrinsic rather than instrumental importance naturally aligns with this normative tenet of cosmopolitanism. Health, as was previously discussed, is of fundamental importance to all individuals, both as a precondition of human wellbeing and as a basic right necessary to the exercise of all other human rights (Shue, 1980); it therefore follows that health ought to be pursued as an end in itself. This conception of health is elucidated by Sridhar Venkatapuram, who positions his analysis of health firmly within a cosmopolitan framework as a fundamental requisite to universal human wellbeing (Venkatapuram, 2011, 219).

Venkatapuram bases his analysis of health on the capabilities approach originally advanced by Amartya Sen and Martha Nussbaum. Underscoring this approach is the idea that, while an individual's human rights formally convey a normative standard of basic goods and rights they are entitled to, human flourishing substantively consists in the equitable ability of humans to exercise certain capabilities. Drawing on this approach, Venkatapuram argues that health is a necessary requirement for the exercise of all human capabilities. Health is, in this sense, a meta-capability and precondition of human flourishing. This idea can be construed outside the terminology of capabilities, as the claim that health is a fundamental requisite to broader human wellbeing. Crucially, by tying health directly to a notion of broader human wellbeing, Venkatapuram's argument imbues the concept of health with normative significance, rejecting the "value-free and scientific notion of health […] that is wholly centered on the concept of disease" (2011, 63). This highlights a disjunction between a cosmopolitan approach to health and that advanced by the securitisation approach. As I argued in the previous section, the securitisation approach tends to favour a negative conception of security that understands health as a matter of freedom from disease and survival, isolating it from a more holistic picture of human wellbeing. Venkatapuram's analysis of the concept of what health means contradicts this view, imbuing health with normative significance as a constituent of universal human wellbeing.

Furthermore, recognition of the fact that health is necessary for human wellbeing extends obligations to secure the

basis of health for others beyond one's own particular context. The recognition that health is necessary for the exercise of a flourishing human life establishes health as a universal human interest. This diverges from the view of health within the securitisation frame, as a value-free descriptive concept of freedom from disease. Recognition of the normative significance of health for all humans ties this conception of health into a framework of cosmopolitan global justice, entailing obligations to ensure an adequate[2] standard of health for each human (Venkatapuram, 2011).

Closer analysis of a cosmopolitan approach to health such as that advanced by Venkatapuram reveals three important characteristics:

1. Because a normative cosmopolitan framework considers humans the ultimate referents of moral concern, health will be pursued as something intrinsically valuable due to its fundamental importance to all humans, rather than as an instrument to state ends.
2. Recognition of the importance of health to human wellbeing imbues health with normative significance, refuting the negative descriptive conception of health advanced within the securitisation frame.
3. Recognition of the fact that health is a necessary component of human wellbeing for all humans thus extends obligations to ensure the health of others beyond state boundaries.

These three characteristics anchor the argument that will be explored in the next section, that a cosmopolitan approach to health could address two shortcomings of the securitisation approach.

SECTION III

The first criticism I directed at the securitisation approach was that it prioritised pandemic and acute outbreaks, leading to a skewed picture of global health that excluded noncommunicable diseases. As a result of the prioritization of state interests, current negotiations on critical health issues often favour replicating self-interested domestic concerns, and understand the criticality of health issues on the basis of strategic state interests rather than universal human needs (Lencucha, 2013)(Michaud, 2014). A cosmopolitan approach could address this problem. Because the first characteristic of this approach to global health establishes that health is intrinsically rather than instrumentally valuable, the criticality of health issues would be understood according to individual needs rather than state interests. In turn, this thus could reform the skewed prioritisation of infectious and pandemic diseases that occurs as a result of an international health agenda shaped by state interests. Effectively, negotiations on critical health issues would favour the health needs of humans universally, rather than the representation of state interests. Moreover, the extension of obligations to deliver an adequate standard of health beyond state boundaries would further ensure that negotiations on global health issues prioritized the delivery of an adequate standard of health to each individual. These duties of justice stem from the deontological worth that cosmopolitanism attributes to each individual (Pogge, 2014), and would demand the delivery of an adequate standard of health to each individual irrespective of their national or geographical location.

Secondly, a cosmopolitan approach to global health rejects a value free notion of health advanced within the statist security frame which subsequently isolates health from the role it plays as a component of human wellbeing, and frequently overlooks the systemic indices of ill health. Health is a fundamental part of human wellbeing, and thus has normative significance as something that is necessary to leading a fulfilled human life. This is outlined in Article 25 of the Universal Declaration of Human Rights: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care" (United Nations General Assembly, 1948). The understanding of health indicated here resembles the definition of health espoused by the WHO.[3] Both understandings indicate that health ought not to be separated from the role it plays in a broader conception of human wellbeing and quality of life. The concept of health advanced here is as a constituent of a standard of life that meets a benchmark of adequacy. While the securitisation framing tends to reduce the concept of health to a descriptive concept of freedom from disease, a cosmopolitan account of health recognises the role that health plays as a requisite to human wellbeing, and thus imbues it with normative significance and acknowledge the role it plays in a more holistic picture of wellbeing.

This aspect of a cosmopolitan view of health could address the second shortcoming I posed to the statist security

view of health: that the negative conception of health advanced by the statist security view frequently overlooks the systemic causes of ill health. As was argued in section I, the conceptual separation of health from a picture of wellbeing, and from the other constituents of this picture such as adequate housing and nutrition, have led to global health policies which overlook the systemic causes of ill health and respond in ways that are reactive rather than preventative. Reponses to the outbreak of SARS in South East Asia displayed these tendencies. While overcrowding and inadequate housing conditions in urban areas were key factors in the transmission of the disease, global health policies displayed a preoccupation with emergency quarantine and containment measures (Marsh et al., 1999, Schabas, 2004). In cases like SARS, preventative strategies could have impeded disease transmission by focusing on the building of healthcare capacity and by addressing the background causes of ill health, such as ensuring adequate housing and welfare standards. A cosmopolitan approach is concerned with human wellbeing and the interests and rights of individuals. Rather than separating health from it's systemic and socioeconomic determinants such as overcrowding and poverty, a cosmopolitan approach views health as a constituent of a standard of wellbeing to which each human is entitled. Adopting this approach entails addressing the socioeconomic and systemic determinants of ill health (Brown and Stoeva, 2014). This would be more conducive to health policies that preclude reactive responses to health issues by tackling the root causes of ill health.

Cosmopolitanism places individuals as the ultimate locus of moral concern and can be seen as aligning with a conception of health as a constituent of human wellbeing rather than a reductive view of health as survival or freedom from disease. On this basis, I have suggested that a cosmopolitan approach could address two shortcomings of a statist securitisation framing. Now, I will pose the question of whether global health security could ever be compatible with the sort of cosmopolitan approach I have outlined here.

SECTION IV

This essay has focused on the theory of securitisation housed within a statist view of global health. The question remains of whether a cosmopolitan approach to global health could coexist with the current proclivity within international relations literature to understand global health as a security matter. As was outlined at the beginning of this essay, approaches to global health can be separated into statist and globalist camps. While I have analysed a view from the statist camp, it is worth exploring whether a globalist account of security, such as the theory of human security, could align with a cosmopolitan approach to global health and accommodate both the normative concerns of cosmopolitanism and the pragmatic concerns of the security prism. This will answer the question of whether a cosmopolitan approach to health is compatible with, or antithetical to, the idea that global health ought to be understood as a security matter.

The theory of human security diverges from a state centric view of security and advances a people centred approach that places individuals as the ultimate referents of security (DeLaet, 2014, Khong, 2001). In contrast to securitisation theories, which tend to adopt a negative security approach, human security is founded on a positive view of security that encompasses the long-term stability and wellbeing of individuals (Gjørv, 2012). The focus of security is shifted from the protection of state interests onto the pursuit of the security of each individual. When applied to the field of global health, this results in the prioritization of health issues on the basis of whether they constitute health threats to individuals rather than to states. Enshrining individuals as the ultimate referents of security concerns, and predicating the justification and efficacy of security upon the basis of whether it serves human interests, makes the theory of human security compatible with a normative cosmopolitan framework, as both treat individuals as the ultimate referents of concern. However, shifting the basis of security from the protection of state interests to that of universal human interests raises questions which indicate the potentially chimerical nature of the theory when applied within a state system paradigm. Is the redefinition of security espoused within this theory too radical to resemble anything like the current concept of security within a state system? Could the theory be assimilated within a state system paradigm? Furthermore, who becomes the provider of security when construed as a universal human entitlement rather than a state activity? I will sketch some ideas that, far from being exhaustive, intend to explore these difficulties.

First, human security adopts a view of security that is people focused, aligning with the idea that security is a human entitlement.[4] This raises the question of why the concept of security is needed with regards global health: why

shouldn't health be understood as a human entitlement? Securitization of the individual entails making the security of each individual in the world an object of concern (Khong, 2001, Caballero-Anthony and Gayle, 2014). In this regard, human security resembles the idea that humans are normatively entitled to certain goods, including that of security. However, as Khong (2001, 235) notes, it will make little difference to people living in privation to insist that they are entitled to security. They would do better to appeal to their government using the language of human rights. The theory of human security understands security as something to which individuals are universally entitled to, yet if 'human security' is understood as a normative entitlement like that of health, why frame global health as a matter of security and not as a matter of normative entitlements?

Furthermore, if security is construed as a matter of universal entitlements more closely akin to human rights, this constitutes a radical departure from the concept of security within our current state system. It involves shifting the locus of security from the state to individuals globally, which raises two problems. The first is whether this version of security is operable in the state system paradigm where the provider of security seems to be a priori the state. If security is understood as a universal human entitlement, its substantive basis must be provided for. Within a state paradigm, the provider of security is the state (Burgess and Gräns, 2011). Does this mean that an operable concept of security is tied inextricably to a statist basis? While I do not have the space to discuss this further, it is interesting to consider whether a notion of security predicated upon universal individual interests could be realizable in our current state system paradigm, or whether it would demand structural cosmopolitan conditions for it to be realizable.[5] Second, putting aside the question of whether or not this version of security would be operable in a state system, the previous question arises again: why is the concept of security needed to understand global health if security is redefined to have more to do with human entitlements than security interests? If both security and health are understood as universal human entitlements, it seems illogical to understand health through a prism of security rather than as a human entitlement.

The human security approach to global health attempts to find a solution to the state-centric basis of global health security by reconfiguring security as a people focused entitlement. However, in doing so, it undermines justification for applying a security paradigm to the matter of health. If the theory of human security espouses a view of security as a universal human entitlement, it begs the question of why global health shouldn't also be understood as a universal human entitlement. Thus we face a dilemma: either, accept that viewing health as a matter of security involves adopting a framework that is state centric, or else concede that a people-centered approach to global health prioritizing the interests and entitlements of individuals would be better understood through a normative framework which viewed health as a fundamental human right and requisite to wellbeing. This brings us to a possibly irresolvable tension between global health security and a normative cosmopolitan framework. If we desire to frame health as a universal human right and requisite to wellbeing, it seems that this is incompatible with an understanding of security as found in our current state system.

One possible response to this dilemma is that the state can play an instrumental role in realising cosmopolitan ends. Accepting health provision as a contingent component of state security has often contributed positively to health issues. For example, overseas spending on maternal health has been channelled through the intention to protect states against the spread of HIV (DeLaet, 2014). While the intention here is more preoccupied with state security than a universal right to health, this example shows how a state security framing of global health can sometimes bring about cosmopolitan ends. However, the issue at stake here is that these cosmopolitan consequences will be no more than lucky coincidences as long as health is still perceived as an instrument to state interests.[6] This reveals the profound tension between the instrumental and intrinsic views of health that runs as a current throughout this essay, posing further, more profound questions; can a view of global health in terms of security ever satisfy the idea that health is a fundamental, universal human right and necessary constituent of human wellbeing? And, if not, why adopt a security framework through which to understanding global health?

Conclusion

My intention in this essay was primarily to show that a normative cosmopolitan framework could answer two shortcomings of the securitisation of global health. Cosmopolitanism attributes ultimate and universal concern to individuals, and understands health as an enabling requisite to a broader picture of human wellbeing. I argued that

these characteristics could address both the tendency to prioritize pandemic diseases and the inclination towards an understanding of health isolated from a broader picture of wellbeing within the securitisation frame. This led to the question of whether the current status quo of global health security could ever be compatible with this normative approach. Human security injects the security framing of global health with humanitarian concern. However, understanding security as a human entitlement alongside global health begs the question of why security is then needed to conceptually frame global health. This brings us to an embedded and irresolvable tension between the security framing and a normative, people-focused understanding of global health, where it seems that one cannot be adopted without rejecting the other.

References

Amon, J. (2014) "Health Security and/or Human Rights?". In: Rushton, S. and Youde, J. (eds.) Routledge Handbook of Global Health Security. London: Routledge. pp. 293-303.

Booth, K. (2007) Theory of World Security. Cambridge: Cambridge University Press.

Brown, G. (201) Bringing the State Back into Cosmopolitanism: The Idea of Responsible Cosmopolitan States. Political Studies Review 9 (1): 53-66.

Brown, G. and Stoeva, P. (2014) "An Ounce of Prevention is Worth a Pound of Cure: Reevaluating Health Security from a Cosmopolitan Perspective". In: Rushton, S. and Youde, J. (eds.) Routledge Handbook of Global Health Security. London: Routledge. pp. 304-317.

Burgess, J. and Gräns, J. (2007) "Human Security". In: Snyder, C. Contemporary Security and Strategy. pp. 89-104. UK: Palgrave Macmillan.

Caballero-Anthony, M. and Amul, G. (2014) "Health and Human Security: Pathways to advancing a human-centered approach to health security in East Asia". In: Rushton, S. and Youde, J. (eds.) Routledge Handbook of Global Health Security. London: Routledge. pp. 32-47.

Davies, S. (2015) Ebola Outbreak: Politics of Prevention and Engagement. Australian Institute of International Affairs. Available at: http://www.internationalaffairs.org.au/australian_outlook/ebola-outbreak-politics-of-prevention-and-engagement/

Davies, S. (2010) Global Politics of Health. Cambridge: Polity Press.

DeLaet, D. (2014) "Whose Interests is the Securitisation of Health Serving?". In: Rushton, S. and Youde, J. (eds.) Routledge Handbook of Global Health Security. London: Routledge. pp. 339-348.

Dry, S. "Epidemics for all? Governing health in a global age". In: STEPS Centre Working Paper 9. Brighton: STEPS 2009. Available at: http://steps-centre.org/wp-content/uploads/STEPSsumEpidemics.pdf.

Gjørv, G. (2012) Security by any other name: negative security, positive security, and a multi-actor security approach. Review of International Studies, 38 (4): 835-859.

Held, D. (1995) Democracy and the New International Order. In: Archibugi, A. and Held, D. (eds.) Cosmopolitan Democracy: An Agenda for a New World Order. Cambridge: Polity Press.

HM Government. (2008) Health is Global: An outcomes framework for global health 2011-15. UK: HM Government. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67578/health-is-global.pdf

Karunakara, U., Klitzman, R., Myers, J. (2015) Ebola and Other Viral Outbreaks: Providing Health Care to the Global

Poor in Times of Crisis. Transcript from Carnegie Council panel discussion. Available at: http://www.carnegiecouncil.org/calendar/data/0547.html.

Khong, Y. (2001) Human Security: A Shotgun Approach to Alleviating Human Misery? Global Governance 7 (3): 231-236.

Lakoff, A. (2010) Two Regimes of Global Health. Humanity: An International Journal of Human Rights, Humanitarianism and Development, 1 (1): 59-79.

Lencucha, R. (2013) Cosmopolitanism and foreign policy for health: ethics for and beyond the state. BMC International Health and Human Rights, 13 (1): 29.

Marsh, A., Gordon, D., Pantazis, C. and Heslop, P. (1999) Home Sweet Home? The Impact of Poor Housing on Health. Bristol: Policy Press.

McInnes, C. and Lee, K. (2012) Global Health and International Relations. Cambridge: Polity Press.

McInnes, C. and Kamradt-Scott, A. (2012) The securitisation of pandemic influenza: Framing, security and public policy. Supplement in Global Public Health, 7 (Supplement 2): S95-S110.

McInnes, C. and Rushton, S. (2012) Smart power? Health interventions for strategic effect in Iraq and Afghanistan. International Political Sociology, 6 (3): 328-331.

Michaud, J. (2014) “Health Security and Foreign Policy”. In: Rushton, S. and Youde, J. (eds.) Routledge Handbook of Global Health Security. London: Routledge. pp. 265-276.

O’Neill, O. (2002) Public Health or Clinical Ethics: Thinking beyond Borders. Ethics & International Affairs, 16 (2): 35-45

O’Neill, O. (2005) The Dark Side of Human Rights. International Affairs 81 (2): 427-439.

Rushton, S. (2011) Global Health Security: Security for Whom? Security from What? Political Studies 59 (4): 779-796.

Pattison, J. (2008) Humanitarian Intervention and a Cosmopolitan UN Force. Journal of International Political Theory 4 (1): 126-145.

Pogge, T. (1992) Cosmopolitanism and Sovereignty. Ethics, 103 (1): 48-75.

Pogge, T. (2014) Human Rights and Global Health: A Research Program. Metaphilosophy 36 (1/2): 182-209.

Pogge, T. (2004) “Relational conceptions of justice: responsibilities for health outcomes”. In: S. Anand, F Peter and A. Sen (eds.) Public Health, Ethics, and Equity. Oxford: Oxford University Press

Schabas, R. (2004) Severe acute respiratory syndrome: Did quarantine help? Pulsus Infectious Diseases & Medical Microbiology 15 (4): 204.

Shue, H. (1980) Basic Rights. Princeton: Princeton University Press.

UN General Assembly. (1948) Universal Declaration of Human Rights.

Venkatapuram, S. (2011) Health Justice: An Argument from the Capabilities Approach. Cambridge: Polity Press.

The World Health Organization. (1946) Constitution of the World Health Organization.

The White House. (2009) Statement by the President on Global Health Initiative. USA: The White House. Available at: https://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/

Endnotes

[1] My approach is focused on the normative recommendations (Brown and Stoeva, 2014) that cosmopolitanism could generate, rather than calling for the structural realization of a cosmopolitan system of democracy (Held, 1995). I want to acknowledge the empirical fact of the state system rather than render it "*otiose"*. (Brown, 2011, 54).

[2] What constitutes an 'adequate' standard will be contentious. One version of what adequacy could stand for here is suggested by Thomas Pogge, who argues that rights are fulfilled if and only if a person enjoys *"secure access to the object of this right"* (Pogge, 2005, 195). When applied to a right to health, this would identify specific obligations of governments, e.g. access to health care, rather than guaranteeing all individuals a healthy life (Amon, 2014).

[3] ibid.

[4] of the sort outlined in article 3 of the UDHR (UN General Assembly, 1948)

[5] For example, the ideas explored by Pattison (2008) surrounding his cosmopolitan humanitarian intervention force: Pattison concedes that for such a force to be operable, it would demand the structural realization of a cosmopolitan system of governance, i.e. the sort of cosmopolitan democracy articulated by Held (1995).

[6] This is because the initial criticisms that arose from health being viewed as an instrument to the pursuit of state interests will still apply

Written by: Hettie O'Brien
Written at: The University of St Andrews
Written for: Patrick Hayden
Date Written: April 2015