Globalization: Present

Globalization and Health
in the COVID Era

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ABSTRACT

In 2019, I published my book *Globalization and Health*, which looked at the relationship between these two key concepts. In it, I argued that globalization may increase our vulnerability to infectious disease outbreaks, but it also provides us with the tools and opportunities to stop disease outbreaks before they spread too quickly. A few months after the book was published, the global COVID-19 pandemic began. In this chapter, I reflect on how the book's arguments hold up in light of our collective lived experience with the pandemic since 2019. I highlight three areas in which the interplay between health and globalization(s) deserves greater attention, and I take myself to task for not giving more direct and explicit attention to the international political economy of global health.

KEYWORDS

gender, global health, globalization, international political economy, multilateralism, One Health

In the summer of 2019, I had the good fortune of seeing my most recent book, *Globalization and Health* (Youde, 2019), appear in print. The core message of the book was that the ease and speed with which people and goods can cross borders thanks to globalization may increase the chances of an infectious disease outbreak, but globalization also provides us with the sort of knowledge and connection that can allow us to work together to stop such outbreaks relatively quickly.

It is safe to say that no one foresaw that a global pandemic caused by a brand-new disease would begin mere months after the book's publication. That is not to say that anyone would have credibly argued that global pandemics were a thing of the past; indeed, just a month or so after my book came out, the online news site

Vox published an article with the ominous title "The Next Global Pandemic Could Kill Millions of Us. Experts Say We're Really Not Prepared" (Samuel, 2019). Even with these warnings, there was little sense of global urgency when the Wuhan Municipal Health Commission issued two emergency notices on December 30. 2019, about a new unknown pneumonia (Worobey, 2021: 1202). Unfortunately, we are now all far too familiar with the subsequent political, economic, and social effects of COVID-19.

This chapter represents an exercise in scholarly reflexivity (Amoureux and Steele, 2016). Too often as scholars, we neglect to reflect on what we got right and wrong. For better or (very much) worse, the emergence of the COVID-19 pandemic and the international response provided a very direct test of the assumptions I embedded in my book about the relationship between globalization and health and what would happen when push came to shove.

Prior to the pandemic's emergence, one could argue that the scholarly consensus acknowledged many significant shortcomings in the global health governance architecture that had developed since the early 1990s, but that there was a general acceptance of the international norms that governed health-related behavior (see Davies, Kamradt-Scott, & Rushton, 2015). At the same time, though, there was a growing concern that the impulse toward multilateralism that is at the heart of global health governance was fraying. While the election of Donald Trump and his openly antagonistic attitude toward any sort of international political agreement was perhaps the starkest evidence of this shift, it was not the cause of this morass. The global response to COVID-19 is instead the unfortunate, albeit understandable, outcome of years of unresolved tensions and a long-standing unwillingness to reform global health governance institutions. These issues highlight the ongoing tensions between the need to address global challenges on a more collective basis with the desires of governments to retain their sovereign decision-making. As a result, member-states hesitate to reform institutions created in very different geopolitical and economic circumstances—even when such stasis comes at the cost of creating more effective institutions.

In the case of the underexplored and unresolved issues that I identified at the end of *Globalization and Health*, I would argue that all three core aspects mentioned—the role of gender in responding to global health issues, the interplay between human and animal health, and rising skepticism about multilateral responses to global crises—were accurate and relevant, but missed out on the bigger-picture issues. In particular, my analysis did not adequately examine the depths of skepticism about multilateral responses among certain key actors. It also failed to sufficiently interrogate just how brittle and hamstrung global health governance institutions would be—due to both their own inadequacies and the shackles placed on them by powerful actors. Additionally, I failed to examine the extent to which international political economy—especially when it comes to issues of intellectual property rights and pharmaceutical manufacturing—would determine the course of a global response and its efficacy.

In this chapter, I want to briefly explore how the three underexplored issues that I identified at the end of *Globalization and Health* have played out in the face of the ongoing COVID-19 pandemic and why ignoring international political economy was such an oversight. These issues will continue to challenge the interplay between globalization and health now and into the future unless we seriously address them—and figure out how to balance national sovereignty and the need for collective responses to address pressing problems.

GENDER AND GLOBAL HEALTH

Academic work on global health politics, including my own, has paid far too little attention to gender. This is not to say that it has been completely ignored (see, among other great works, Davies & Bennett, 2016; Harman, 2016; Hawkes & Buse, 2013; Vaittinen & Confortini, 2019; and Wenham, 2021), but rather to call attention to the fact that, like in so much work in international relations, gender is frequently relegated to a secondary or tertiary level of importance.

Our collective unwillingness to center gender more fully within our analyses of global health politics leads to detrimental consequences. Colleen O'Manique stresses, "Social and political life is profoundly gendered, and feminist scholarship has a crucial role to play in illuminating both the foundations of health insecurities and the effects of insecurities on differently gendered and located bodies" (2015: 48). Gender powerfully affects the ways in which a person experiences health and health care, and access to health and health care is mediated by the social, cultural, and power relationships that are inextricably linked to gender. These effects become even more profound in the context of globalization.

Including gender in our analysis of global health politics calls attention to a number of key issues. For example, most responsibilities for taking care of the ill, in both formal and informal settings, fall to women. As a result, global health policies rely heavily on this uncompensated labor, even though the institutions promoting those policies rarely (if ever) acknowledge this reliance (Davies et al., 2019). This can have a very direct effect on the ability to implement policies as they have been devised—and the failure to do so is thus frequently chalked up to "noncompliance" rather than understanding the broader political, economic, and social conditions that women are attempting to navigate (Farmer, 1999: 247–70). The failure to mainstream gender as part of an institutional response to global health emergencies also leads to tone-deaf policy responses. During the Zika epidemic in Central and South America, many governments in the region cautioned women to avoid pregnancy—yet this advice wholly ignored the lack of access to reproductive health and abortion services, nor did it account for the prevalence of sexual violence perpetrated against women (Wenham et al., 2019). As a result, we end up with (at best) impractical policy guidance—and a ready excuse to blame women for "failing" to comply with government advice if they happen to fall pregnant.

Gender has played a significant role in how governments have responded to COVID in a variety of ways. In a transnational feminist political economy evaluation of policies in China, Hong Kong, Canada, and the United Kingdom, Julia Smith et al. (2021) find strong and consistent evidence that structural conditions disadvantage women both in terms of their exposure to the pandemic because of the reliance on women as frontline workers and caregivers in the home and in terms of policies that directly deny women personal, health, and economic security. They highlight that these inequalities are further exacerbated because of the intersectional connections with racism and other marginalizations.

More broadly, Ginette Azcona et al. raise important questions about whether COVID will erase the hard-won gains that have been made in recent years in promoting gender equity and life conditions for women that are a part of the Sustainable Development Goals. Efforts to reduce poverty, improve access to quality education, promote gender equality, provide decent work and economic growth, and reduce systemic inequalities are all innately gendered, so having backslid on these SDGs during the pandemic will necessarily have direct and negative effects on women and nonbinary people. They stress, "Though a particular microbe or disease may not discriminate, they exist in societies that do" (2020: 2). As a result, any policy that does not take gender seriously can exacerbate these inequalities—even if the policy is seemingly "gender-neutral."

These findings all point to the need to center feminist analyses more firmly within the global health politics literature. Assuming that policies are gender-neutral will lead to a host of unintended consequences, and a gender lens is vital in helping us to understand the success or failure of particular policies.

ANIMALS AND HUMANS AND MICROBES, OH MY!

The global health governance system is designed almost exclusively to focus on human health, but that ignores the realities of the interplay between human, animal, and environmental health. An estimated 60 percent of all human infectious diseases, and 75 percent of new or emerging infectious diseases, are zoonotic in origin (Salyer et al., 2017). Climate change exacerbates these problems, as it alters the zones in which insect vectors can live, changes the environmental conditions in which animals live, and can increase the opportunities for human-animal exchanges to occur (Epstein, 2005). All of these interconnections make it all the more important that we have institutions that can work across disciplinary boundaries, but also make facilitating such connections all the more difficult.

The concept of One Health brings human, animal, and environmental health together to recognize the interconnections and the need to blend analyses together if we are to make progress (Centers for Disease Control and Prevention, n. d.). The idea of One Health initially emerged in the mid-1960s, when veterinarian Calvin Schwabe wrote about the interconnections between human and animal

health under the moniker of "One Medicine." Over the next forty years, the idea of linking human, animal, and environmental health received greater attention. In 2004, the Wildlife Conservation Society sponsored a conference in New York called "One World, One Health." This conference developed the Manhattan Principles, which are twelve recommendations for creating a more holistic approach for improving health and biodiversity. Four years later, the Food and Agriculture Organization (FAO), World Organization for Animal Health (OIE), and World Health Organization (WHO), among other international institutions, developed a One Health framework, and each organization has subsequently created initiatives to further the aims of integrating human, animal, and environmental health in an effort to better protect all three (Gibbs, 2014). Though the intellectual work on this concept has been incredibly important, it has not necessarily translated into a change in institutional structures in a substantial manner.

The COVID-19 pandemic has demonstrated why it is so important to work on human, animal, and environmental health simultaneously. Our best understanding about COVID's origins, as I write in mid-2022, is that the virus made its way from bats to humans via another unidentified nondomesticated animal species sold for human consumption (Zimmer, 2021). As people come into closer contact with animals due to habitat destruction and meat-based diets, the likelihood of a disease making the jump from animals to people increases. This is also consistent with other new and emerging infectious diseases, such as Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS), both of which are caused by a coronavirus related to COVID and believed to be of animal origin (Gong and Bao, 2018).

The existence of animal reservoirs for human diseases complicates strategies for combating outbreaks, as they give viruses a place to circulate until they have the opportunity to jump to humans. To put it bluntly, the presence of animal hosts means that we will never completely wipe out COVID-19. As a result, we need to think about our current global strategies to address the disease. The larger structural problem in global health governance is less focused on the internal workings of any particular institutions, but rather on the ability of different institutions to work together effectively. WHO's mandate focuses on human health, while the OIE pays attention to animals and the United Nations Environment Program (UNEP) looks after the global environment. All three should be intimately linked in addressing (post-)COVID, yet collaboration among the three remains relatively weak—to our collective detriment. From a global governance perspective, the problem is that there is no single organization focused solely on One Health. As a result, it can easily fall through the cracks or be deprioritized as organizational leadership changes. No organization has ownership over the issue, so One Health's place on the global health agenda is uncertain—and that means fewer human and financial resources are devoted to such collaborations. If recent reform efforts within WHO are any indication (Guarascio, Hunnicutt,

& Nebehay, 2022), there is not enough appetite within the global community to address this oversight. Again, we witness a situation in which the need for a collective response comes into conflict with the desire by (some) governments to privilege their sovereignty.

STAND TOGETHER OR FALL SEPARATELY?

The global health governance system is largely premised on norms that emphasize multilateralism, cooperation, and provisioning global public goods. Sadly, if there is any one issue that definitively hampered our collective global response to COVID, it is the mistrust (or distrust) of global health institutions by key players in the early days of the pandemic. This caused members of the global community to spend vital time when the pandemic was first emerging to fight amongst themselves and trade recriminations while the virus continued to spread. Viruses may not care about our politics or borders, but they can certainly take advantage of them.

When I wrote the book, it was clear that the Trump administration had little interest in global health governance. Perhaps unique among America's multilateral commitments, the Trump administration evinced an abject and overt hostility toward global health. While I tried to make an argument to the Trump administration to engage with global health on securitized grounds in the book and another article (Youde, 2018), they did not heed my advice. Indeed, Trump's antipathy toward WHO went far beyond what I expected—and it had direct effects on the global community's ability to respond to the COVID pandemic.

The emergence of COVID exacerbated Trump's America First mindset, his distrust of multilateralism, and his dismissal of global health. Though Trump initially gave the Chinese government praise for its response to the emergence of COVID (Riechmann, 2020), he and his government officials soon blamed China for the disease and described COVID in racist terms in public statements and at political rallies (which had the knock-on effect of encouraging discrimination and violence against Asians and Asian-Americans in the United States) (Itkowitz, 2020; Zhou, 2021). By April 2020, a few months after the pandemic began, Trump was lashing out at WHO, calling it "China-centric" and saying that it "called it wrong." At a press conference that month, he made his first public threat to pull the United States' funding for WHO and withdraw the country from the organization (Wamsley, 2020). Finally, in July, the Trump administration sent notice to WHO of its official intention to withdraw from the organization in one year (Rogers & Mandavilli, 2020). While the WHO's Constitution does not contain any formal mechanism for a country to withdraw from the organization, a 1948 joint resolution passed by the U.S. Congress gave the American government the right to leave WHO if it gave a year's notice (Congressional Research Service, 2020: 2). Even if President Trump had the authority to make such a decision (and this is an ambiguous and debated point), global health scholars and policy makers roundly

criticized the decision as threatening American and global health (Gostin et al., 2020). None of this absolves China of its desultory engagement with the WHO, but when the country that has been the largest provider of development assistance for health and the largest single contributor to the WHO rejects the leading global health governance institution in the midst of a crisis, it sends a signal to international partners—and that signal can last a long time and further undermine efforts to arrive at collective responses to a crisis that requires cooperation to address.

In one sense, Trump's decision to pull the United States out of the WHO was the ultimate expression of a fit of pique. The WHO largely stayed silent in response to Trump's decision, trying to wait out the election to see if temperatures cooled (P. Huang, 2020). Administration officials floated the idea of creating new U.S.-led health organizations to replace WHO, but there was little appetite for such a change among other governments and the efforts went nowhere (Rotella, Bandler, & Callahan, 2020).

In the end, we might be tempted to think that this was more about bluster and electoral posturing than consequence. After all, Biden canceled Trump's withdrawal order on his first day in office. This view, though, misses the larger consequences of the Trump administration's efforts. In those initial months of the COVID pandemic, valuable time was lost to internecine fighting. Instead of building a united front, we had leading world powers hurling insults at each other—and at the organization with a mandate to respond to global health emergencies.

Yet the latter is precisely why we create international institutions. We need them there laying the groundwork and building relationships so that they can spring into action when emergencies occur. It is surely better to have a fire department that trains ahead of time so that it is ready to respond when a fire breaks out than trying to cobble something together for the first time when a building has gone up in flames.

The fact that we have faced such a public questioning of the value of a key global health institution should encourage WHO and other such organizations to take these challenges seriously. That is not to say that the Trump administration was right, but it does show that the consensus that undergirded global health governance for all of these years is more fragile than we may have assumed. One of the problems that has befallen WHO and other global health governance institutions during the twenty-first century is that they have been too slow to adapt to contemporary realities. There have been accusations that their structures and financing models are out of date, reflecting the international political dynamics in the late 1940s instead of the current arrangements and the need for more holistic, coordinated responses to address global challenges that necessarily cross borders and require strategies that go beyond individual state interest. There have been a host of reviews and independent panels that have proposed reforms—but far too few of these reports have done anything except collect dust on the shelves. If WHO and other global health organizations cannot show some measure of responsiveness

to criticisms—and if no member-states are willing to take up the mantle to lead serious reform efforts—it is inevitable that we will see more challenges to the legitimacy of multilateralism in the global health realm.

DON'T OVERLOOK IPE

Not counting the introduction and conclusion, *Globalization and Health* consists of seven chapters. When I originally proposed the book, it had eight chapters. Over the course of the research and writing, though, I decided to scrap one of the chapters. It was not coming together very well, and I was finding it difficult to identify a compelling "in" that would engage the reader.

The subject of that chapter? The international political economy of health.

What drove my decision? Part of it was that I knew that I was not matching the clarity and insight of some of the best work already out there on the international political economy of global health (see, for example, Kay & Williams, 2009; Benton & Dionne, 2015; and Harman, 2015). Part of it was that the topic felt so broad that it was hard to know where I could offer something unique and insightful in the span of a single chapter in the book.

Most importantly, though, what I failed to properly appreciate was the scope and scale of institutional competition in global politics. I am, by nature, an institutionalist. Global health governance institutions clearly and certainly matter, but my focus on them led to a certain myopia that, in hindsight, exposes some of the problems with global health governance institutions. When we think about the major global health governance institutions, we (or at least I) tend to think of intergovernmental bodies like the WHO, nongovernmental organizations like Rotary International, public-private partnerships like Gavi, and philanthropic organizations like the Bill and Melinda Gates Foundation. These all matter and have played significant roles in shaping the conduct and course of global health politics.

What they have generally not done, though, is take up the cause of overhauling intellectual property rights and the broader international political economy of health. That is not to say that they have not championed the need for policy to pay attention to the social determinants of health, but they are rarely challenging the status quo of contemporary international political economy. This is a problem—not just because it allows inequities to continue, but also because it plays into the relative weakness of health-related organizations vis-à-vis economic-related organizations. The World Trade Organization (WTO), despite the challenges it has faced in the face of COVID (Narlikar, 2021), remains vastly stronger in global health than the WHO, has (relatively) serious enforcement mechanisms, and commands international attention that WHO simply does not. We do not see the powerful global health governance institutions being willing to upset the economic apple cart.

Indeed, when we look at the sorts of responses to global inequities highlighted by the COVID-19 pandemic, we see deliberate attempts to work within the existing

system. The COVID-19 Vaccines Global Access, better known as COVAX, was created in April 2020 as a partnership between WHO, the Center for Epidemic Preparedness Innovations (CEPI), and Gavi with a specific aim to "accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world" (World Health Organization, n.d.). The underlying idea was that COVAX would funnel international resources to low- and middle-income countries to ensure access to COVID tests and vaccines. COVAX would serve as a massive vaccine purchaser and distributor, leveraging its collective buying power. Wealthy countries would provide the financing, and ninety-two low- and middle-income countries would receive vaccines through this purchasing mechanism. COVAX had received financial pledges from wealthy countries of more than $6 billion by the fall of 2021 and set a goal of distributing two billion vaccines by the end of 2021 (BBC News, 2021). This was essentially a program that sought to change the market calculus rather than change the market to provide more equitable vaccine distribution—a pragmatic response to the realities of the current state of the international pharmaceutical market. It also relied on a recognition of our collective vulnerability.

Unfortunately, COVAX's promises have not come to fruition. By mid-March 2022, COVAX had delivered 1.37 billion vaccines—a significant number, but a far cry from its initial ambition (Reuters, 2022). One of the biggest problems limiting COVAX's ability to purchase vaccines was a lack of cash. In early 2022, Gavi CEO Seth Berkley said that COVAX was "basically out of money" and started an urgent funding round to raise $5.2 billion (Associated Press, 2022). Of the 1.1 billion COVID vaccine doses pledged by the United States in 2021 for delivery by 2023 (not all of which were intended to go through COVAX), there were still more than 400 million doses yet to be shipped or delivered by May 2023 (Kaiser Family Foundation, 2023).

What explains these discrepancies? Many wealthy countries had pledged funds or vaccine doses to COVAX—but their magnanimous commitments ran into market logic. These states made large advance purchase commitments for their own citizens, which in turn drove up the prices of remaining vaccine stocks before COVAX could get set up. As a result, the actions of these wealthy states diminished COVAX's purchasing power and increased the prices COVAX would have to pay—and the delays in wealthy countries fulfilling their financial pledges hampered COVAX's ability to actually make purchases (Reardon, 2021). While this outcome may be frustrating, it is entirely consistent with existing international political economy rules.

This behavior was further exacerbated by donor states engaging in both vaccine nationalism and vaccine diplomacy. Vaccine nationalism "refers to the pursuit of vaccines in the national interest . . . through supply agreements or export bans, including where this might be to the detriment of other countries" (Vanderslott et al., 2021), but a pithier description would be that it is a "my country first" approach

to vaccines (Bollyky and Brown, 2020). Countries may have been willing to make pledges to an international effort to vaccinate the world, but they would only do so after hoarding enough vaccines for their own people. Rather than seeing COVID vaccines as a global public good, wealthy governments interpreted them as a zero-sum good, meaning that if one side gained something, another side necessarily had to lose. This mindset exacerbated the very problem that these governments were ostensibly trying to combat because it encouraged wealthy states to buy up as much vaccine as they could, leaving inadequate supplies for less-wealthy states—and leaving them vulnerable (Peacock, 2022). Vaccine diplomacy refers to the process of countries using vaccine doses as a tool to improve their relationships with recipient states. While Peter J. Hotez (2021) presents vaccine diplomacy as a tool to promote the common good, many analysts see it as more transactional. Yanzhong Huang (2021) comments on China's vaccine diplomacy efforts, "where Beijing's inoculations go, its influence will follow." This sort of behavior is not unique to China; Samantha Kiernan, Serena Tohme, and Gayeong Song (2021) note that the United States, Germany, France, and other leading donor states have earmarked a significant portion of their vaccine dose donations to "be distributed in a manner that cements donors' traditional spheres of influence" rather than being based on need and global equity.

Both vaccine nationalism and vaccine diplomacy can thwart many of the aims of global health governance, but they are consistent with the current rules of the international political economy. Antoine De Bengy Puyvallee and Katerini Storeng (2022) show how these ideas conflict with each other, leading to a situation in which COVAX's "impact was undermined by donors' and industry's pursuit of national security, diplomatic, and commercial interests, which COVAX largely accommodated."

It is beyond the scope of this chapter to provide a comprehensive evaluation of the shortcomings of COVAX or an overview of the rules of the international political economy when it comes to pharmaceuticals, but this short digression illustrates that we cannot—and should not—try to separate international political economy from global health governance. When health and trade come into conflict with each other, health generally loses. The global trade governance system has more teeth, and organizations like the World Trade Organization have the power to levy penalties that can have direct effects on states. The global health governance system, by contrast, relies predominantly on normative consensus and naming-and-shaming to encourage compliance. This is not to say that norms are not powerful in global health, as most countries comply with global health rules in most instances (Ruger, 2012). The fact remains, though, that there are multiple and competing subsystems of global governance, and states have decided to give greater power and authority to the economic systems than those governing health. Our systems prioritize those who can pay—and do so at our collective peril.

CONCLUSIONS, OR AT LEAST FINAL THOUGHTS

In September 2019, I had the opportunity to give a lecture as part of the launch of my book at my home institution. I could never have imagined that the issues that I was sharing with my audience about the nature of global health governance and the interplay between globalization and health would become front and center for the global community in a few months. One message that I tried to stress to the audience, and in the text of *Globalization and Health*, is that the ease of movement of people and goods across borders—the very hallmarks of globalization—may indeed increase the risk of disease outbreaks. At the same time, though, those very qualities that may heighten the risk we face also provide us with the tools that we can use to fight back against these outbreaks.

Despite everything that has happened over the past two years, I still believe that. At the same time, the COVID pandemic should be a catalyst to push us to continue to explore the interplay between globalization and health and better prepare ourselves for the next outbreak. We know that we will see pandemics in the future; we just do not know when they will happen, where they will start, and what will cause them. This is why we need to be on guard and avoid the panic-neglect cycle that tends to characterize so much of the approach that policy makers tend to take toward global health (Yong, 2022). We may not be able to predict the future, but it behooves us to continue applying the lessons that we learn now to improve our ability to navigate the future.

Diseases do not respect borders, and the COVID-19 pandemic has provided stark reminders about the need for countries to look beyond their own myopic sovereign self-interest to take a more collaborative approach. In many ways, this is the same lesson we have learned on a whole host of other issues, like addressing climate change, protecting the oceans, and combatting pollution. At the same time, though, the intersection of globalization and health brought forth by the COVID-19 pandemic demonstrates the need for holistic policies that center the social determinants of health (including gender) in international politics, the importance of designing institutions that can incentivize the cooperative approaches that are necessary to adequately address the challenges, and the vital need to recognize the interconnectedness of political and economic policies. Rather than seeing this as a conflict between widespread collectivism versus strict notions of Westphalian sovereignty, COVID-19 shows us the need to build policies, institutions, and diplomatic venues that can appreciate local concerns and needs while keeping our shared global needs in mind. Globalization may heighten our risk of pandemics, as the increased flow of people and goods across borders with ever increasing speed makes it easier for microbes to spread, but globalization can also provide us with the tools and information necessary to respond in a timely manner.

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