

INDIA AND SHIFTING DYNAMICS OF GLOBAL HEALTH GOVERNANCE SINCE 1990S

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**DOCTOR OF PHILOSOPHY
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BY
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DECLARATION

I, **Vivek N.D. (Enrolment No. 15SPPH03)**, hereby declare that the PhD thesis entitled **“India and Shifting Dynamics of Global Health Governance since 1990s”** submitted by me under the guidance and supervision of Dr. S. Shaji, Department of Political Science, University of Hyderabad, is a bonafide research work, which is also free from plagiarism.

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CERTIFICATE

This is to certify that the research work embodied in the present PhD thesis entitled **“India and Shifting Dynamics of Global Health Governance since 1990s”** submitted by **Mr. Vivek N.D.** bearing **Enrolment No. 15SPPH03** in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy in the Department of Political Science is a bonafide work carried out by him under my guidance and supervision.

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A. Publications:

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LIST OF ABBREVIATIONS

ASHAs	Accredited Social Health Activists
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
CHC	Community Health Centre
CHE	Current Health Expenditure
COVAX	COVID-19 Vaccines Global Access
CSDH	Commission on the Social Determinants of Health
CSOs	Civil Society Organisations
DMA	Disaster Management Act of 2005
EDA	Epidemic Diseases Act of 1897
FCTC	Framework Convention on Tobacco Control
G20	Group of 20
G7	Group of Seven
G8	Group of Eight
GAIN	Global Alliance for Improved Nutrition
GATS	General Agreement on Trade in Services
GAVI	Global Alliance for Vaccines and Immunisation
GFTAM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GHG	Global Health Governance
GHI	Global Health Initiatives
GHSA	Global Health Security Agenda
GOARN	Global Outbreak Alert and Response Network
HSRs	Health Sector Reforms
IAVI	International AIDS Vaccine Initiative
IDSP	Integrated Disease Surveillance Programme
IGOs	Intergovernmental Organisations
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IMF	International Monetary Fund
INGOs	International Non-Governmental Organisations
IPHS	Indian Public Health Standards
MDGs	Millennium Development Goals
MNCs	Multinational Corporations
MSF	Médecins Sans Frontières (Doctors Without Borders)
NATO	North Atlantic Treaty Organisation
NCDC	National Centre for Disease Control
NCDs	Non-communicable diseases

NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHM	National Health Mission
NHP	National Health Policy
NRHM	National Rural Health Mission
NTS	Non-Traditional Security
OECD	Organisation for Economic Cooperation and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Centre
PHM	People's Health Movement
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPPs	Public Private Partnerships
SAPs	Structural Adjustment Programmes
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
THE	Total Health Expenditure
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UK DFID	United Kingdom Department for International Development
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UNSC	United Nations Security Council
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation
WTO	World Trade Organisation

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CHAPTER 1

INTRODUCTION

1.1 Introduction

Historically, illnesses of various kinds have been a threat to mankind, and despite the advances in medical sciences and technology, they continue to be a threat in the present and will be for a foreseeable time. This study discusses aspects of the role of health as a non-traditional area in the field of International Relations (IR)ⁱ and the changing contours of how health has been understood within the field more specifically so within the context of India since the 1990s. It focuses on the nature of health as an issue which is generally considered a matter of individual choice to how there are global ramifications on the health outcomes of individuals via the interactions of the state as well as non-state actors in the globalised context. Further, this study analyses the changing role of the state with respect to how health policies are implemented at the national level with particular reference to the states from the Global South, especially India. The context for the changing nature of the state with respect to health policy is the increased economic globalisation witnessed since the end of the Cold War. The increased interdependence seen in the relations between states in the global system seemingly indicates not only how national health policies are dictated by policymakers at the national level, but also influenced by the ideas and institutions that are borrowed or imposed within the larger global sphere of governance and policymaking.

This study also details the changing notions of what is considered important in terms of policy issues and concerns within this larger field which links health and

ⁱ International Relations (IR) refers to the academic study of relations between two or more states as well as the international governance structure that has emerged since the end of the World War II. International relations (without the capitalisation) refers to the broader acts of foreign policy and daily interactions between states that lead to policy and decision-making.

international relations. This study argues that health has become a policy choice that is not only affected by the decisions of individuals at the local level, but is a result of national and global political and socio-economic interests. Further, these political and socio-economic interests are often mediated by institutions and international organisations that frame debates of and about health in the global arena. The term “global health” has been used in this study to refer to the policies and agendas of international organisations that enable an understanding of health as one that has universalⁱⁱ implications.

“Global health” started to be used more frequently in the public policy literature in the 1990s, picked up momentum around 2000s, and eventually surpassed the phrase “international health” at the beginning of the 21st Century¹. The term “global health” came into existence in the 1990s as a result of broader historical and political developments, in which the World Health Organisation (WHO), a prominent intergovernmental organisation under the institutional framework of the United Nations Organisation (UNO), faced scrutiny over its dominant role and began adapting within the evolving power dynamics². From 1948 to 1998, the WHO transitioned from a widely acknowledged leader in global health to an organisation facing reduced influence and financial constraints. This transition was exacerbated by the growing prominence of formidable new actors like philanthropic organisations such as the Bill and Melinda Gates Foundation (BMGF) and emerging economic powers like China, which increased their financial support to the revival of the WHO³. Responding to these changes, the WHO began redefining its role as the supervisor, principal architect, and principal manager of global health endeavours⁴. Over the past two decades, the term global health has gained a political visibility and status that was hitherto accorded only to matters of strategy, trade, security, energy and other elements of “high politics”.

ⁱⁱ The study understands the idea of the universal as one that cuts across various sections of societies and nationalities over a period of time.

While the general understanding within both public health and international relations literature view each other differently in terms of theoretical approaches and methods to understand this emerging terrain, health related issues are relatively prominent now on the global agenda. The Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) envisioned by the United Nations (UN) have served as distinctive focal points for bringing together civil society, donors and states to address development concerns, especially health⁵. In general, attaining good health and well-being (SDG 3) not only reflects the intrinsic value of a healthy population but also acts as a catalyst for achieving other SDGs. Health contributes to poverty eradication (SDG 1), quality education (SDG 4), gender equality (SDG 5) and economic growth (SDG 8), emphasising its central role in fostering a sustainable and equitable future for all.

Placed within the debates and contexts of how global health is understood, this introductory chapter begins with a background of the study. The survey of relevant literature is set out thereafter. It then lists the main research questions and research objectives employed in framing the study. This is followed by a section on the theoretical framework, methodology and key concepts used in the study, to interpret the data and evaluate the impact of globalisation on health policy in the context of the states in the Global South, especially India. The chapter ends with an outline and organisation of the study, highlighting some of the key issues each of the following chapters will focus on.

1.2 Background of the Study

The discourse on Global Health Governance (GHG) rose around the early 2000s as a response to the new dynamics of global health structures⁶. These dynamics were characterised by growing challenges to the management of health issues associated with the greater presence of multinational corporations (MNCs) as well as substantial extension of inter-sectoral interdependence such as trade and commerce⁷. The period

starting with the early 2000s also witnessed an increasing pressure to address health problems in countries from the Global South especially human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) and tuberculosis (TB)⁸. Health issues were beginning to be seen as security threats that affected nation-states as well as from the perspective of human rights in terms of policies pushing for more equitable access to quality healthcare⁹. There was also a significant increase and plurality of actors in health policy making and implementing. These developments were accompanied by important changes in the institutional level leadership around global health policy leading, in particular, a perceived lesser role of the WHO and the birth of new hybrid organisations involving public-private partnerships¹⁰. These developments initiated a new relationship between health, foreign and development policy making and the actors involved. Some of the key factors in the changing of these dynamics included a new global context post the end of the Cold War and the rise of neo-liberal policy across the globe since the late 1980s.

Until the mid-1990s, issues pertaining to international health were still largely managed by the WHO and a few other international organisations like the World Bank (WB) and International Monetary Fund (IMF) involving health cooperation in Global South countries¹¹. The situation, however, drastically changed in the following years. Non-state actors such as civil society organisations (CSOs), large foundations and MNCs greatly increased their involvement in global health, and new types of hybrid organisations were created. These new set of important actors in global health including bodies such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM launched in 2002), the Global Alliance for Vaccines and Immunisation (GAVI launched in 2000), BMGF founded in 1994 (health programmes commenced in 1999) and the proliferation of a multitude of smaller and medium sized actors have significantly changed the agenda and the dynamics in the global health arena. The shift in agenda setting has occurred through their command of their own financial and technical resources¹². The change in agenda has also proved to be attractive partners

for national governments to bypass difficult processes of reconciliation of interests in intergovernmental organisations (IGOs)¹³. Since the mid-2000s, IGOs like the Organisation for Economic Cooperation and Development (OECD), the G7/8 and G20 have also become active in international health diplomacy¹⁴. The increasing interconnectedness of the global economy has led to a proliferation of opportunities for private actors to organise transnationally, bringing about a shift in the landscape of global health and fostering new avenues for cross-border collaboration and innovation.

The significant changes in these processes are not only characterised by growing opportunities for private actors to organise transnationally, an after effect of increased globalisation, but have also provided a critique of many multilateral organisations, including the WHO, for being excessively bureaucratised, political in nature and left lacking for want of concrete results since the late 1980s¹⁵. As a result, private actors now are well situated to make use of the growing opportunities in the transnational space to position themselves as effective actors through novel initiatives of their own. The issues that have been recognised and the efforts that have emerged are numerous and diverse, ranging from tobacco control (the Bloomberg Foundation) to child and maternal health to the development of an HIV vaccine (International AIDS Vaccine Initiative, IAVI) to basic hygiene (Global Public-Private Partnership for Handwashing with Soap) (the Bloomberg Foundation)¹⁶. Further, states themselves have developed strategies to side-line multilateral organisations in order to better link programmes related to health and other arenas to their own foreign policy interests¹⁷. Growing health problems called for new solutions on a global scale, and the creation of large global health initiatives in the form of hybrid organisations arose as an important strategy of Global North countries to change the institutional framework for tackling global health problems together with other non-state actors.

A prime example is the GFATM, which was instituted in 2002 to combat TB, malaria, and HIV/AIDS¹⁸. The concept was first mooted at a G8 meeting held in

Okinawa, Japan, in 2000. Genuine engagement started to consolidate at the 2001 African Union summit, extended during the Special Session of the UN General Assembly in June of that same year, and was eventually approved by the G8 at their summit in Genoa, Italy, in July 2001¹⁹. Established in January 2002, the Global Fund emerged following the formation of a Transitional Working Group tasked with defining its guiding principles and operational framework. This collaborative initiative pools international resources to strategically combat AIDS, tuberculosis, and malaria as public health threats. The Global Fund represents a partnership among governments, civil society, technical agencies, the corporate sector, and individuals affected by these diseases²⁰. Thus, the Global Fund is a pioneering international financing partnership committed to combating three major infectious diseases—HIV/AIDS, TB and malaria. By mobilising resources, fostering partnerships and supporting health programs worldwide, the Global Fund plays a pivotal role in advancing global health and working towards the sustainable development goal of ensuring healthy lives for all.

The rise of GHG, in contrast to the narrow confines of a multilateral state-based model, which has been called ‘international health governance’²¹, has transformed global health into a field of complex and dynamic relationships between governments, multilateral institutions, and national and transnational non-state actors. This has correspondingly shifted the intersection between global health and national policies proposed by health ministries (of different federal/central/provincial governments) with a more technical orientation towards foreign policy considerations linked to human rights, development policy and trade as well as security issues²². An exemplary endeavour, the “Global Health and Foreign Policy Initiative”, inaugurated in September 2006 in New York, was spearheaded by the Foreign Ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand. On March 20, 2007, the above-mentioned ministers issued a statement²³:

“We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time. Life and health are our most precious assets. There is a growing awareness that investment in health is fundamental to economic growth and development. It is generally acknowledged that threats to health may compromise a country’s stability and security. We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make impact on health a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective.”

In making health a concern of foreign policy, the consortium of nations who participated in the conference recognised the global impact that health has in modern economies. The ‘Global Health and Foreign Policy Initiative’ marked a significant collaborative effort among nations across the world. It also underscored the critical interconnection between health and foreign policy. By uniting diverse nations under a common framework, the initiative sought to address global health challenges comprehensively, recognising the intricate links between health, development and diplomacy. The commitment of these influential nations highlighted the importance of fostering a collective approach to tackle health issues on the international stage, emphasising cooperation, shared strategies and the recognition that health security is integral to global stability and prosperity.

Following this trajectory, since early 2000s, a new system of GHG has emerged which is characterised by – an increasingly diverse group of actors, changing roles in governance processes and an increasingly complex set of interactions at multiple levels. However, the proliferation of actors has led to a widespread concern that this increasingly interconnected and complex system could lead to a waste of resources through duplication and inconsistencies with the design of solutions and activities in line with local cultural and social contexts, thus making the system difficult to

coordinate²⁴. Thus, GHG in the context of globalisation involves the coordination and regulation of health-related policies, programmes and initiatives across nations and international organisations to address shared health challenges and promote equitable access to healthcare resources on a global scale.

GHG and global politics link to the processes of globalisation, which have been described as the “intensification of cross-border flows of goods, services, finance, people, and idea”²⁵. Responses in many areas of global concern such as the environment, transport, communication and progressively health have led to rule and norm building processes at the global level and within international organisations²⁶. This is complemented by the increasing transnational connectivity of people, communities, corporations and countries which has led to an increased density of transnational relations supported by spatial, temporal and ideational shifts and changes²⁷. Emerging common identities based on characteristics other than nationality, for example ‘People living with HIV/AIDS’ or among people in civil society networks such as the People’s Health Movement (PHM) fighting for health as a human right, create a new political space occupied by transnational communities with shared norms and political goals²⁸. The increased process of globalisation has led to notable changes in GHG, emphasising collaborative efforts, information-sharing and coordinated responses among nations and international organisations to address emerging health threats and promote collective health outcomes worldwide.

The transformation of GHG reflects a complex reconfiguration of traditional international relations into a system of global politics, where not only new non-state actors but also rising states like China and India have gained influence²⁹. Health is not a standalone concern, and the issues that it causes are a result of the interplay of a variety of different elements with health aspects³⁰. Population dynamics (both population increase and mobility), migration, urbanisation, and globalisation all interact with health to produce a non-traditional challenge. Such a challenge can be seen as an outcome emerging out of intriguing links between and among various

actors³¹. Global health issues have been transformed from matters of inter-governmental negotiation of a mainly technical nature into issues of global significance for many sectors in many political avenues. Recently, the significance of global health challenges in foreign policy has grown, gaining recognition at the highest echelons of international politics³². Advocates of global health view this heightened political attention as a positive shift, as it has resulted in increased funding and attention directed towards critical global health issues³³. This is an emerging area wherein the linkages between foreign policy and global health are analysed, especially in the study of IR. In addition, in the policy realm there are very few attempts to link foreign policy and global health as well as on developing policy scenarios coordinating global health initiatives with national objectives in foreign policy. With the rise of multiple actors the practice of GHG has become complex and fragmented but also flexible and creative, linking global health to a broad field of global governance processes³⁴.

India reflects the global scenario in terms of global health governance through various national linkages with the WHO and the involvement of philanthrocapitalist initiatives. India actively engages with the WHO in various health-related programs and initiatives, leveraging its resources and expertise to contribute to global health efforts. For example, India participates in WHO's campaigns and initiatives aimed at tackling diseases like TB, malaria, and polio, which have global implications³⁵. Additionally, India hosts regional WHO offices, in New Delhi and collaborates with the organisation on research, policy development, and capacity-building initiatives³⁶. Moreover, philanthrocapitalist initiatives, spearheaded by individuals or organisations with significant financial resources, play a crucial role in addressing healthcare challenges in India. Initiatives such as the BMGF's partnerships with the Government of India, state governments and other stakeholders have helped fund and implement various health programs, particularly in areas like immunisation, maternal and child health, and infectious disease control³⁷. These examples

underscore India's active participation in global health governance and its commitment to addressing health challenges both domestically and internationally.

Thus, GHG involves addressing health challenges through collaborative efforts, emphasising the need for effective coordination, international partnerships and shared responsibilities to overcome global health issues within the broader context of global governance. These processes take place at all levels of governance including national and local level politics. In fact, global politics is not only a global level phenomenon but a complex multi-level system. An expanding array of non-state and non-governmental entities, including influential foundations, MNCs, multi-sectoral partnerships, and civil society organisations (CSOs), are exerting influence on global health policy³⁸. The continued evolution of GHG is significantly influenced by the current phase of globalisation, which has led to enormous increases in bilateral and multilateral spending in global health. Due to the processes of globalisation, however public institutions at the national level are required to balance their roles as the primary setter of binding rules and authoritative decision-making with concurrent collective action at the international level³⁹. In such a situation, non-state actors (such as MNCs, philanthrocapitalist organisations, etc.) are well organised to operate on a global scale and are thus in a position to circumvent national policies. As a result, the requirement for international rule-making becomes stronger. It also leads to newer types of transnational alliances, for example, governments of developing countries allying themselves with CSOs to push the adoption of the WTO's Doha Declaration in 2001^{iii 40}. GHG has witnessed the emergence of new forms of hybrid actors within the global health system, reflecting a shift towards more inclusive and diverse

ⁱⁱⁱ The November 2001 declaration of the Fourth Ministerial Conference in Doha, Qatar, provides the mandate for negotiations on a range of subjects related to trade and development including issues concerning the implementation of the present agreements. These negotiations take place at the level of the Trade Negotiations Committee and its subsidiaries where developing countries have a better position to bargain for their trade and developmental needs. Other negotiations under the work programme are conducted as part of WTO councils and committees.

collaborations involving non-state actors, CSOs and private sector entities alongside traditional governmental institutions.

These new types of hybrid actors comprise members of at least two of the three types of political actors (states, private for profit actors and CSOs) in their governing bodies and together with other forms of Public Private Partnerships (PPPs), they have begun to engage with, address and deliver to the health needs of populations in developing countries. They also ensure research that corresponds to the needs of the developing countries⁴¹. GHIs strive to integrate the specific requirements identified by national governments, intergovernmental organisations (IGOs), and CSOs with the scientific and technological capabilities of private corporations, alongside the financial backing from donor countries, public funds, and private foundations. As of 2023 there were more than 200 PPPs working in the health sector worldwide, with 218 accredited NGO's in an official relationship with the WHO⁴².

The roots of health governance can be traced back to negotiations initiated among nation-states in the mid-19th Century, with a primary mandate to safeguard and enhance public health, particularly through the implementation of quarantine measures aimed at controlling infectious diseases⁴³. The evolutionary process of health governance began in the mid-19th Century with the first efforts among states to craft international standards for the implementation of sanitation through the International Sanitary Conferences and the setting up of the League of Nations Health Office a technical body created in 1920 to address international health issues⁴⁴. In response to rising worries about human disease outbreaks, 14 worldwide conferences known as the International Sanitary Conferences were convened. In 1851, the French government hosted the inaugural Sanitary Conference, aimed at standardising global quarantine regulations to combat the dissemination of diseases such as yellow fever, plague and cholera. Between 1851 and 1938, 14 conferences were held; they were instrumental in establishing the Office International d'Hygiène Publique before World War II and the WHO in 1948⁴⁵. These negotiations were conducted initially for specific

purposes – primarily to contain communicable diseases, then through more formalised institutions and treaties, leading to the establishment of the WHO under the UN structure on April 7, 1948.

The WHO's role in GHG is made clear in its Constitution which notes its main function is to act as “the directing and coordinating authority on international health work”⁴⁶. The underlying principle of GHG is to ensure effective and fair deployment of the world's resources to enhance people's health. Thus, health governance implies “the use of formal and informal institutions, rules and processes by states, IGOs, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively”⁴⁷. However, with increased economic globalisation and integration into a global market economy in the post-Cold War era, most states have undergone changes in their health systems, making it a challenge for states to take collective action resulting in various gaps and challenges in the health governance system. The scope of GHG has thus broadened as a result of various factors. A 2013 report by the Director General of the WHO titled “WHO's role in Global Health Governance” summarised the changing circumstances quite succinctly⁴⁸. The changes noted include the following.

The landscape of health governance has evolved beyond the exclusive realm of national governments. With the emergence of information technology and social media, a diverse array of actors—including the media, nation-states, MNCs, professional associations, philanthropic foundations, trade associations, individuals and informal diffuse communities—now wield significant influence and contribute to decision-making processes that profoundly shape health outcomes. These actors collectively contribute to shaping decisions that significantly impact public health. The emphasis on fostering new organisations, financing channels and monitoring frameworks rather than reforming existing ones complicates the institutional landscape of global health. This complexity is particularly critical in Global South countries with numerous development partners. Emerging entities such as Doctors

Without Borders (Médecins Sans Frontières, MSF) and international foundations like the BMGF have significantly bolstered their influence in GHG, shaping agendas and political processes. The proliferation of new global health initiatives since the early 2000s, including the GFATM, GAVI, Roll Back Malaria, the Stop TB Partnership, and the Global Network for Neglected Diseases, has brought forth increased medical expertise and substantial financial resources to the field.

Global governance and policy discussions often revolve around the intricate task of safeguarding human health without unduly impeding trade, travel and economic prosperity. While achieving this delicate balance remains paramount, there is a growing chorus of voices from NGOs and CSOs from across the world advocating for broader considerations, particularly concerning fairness and equity. A notable instance highlighting efforts to enhance fairness and equity in global health occurred in the early 2000s when CSOs successfully pursued strategies, such as securing a Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement waiver, to broaden access to antiretroviral drugs for HIV/AIDS treatment. As outlined in the “Rio Political Declaration on Social Determinants of Health (2011)”, two distinct concepts emerge: "governance of health," which addresses various aforementioned challenges, serving as a coordinating mechanism aimed at ensuring coherence and direction within the health sector. The second notion, termed "governance for health," encompasses lobbying and public policy efforts directed towards influencing governance across diverse domains to positively impact human health outcomes.

Thus, instead of a hierarchy or a market system, the simplest way to describe contemporary GHG is as a network, where autonomous, purposeful people negotiate the rules that will govern their interactions⁴⁹. Over the past few decades, hundreds of new players have started participating in GHG, influencing agendas, rule-making, implementation, monitoring, and enforcement⁵⁰. These actors are linked by intricate webs of financial connections, professional networks and official and informal governance structures⁵¹. The primary strength of global health is its multidisciplinary

nature, particularly the use of methods from fields other than biomedicine. It broadly implies that the new methods acknowledge the role of political, social, and economic issues which shape the poor health of people across countries⁵². An analysis of the origins and social determinants of non-communicable diseases reveals a complex and expansive range of interconnected social, economic, and environmental factors, even as governance actions in other sectors significantly impact many health issues. These factors encompass tobacco consumption, dietary habits such as excessive salt and alcohol intake, and increasingly sedentary lifestyles, among others⁵³. These factors, in turn, are intertwined with policies regarding income distribution, housing accessibility, employment opportunities, transportation infrastructure, agricultural practices, and educational systems. These policies, in turn, are influenced by trends in global trade, finance, advertising, cultural dynamics, and communication networks. Even though each of these issues has a set of potential policy levers, coordinating a cogent response across nations continues to be one of the biggest governance difficulties in global health. Recent developments in GHG increasingly emphasise addressing social determinants of health (SDH), recognising their significant impact on health outcomes worldwide. Efforts are being made to integrate social determinants considerations into policy-making processes to ensure more comprehensive and effective approaches to improving global health equity. Political tensions surrounding global health initiatives, such as vaccine distribution and pandemic response strategies, are shaping the discourse in Global Health Governance. Moreover, socio-economic disparities exacerbated by historical inequalities are driving discussions on the need for more inclusive and equitable policies in addressing global health challenges. By acknowledging the multifaceted influences on health outcomes and governance, the current study aims to contribute to a significant understanding of how policies and decisions in various sectors intersect with health outcomes, thereby informing effective strategies for improving global health equity and fairness.

Hence, the landscape of global health governance is undergoing significant changes, with a shift towards more collaborative and multi-stakeholder approaches to address complex health challenges. India's national health governance is increasingly intertwined with these global processes, reflecting its growing role and influence in the global health arena. As India emerges as a key player in global health governance, it is actively engaging with international organisations like the WHO and participating in global health initiatives and partnerships. India's national health policies and programs are increasingly aligned with global health priorities, reflecting a recognition of the interconnectedness of health issues across borders. By integrating its national health governance into the larger scheme of global health governance, India is contributing to collective efforts to improve health outcomes and address global health inequities.

1.3 Review of Related Literature

David P Fidler, a senior fellow specialising in global health and cybersecurity at the Council on Foreign Relations, asserts that the heightened human mobility and societal transformations linked with modern globalisation have escalated the cross-border risk posed by both communicable and non-communicable diseases⁵⁴. Bio-medical solutions to combat diseases were successful from the 1940s in the post-World War II era. The discovery of penicillin and other antibiotics are cases in point. Henk van den Berg, a noted entomologist, points out that other scientific advances such as the increased use of dichloro-diphenyl-trichloroethane (DDT) against disease-carrying insects since 1939 helped in immunising people against the direct attack of various threatening diseases⁵⁵. The period after World War II also witnessed the setting up of the WHO in 1948 and its expansion in operations across all countries. As Chandrakant Lahariya notes, the WHO was mandated with promoting good health across the globe by leading various campaigns including immunisation leading to the eradication of small pox in 1978⁵⁶. Efforts to combat disease saw success until the 1970s, but ultimately led to heightened resistance to drugs and pesticides among

populations, triggering a resurgence of certain diseases such as malaria⁵⁷. It underscores the complex nature of disease control efforts and the need for sustainable strategies that take into account the potential for the development of resistance over time.

This return of infectious diseases (malaria, TB, etc.) motivated the WHO to endorse a more “horizontal” approach to global public health. The “horizontal” approach to global public health refers to an integrated and comprehensive strategy that seeks to address multiple health issues simultaneously, rather than focusing on individual diseases or health challenges in isolation. It emphasises the interconnectedness of health problems and recognises that a single health issue often has implications for other health outcomes and the overall well-being of communities and populations. Within the new policy framework, the WHO prioritised addressing the root causes of susceptibility to disease. Thus, promoting the idea of provision of primary health care to citizens across the world. Such an approach resulted in the signing of a major multilateral agreement – the Alma Ata Declaration in 1978, which states⁵⁸:

“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.”

At the same time, a plethora of state and non-state actors including NGOs and MNCs (involved in health care and policymaking), continued with the “vertical” approach of seeking to eradicate diseases. The “vertical” approach to global public health refers to a disease-specific or single-issue strategy that focuses on tackling one specific health problem or disease at a time. Unlike the horizontal approach that

integrates interventions and addresses multiple health challenges simultaneously, the vertical approach dedicates resources, efforts, and interventions to combat a particular health issue in isolation. This approach is often associated with targeted and intensive efforts to control or eliminate a specific disease or health problem. According to HIV experts Helene D Gayle and Gena L Hill, starting with the 1990's the conventional state security significance of diseases like HIV/AIDS has led to greater efforts by institutions and increased funding interest in global public health policy⁵⁹. This shift suggests a recognition of the interconnectedness between health and security, as well as the recognition that infectious diseases pose significant threats to national and international stability. Further, this reflects a broader understanding of security that encompasses not only military threats but also health and social challenges that affect populations worldwide.

As the Global Health Policy researchers, Preslava Stoeva, Johanna Hanefeld and Benjamin Hawkins identify, beginning in the 20th Century, health concerns acquired an enduring position on the global political agenda, as seen by the relatively quick development of regional and global intergovernmental institutions⁶⁰. However, because they were viewed by conventional IR experts as being of "low politics," or not being of strategic importance, they continued to fall outside the ambit of IR. The 1990s saw the emergence of the next wave of security challenges, and it was then that U.S. analysts such as Laurie Garrett began to warn of the threat that bioterrorism and worldwide pandemics of newly and re-emerging infectious illnesses presented to the country⁶¹. Other academics such as David P Fidler and Andrew Price-Smith asserted that the issue of global health involved national security, foreign policy, and international security politics because it affected not only the United States but the entire world⁶². Since then, a number of facets of health politics have been studied in an IR framework, with an emphasis on issues relating to governance, international organisations, human rights, commerce, globalisation, and intellectual property rights.

Moreover, health studies within the realm of International Relations discussions frequently align with the Non-Traditional Security (NTS) and Human Security frameworks, a trend that emerged in the 1990s, as they address broader security issues beyond conventional military threats. Both NTS and Human Security frameworks substantially subscribe to liberal/liberal institutionalist ideas. They emphasise the well-being and safety of individuals and communities in the face of various non-military challenges, including health-related issues. As Mely Caballero-Anthony notes within the Non-Traditional Security (NTS) framework, NTS refers to threats and challenges that do not originate from traditional military sources but have significant implications for the security of states and individuals⁶³. Health-related issues, such as infectious disease outbreaks, pandemics, food and water insecurity, and environmental health risks, fall within the purview of NTS. Health studies in the context of NTS by Rebecca Katz and Daniel Singer analyse the impact of health challenges on national and international security, including their potential to cause social, economic, and political instability⁶⁴. As a result, addressing health challenges becomes not only a matter of public health policy but also a crucial component of broader security strategies aimed at maintaining stability and resilience in societies.

In the Human Security framework, Shahrbanou Tadjbakhsh and Anuradha M Chenoy emphasise the need for the protection and empowerment of individuals and communities, recognising that the well-being of people is inseparable from state security⁶⁵. Health is a central component of human security, as access to healthcare, protection from health threats, and the ability to lead healthy lives are fundamental aspects of human well-being⁶⁶. Health studies within the human security framework focus on the intersection of health and security, examining health vulnerabilities, inequalities, and the impact of health crises on human rights and human dignity.

In both the NTS and Human Security frameworks, health studies offer insights into how health challenges can affect the stability and well-being of individuals and societies. Scholars such as Garret Wallace Brown et al., highlight the interconnectedness between health and security, underscoring the need for effective

governance, cooperation, and global responses to health crises⁶⁷. By placing health studies within these frameworks, scholars such as Ya-Wen Chiu et al., show how one can better understand the multidimensional nature of health security⁶⁸, address health disparities and design policies that prioritise the protection and empowerment of people in the face of health threats.

The human security approach to global health has sparked several debates and discussions within the academic and policy circles⁶⁹. While the human security framework emphasises the centrality of individuals and communities in addressing health challenges, there are varying perspectives on its implementation and effectiveness as noted by Jenifer Prah Ruger⁷⁰. These perspectives include, a critique of the individual-centric approach that overlook systemic issues and structural determinants of health, concerns about limited scope that may not fully capture the complex interplay of various factors affecting health outcomes, such as environmental degradation, infectious diseases and access to healthcare services and an emphasis on the need for multi-sectoral collaboration in implementing human security approaches to health, highlighting the involvement of various stakeholders beyond traditional health sectors.

Some scholars and policymakers such as Ilona Kickbusch and Kelly Lee advocate for a broad interpretation of health security, encompassing not only traditional health threats like infectious diseases but also considering social determinants, environmental factors, and access to healthcare as crucial elements⁷¹. Others such as Jeremy Farrar and Mirta Roses argue for a narrower understanding of health security, focusing primarily on the management and containment of specific health crises and diseases, which may lead to a more targeted and effective response⁷².

Critics including Theodore H. Tulchinsky and Elena A. Varavikova raise concerns about the potential securitisation of health within the human security framework, whereby health issues are framed as security threats. This perspective prioritises militarised responses to health emergencies by diverting resources from long-term health development initiatives⁷³. By allocating resources towards military

interventions for addressing health crises, such as deploying armed forces for containment or control measures, there may be a diversion of funds, attention and efforts away from sustainable, preventive healthcare programs and infrastructure development. This shift in focus could hinder progress in building resilient healthcare systems, addressing underlying health disparities and promoting overall public health and well-being in the long run.

Proponents of the human security approach to health such as Gary King and Christopher Murray, however, call for a balance between individual and state security⁷⁴. Human security emphasises the protection of individuals and communities, sometimes challenging the state-centric approach to security. As Preslava Stoeva underscores, the debate centres on finding a balance between individual security needs and state responsibilities in providing public health services and safeguarding health of the people⁷⁵. The human security approach calls for addressing interconnected health challenges. This debate revolves around how to allocate limited resources effectively to maximise health outcomes for vulnerable populations⁷⁶. One of the approaches could be to effectively allocate limited resources and maximise health outcomes for vulnerable populations in the Global South in order to prioritise investments in primary healthcare infrastructure, preventive services and community-based health initiatives tailored to local needs and contexts.

Apart from the NTS and Human Security and Health debates, political economists such as Kent Buse, Nick Drager and Wolfgang Hein draw attention to the role of corporate actors, epistemic communities and civil society in the governance of health issues⁷⁷. The formation of the World Trade Organisation (WTO) and the subsequent ratification of the General Agreement on Trade in Services (GATS) and TRIPS agreements in Marrakesh in 1994 spurred investigations into the political economy of global health. Following this trend, scholars in the field, such as Devi Sridhar and Mayur Patel, have examined topics including the intersection of international trade and health, the impact of TRIPS on healthcare accessibility and affordability, and the correlation between GATS and the delivery of healthcare

services⁷⁸. IR researchers such as Kelly Lee have also looked at the relationship between health and the rising amount of international commerce and travel, which is sometimes referred to as the essence of globalisation. They analyse the impacts of globalisation on health, along with the repercussions of poor health on a globalised economy⁷⁹. However, as the political scientists Kasturi Sen, Imrana Qadeer and Eduardo Missoni note, the politics of health governance have been confined to a more peripheral position in the larger field since scholars have seldom tried to join in the discussion or add their own perspectives to IR's theoretical discussions⁸⁰. This suggests that there is a gap in the exploration of health governance within the context of IR theory, potentially limiting the depth of understanding and analysis in this area.

Referring to emerging and re-emerging infectious diseases, numerous political scientists sought to integrate epidemiological insights into their analyses. In the early years of the new millennium, publications in political science featured contributions from IR scholars like Simon Rushton and Gwyn Prins. They delved into the actual and anticipated global epidemics of HIV/AIDS and influenza, focusing on their ramifications for regional and international security⁸¹. Despite the globe coming near to some of the projected critical scenarios due to the fast spread of HIV/AIDS, after the introduction of anti-retroviral medications, the situation did not become worse. Consequently, other experts in IR, such as Stephan Elbe, have proposed that health issues ought to be removed from the global security agenda. Moreover, the attention to infectious diseases and bioterrorism as security threats has waned⁸². Further, in analysing health issues in the post-COVID-19 context, realist scholars may exhibit techno-triumphalism by emphasising the role of technological innovations, such as vaccine development, digital surveillance and healthcare infrastructure improvements, as primary solutions to global health challenges, overshadowing other socio-political and economic factors.

However, in non-realist perspectives, health entails more than merely the existence or nonexistence of disease or illness. Health encompasses more than simply the state of being free from illness or disease. It is also shaped by social determinants

of health (SDH), a concept advocated by public health authorities like Michael Marmot and Richard Wilkinson. These determinants encompass various factors such as local historical factors, globalisation, cultural influences, socio-economic status, and other elements that define the everyday circumstances of populations⁸³. Priority setting in health policy has primarily been disease-oriented, centring on biomedical interventions and technical innovations to treat diseases and reduce mortality rates. However, there has been less emphasis on understanding the broader socio-political factors that contribute to shaping disease outcomes⁸⁴. Thus, the priority in GHG often leans towards a disease-centric approach rather than addressing underlying socio-political determinants, potentially limiting the effectiveness of interventions in tackling broader health disparities and systemic challenges.

For example, economists Jeffery D Sachs and John W McArthur observe that at the global level, the emphasis on illness and fatality is evident in the fact that three out of the eight Millennium Development Goals (MDGs) were related to health⁸⁵. These objectives aimed to achieve a two-thirds reduction in under-five mortality and a 75% decrease in maternal mortality between 2000 and 2015. Additionally, they targeted achieving MDGs 4, 5, and 6, which involve halting the spread of HIV/AIDS, malaria, and other diseases⁸⁶. According to the MDGs Report (2015) by the UN, although none of these targets were achieved by their 2015 deadline, significant progress was evident in certain indicators. Below-five fatality figures decreased by over 50%, maternal fatality by 45%, and fresh HIV infections by 40%. Furthermore, it's estimated that 6.2 million fatalities from malaria were averted⁸⁷. A significant portion of these advancements can be directly credited to effective health and therapeutic mediations. These include the improved access to antiretroviral therapy, the rise in institutional births attended by professional mid-wives and the implementation of vaccination programmes⁸⁸.

Although the MDGs demonstrate the effectiveness of clinical strategies in enhancing health, there is a widespread agreement that medical interventions alone are inadequate to comprehensively and efficiently tackle health disparities. According

to public health researchers Paula Braveman, Susan Egerter, and David R. Williams, addressing the underlying social determinants driving global health patterns is also essential⁸⁹. A significant portion of the evidence supporting this perspective emerged after the inception of the MDGs, largely through the efforts of the WHO's Commission on the Social Determinants of Health (CSDH)⁹⁰. The emerging health paradigm is also evident in the new Sustainable Development Goals (SDGs), where health is explicitly addressed in only one goal (Goal 3: Ensure healthy lives and promote well-being for all at all ages). However, it is implicitly addressed in numerous other goals that target recognised the SDH (e.g., Goal 1 on poverty, Goal 2 on nutrition, Goal 4 on education, etc.)⁹¹. On one hand, according to economist Christopher J. L. Murray, the SDGs might be interpreted as downgrading the priority of health by addressing it in only one out of 17 goals, compared to three out of eight MDGs⁹². On the other hand, as noted by political scientists Kent Buse and Sarah Hawkes, prevailing discourses in global health recognise that illnesses are shaped by a broad spectrum of explanations⁹³. Prioritising these various external factors is believed to have cascading effects on health outcomes, emphasising prevention over cure.

This transformation in the understanding of global health hasn't been devoid of obstacles. One such challenge pertains to the scope at which health issues are conceptualised and comprehended. While overarching trends in disease prevalence (as depicted by national estimates) have traditionally shaped global health agendas⁹⁴, there's a growing recognition of the importance of local (subnational) health experiences⁹⁵. Yet, public health experts Ronald Labonté and Ted Schrecker acknowledge that significant global determinants still exert influence over these local experiences⁹⁶. This suggests that global health strategies must be tailored to fit regional contexts and cannot be generalisable to other contexts, unlike clinical interventions, which are inherently designed to be broadly applicable for global impact⁹⁷. Other challenges confronting progress in global health include pandemics, environmental factors, differences in income and access to healthcare, rise of non-communicable diseases and forced migration resulting from political crises. Challenges to global

health differ significantly between the Global North (developed countries) and the Global South (developing countries). According to a noted health expert Madhukar Pai, these variations are a result of differences in socio-economic conditions, healthcare systems, and access to resources and technology⁹⁸. Some key challenges faced by the Global North include aging populations and non-communicable diseases (NCDs) like heart disease, diabetes, and cancer. Managing chronic health conditions poses significant challenges for healthcare systems⁹⁹. Further, the burden of mental health problems, such as depression and anxiety, is growing in Global North countries¹⁰⁰. Developed countries also face escalating healthcare costs due to advances in medical technology and rising drug prices. Ensuring healthcare system sustainability while providing high-quality services remains a challenge¹⁰¹. While developed countries generally have better health outcomes, health disparities exist within these countries, particularly among marginalised populations with limited access to healthcare: for instance, African-Americans in the case of the US.

Challenges in the Global South include most prominently – infectious diseases. As Abdesslam Boutayeb notes, Global South countries bear a disproportionate burden of infectious diseases like malaria, HIV/AIDS, tuberculosis, and neglected tropical diseases, due to limited healthcare infrastructure, poor sanitation, and poverty¹⁰². High maternal and child mortality rates persist in the Global South due to inadequate access to skilled healthcare during pregnancy and childbirth. Public health experts from the Global South, including Obinna Ositadimma Oleribe point to inadequate healthcare infrastructure, shortages of healthcare professionals, and financial barriers that hinder access to quality healthcare in many developing countries¹⁰³. Global South countries often face challenges related to malnutrition and food insecurity, leading to stunted growth and susceptibility to diseases in general¹⁰⁴. Inadequate access to clean water and sanitation facilities exacerbates the transmission of infectious diseases and poses substantial health hazards in countries of the Global South. As Global South countries undergo economic transitions, the burden of non-communicable diseases is also increasing due to changes in lifestyle and dietary habits. Global South countries

often have limited health system capacities to respond effectively to health emergencies and outbreaks, such as the COVID-19 pandemic. Global South countries may further face challenges in accessing essential medicines and vaccines due to high costs and inadequate healthcare infrastructure¹⁰⁵. Both the Global North and Global South face unique global health challenges, and addressing them requires collaborative efforts among nations, international organisations, NGOs, and other stakeholders through various multilateral initiatives. Effective strategies should focus on strengthening healthcare systems, promoting preventive healthcare measures, addressing social determinants of health, enhancing healthcare infrastructure, and ensuring access to essential medicines and vaccines. Additionally, global health initiatives should be sensitive to the diverse needs and contexts of different regions and populations.

As public health experts Harley Feldbaum, Kelly Lee and Josh Michaud observe debates around global health are happening in International Relations because global health is deeply interconnected with political, economic, social, and environmental factors on a global scale¹⁰⁶. As a result, it intersects with key concerns and dynamics addressed within IR theories. They are driven by the recognition of health as a critical component of international relations, with implications for security, governance, power dynamics, and global justice. Understanding and addressing global health challenges within IR theories contribute to a comprehensive approach to promoting global health security and equitable health outcomes¹⁰⁷. The field of global health within IR theoretical debates is enriched by the contributions of numerous prominent scholars. These scholars have made significant advancements in understanding the complexities of global health governance, health diplomacy, health security, and health-related issues in the context of international relations¹⁰⁸. Scholars such as Ilona Kickbusch, Kelly Lee, Lawrence Gostin, David Fidler and Devi Sridhar, among others, have contributed extensively to research on global health. The current study intends to focus on the social, political and historical constituents of health

policy, a lacuna that is perceived in the literature. In view of this discussion, the current study poses two research questions.

1.4 Research Questions

The key research questions the study plans to address in this study are:

1. How do political, social, economic and historical factors shape global health governance and its dynamics in the contemporary era characterised by globalisation, a plurality of actors, and the presence of diverse institutions and processes?
2. How do such factors affect the way policy decisions related to health are made and implemented in countries in the Global South, with particular reference to India in the post 1990s?

1.5 Objectives of the Study

The study is planned to analyse the nuances of global governance and policy roles of key actors in the politics of health governance and policy making in India.

The study explores mainly five aspects. They are:

1. To study the evolution of global health governance in relation to major milestones in the area of health at the global level
2. To examine the nature and preponderance of multilateral institutions which includes philanthrocapitalist initiatives within global health governance
3. To understand the processes of agenda setting in global health governance including ideas, institutions and interests
4. To analyse how the intrinsic connections between the private sector/market and policy makers affects health and health governance in the countries of the Global South such as India

5. To understand the nature and involvement of global institutions in the securitisation of health in the context of new pandemics such as COVID-19

1.6 Theoretical Framework and Methodology

The theoretical framework adopted for this study is liberal institutionalism, which provides a lens through which to analyse the evolving dynamics of global health governance. Rooted in liberal political theory, liberal institutionalism posits that international cooperation and governance are best achieved through the establishment of formal institutions, rules and norms. Within the context of global health, this perspective emphasises the role of institutions such as international organisations, treaties and agreements in shaping health policies and responses to global health challenges. By employing liberal institutionalism, this study seeks to examine how these formal structures influence the behaviour of state and non-state actors, shape decision-making processes and ultimately impact the effectiveness of GHG in addressing pressing health issues since the 1990s. Within the framework of liberal institutionalism on global health, scholars like David Resnik advocate for a statist approach, emphasising the role of states in creating and enforcing international health regulations, while others like Kelley Lee advocate for a globalist approach, prioritising intergovernmental institutions such as the WHO to address global health challenges through cooperation and coordination among states.

In essence, global health represents a health paradigm that transcends national boundaries, prioritising the enhancement of health and the attainment of health equity for all individuals across the globe¹⁰⁹. This approach comprehensively tackles health inequalities worldwide by targeting the SDH: the circumstances or environments in which individuals are born, grow, live, work, and age, which significantly influence their health¹¹⁰. Global health differs from its precursor, 'International Health', a concept that emerged in the post-World War II era and was primarily motivated by the desire of Global North countries to assist Global South countries in enhancing their

health¹¹¹. Farmer et al. also links international health to colonial/tropical medicine which was a major factor in expanding and establishing empire¹¹². They also interrogate if global health as such is not a continuity of furthering the interests of the developed countries in the current context of expanding markets in a globalised economy. As global health extends beyond national borders, health concerns in one location are not solely the responsibility of the populations directly impacted¹¹³.

Although evidence supports the connection between SDH and health outcomes, minimal action has been initiated to tackle these determinants on an international level. Further, the effect of SDH interventions on consequences for health is less measurable in comparison to the influence of disease-focused mediations on decreasing afflictions. Consequently, global health funders have shown less interest in these determinants, prioritising interventions with clear targets, rapid results, and quantifiable impacts, such as those promised by biomedical and clinical approaches¹¹⁴. Hence, it's unsurprising that "top-down" clinical interventions aimed at decreasing mortality caused by highly specific and well-understood disease pathways have garnered more attention, given the challenges of altering fundamental socio-economic dynamics¹¹⁵.

To further clarify the concept of global health, Brown, Cueto et al. characterise, contemporary global health to encompass "the process of increasing economic, political, and social interdependence and integration as capital, goods, persons, concepts, images, ideas and values cross state boundaries"¹¹⁶. Consequently, the analytical framework of global health extends beyond technocratic, medical, and traditionally apolitical foundations, departing from earlier concepts like public health or international health. Richard Horton, the editor of the foremost journal for medicine and public health, *The Lancet*, the prominent medical journal stated in a 2009 article, "It [global health] is biomedicine, epidemiology, demography, public health, anthropology, economics, political science, law, engineering, geography, informatics, even philosophy"¹¹⁷. To date, diverse academic contributors have attempted to

conceptualise global health. This group encompasses a wide range of disciplines, including medical doctors, epidemiologists, anthropologists, biologists, medical historians, public health specialists, and political scientists who have embraced approaches such as human security, among others.

The Global North, a concept used in the study throughout, is composed of developed and high-income countries, plays a central role in structuring GHG and influencing debates within the field. This influence is driven by several factors, including economic power, technological advancements, political influence, and historical legacies¹¹⁸. Knowledge production surrounding global health, for instance, has emerged primarily from institutions and scholars within the Global North. These knowledges have been buttressed by health diplomacy practised by countries of the Global North in their foreign policy transactions with the Global South¹¹⁹. The Global North, therefore, plays a significant role in structuring global health governance, shaping health priorities, and influencing debates within the field. It is essential to recognise these dynamics and promote inclusive and equitable global health policies that address the health needs of all nations, including the Global South.

The concept of the Global South comprises several low- and medium-income countries primarily located in Asia, Latin America, the Caribbean and Africa that share common historical experiences of colonisation, underdevelopment and economic marginalisation¹²⁰. Beyond its geographical connotation, the Global South represents a collective identity shaped by shared challenges, aspirations and struggles for socioeconomic development and political agency. Tangibly, the Global South is characterised by persistent disparities in income, healthcare access, education, and infrastructure when compared to the wealthier nations of the Global North. These disparities often manifest in high levels of poverty, inequality, and vulnerability to global crises such as climate change, pandemics and economic downturns. Moreover, the Global South is marked by a complex web of geopolitical dynamics, including

dependencies on Northern economies, efforts to assert autonomy and sovereignty, and collaborations among Southern nations to address common challenges.

In summary, it can be observed that the majority of global health definitions tend to adopt centralised policymaking, wherein global-level repercussions extend to all levels – be it the local, nation or region. Additionally, the political dimension of health may not necessarily be explicitly acknowledged because global health is inherently intertwined with political factors, which are integral to the governance dynamics referenced by most global health concepts¹²¹. In a certain sense, it echoes what Rudolf Virchow, the 19th century physician and public health activist said over hundred years ago, in that “medicine is a social science and politics nothing but medicine on a grand scale”, health should be considered not only as a measure but also as a consequence of broader political dynamics¹²². Health needs to thereby be understood as politics by other means.

The study employs a methodology, combining analytical and empirical approaches that integrate both qualitative and quantitative research methods. The overarching aim is to delve into various aspects of GHG through a case study analysis of the Indian health system. This methodological framework allows for a nuanced examination of the complex interplay between national health policies, international institutions and regulations and the dynamics of global health governance.

Data collection for this study is varied, incorporating both qualitative and quantitative sources to provide a holistic understanding of the subject matter. Qualitative data were gathered through documentary analysis and informed discussions with key public health experts, while quantitative data were obtained from statistical reports, surveys and databases. This mixed-methods approach enables a triangulation of findings, which in turn strengthens the study. A central component of the methodology involves conducting a case study analysis of the Indian health system. By focusing on a specific country context, this approach facilitates an

exploration of the intricacies of health policy formulation, implementation and governance within a diverse and dynamic socio-political landscape.

Primary sources play a pivotal role in the data sources, providing contextually relevant information for analysis. Intergovernmental documents from the WHO, government documents from the Ministry of Health and Family Welfare, Government of India, and policy documents from NITI Aayog serve as valuable sources of information on national health policies, strategies and initiatives. Technical reports and official records of multilateral organisations such as the OECD, government agencies, and non-state actors such as the BMGF and the Global Fund, further contribute to the dataset, offering insights into GHG dynamics.

In addition to primary sources, secondary data sources such as scholarly books and journal articles as well as information available in the public domain through media and other sources are also analysed. This approach ensures a clearer understanding of the GHG landscape, encompassing diverse perspectives and viewpoints. By triangulating data from multiple sources, the research aims to provide a nuanced and multi-dimensional analysis of the subject matter.

The analysis of primary and secondary data is conducted using analytical frameworks which allow the analysis by blending qualitative and quantitative data. By integrating qualitative and quantitative research methods and conducting a detailed case study analysis of the Indian health system, the research aims to make a modest contribution to the field of global health governance, advancing our understanding of the complexities and challenges inherent in this critical area of study.

1.7 Organisation of Study

The study comprises of seven chapters. Chapter 1 provides an overall context for the study and problematises the topic to be researched. Chapter 2 frames the theoretical background to the current study on the politics of GHG through the

liberal institutionalist perspective. Chapter 3 traces a broad summary of the historical developments that led to the emergence of GHG and also examines how its historicity has privileged certain discourses over others within the discipline. Chapter 4 deals with the nature of negotiations and shifts in politics of global health agenda setting including the key actors and their influence over the allocation of financial, technological, human, and other forms of resources towards addressing global health challenges. Chapter 5 assesses India's health system since the 1990s tracing the evolution of India's health policies, financing and health sector reforms that were an outcome of the economic liberalisation that the country underwent starting with the early 1990s. Chapter 6 addresses the development of global health security structures especially the International Health Regulations (IHR) and securitisation of the COVID-19 pandemic in India. Chapter 7 summarises the major arguments of the study and puts forth the conclusion. In essence, the study tries to analyse the nature of national health governance in the contemporary period and its linkages with the architecture of global health governance through the debates in IR by highlighting the Indian experience.

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CHAPTER 2

GLOBAL HEALTH THROUGH LIBERAL INSTITUTIONALISM: AN OVERVIEW

2.1: Introduction

Liberal institutionalism, a prominent theoretical perspective in International Relations (IR), emphasises the role of international institutions, cooperation and the development of norms and rules to manage global challenges, including health. At its core, it seeks to promote stability, order and collective action in the complex and interconnected world of international politics. Further, liberal institutionalism recognises the significant role of multinational corporations (MNCs) and other non-state actors, such as non-governmental organisations (NGOs), in shaping international cooperation and global governance.

This chapter aims to provide the theoretical background to the current study on the politics of global health governance and policy focusing on liberal institutionalism. The chapter commences with a short section on the origins of liberalism and more specifically on notions of liberal institutionalism, a prominent variant within liberalism in the field of IR. This is followed by sections on its various assumptions on the workings and substantial nature of world affairs, as well as the focal themes within liberal institutionalism including multilateralism in IR. Multilateralism is crucial within liberal institutionalism as it fosters international cooperation, promotes the development of shared norms and rules and provides a platform for collective action, helping to address complex global challenges including issues revolving around health more effectively. The following section looks at a few other prominent theoretical perspectives within the larger literature on IR vis a vis liberal institutionalism and the issue of global health. The critiques of liberal institutionalism as an IR theory put forth by academics are covered in the following section. The chapter then examines the two strands that shape perspectives on global

health within the liberal institutionalist framework – viz. statist vs globalist interpretations of issues of health within IR in light of recent developments. The chapter finally concludes with a summary of the main points discussed.

Using a liberal institutionalist approach within the field of IR to study health in the global context can offer several advantages. Liberal institutionalism places a strong emphasis on international cooperation and the creation of international institutions and organisations to address global issues. In the context of global health, this approach recognises that health challenges, such as pandemics or the spread of infectious diseases, often transcend national borders and require coordinated efforts among states and other actors. This perspective is particularly relevant when addressing global health crises. Liberal institutionalism promotes multilateral approaches to problem-solving. Multilateral organisations like the World Health Organisation (WHO) are essential for coordinating solutions to health issues in the field of global health. They set standards and facilitate information sharing among countries. A liberal institutionalist approach acknowledges the importance of these institutions and their role in global health governance. Finally, liberal institutionalism promotes a rules-based international order. In the context of global health, this approach emphasises the importance of adhering to international health regulations and agreements, which can help prevent the spread of diseases and ensure a coordinated response to health emergencies. This chapter explores the question: is it possible that the liberal institutionalist approach to global health, with its emphasis on multilateralism and hybridity in health governance, offers a viable alternative for comprehending global health in the contemporary global landscape?

Liberalism or pluralism is one among the many theories of IR. Liberalism in IR, like any other theory in the social sciences, is based on a variety of presumptions made by many academics from the viewpoints of the various disciplines to which they belong. In the current study, the attempt is to discuss the various tenets of liberalism within IR. Many of these presumptions are not consistent with realism which has a different worldview in terms of ideas related to IR characterised by liberalism.

Liberalism is important to understand, since it provides the theoretical basis for those who advance the role of international organisations such as inter-governmental organisations, NGOs, civil society organisations, private MNCs, religious bodies, etc. in the global system.

2.2: Pluralist Postulates: The Assumptions of Liberalism

Liberal institutionalism traces its roots back to the philosophical insights of Immanuel Kant, whose work laid the groundwork for the liberal tradition in IR. Kant's essay "Perpetual Peace" outlined a vision for a peaceful international order based on republican governance, free trade and the establishment of a federation of states. His ideas emphasised the importance of institutions in promoting cooperation and reducing the likelihood of conflict between nations. Kant argued that institutions, such as international organisations and treaties, could help regulate states' behaviour and create a framework for resolving disputes peacefully. Classical liberal thinkers further developed Kant's ideas in the field of IR and political science. Similarly, economic scholars like Adam Smith and David Ricardo emphasised the benefits of free trade and economic interdependence among nations. They argued that trade could promote peace by creating mutual interests and fostering cooperation between states. Additionally, classical liberals such as John Stuart Mill advocated for individual rights and liberties as essential components of a just and stable international order. These thinkers believed that promoting liberal values globally could contribute to the creation of a more peaceful and prosperous world.

Following those notions, liberal theory emphasises on collaboration, interdependence, and the possibility of advancement through diplomacy and multilateralism. Liberal concepts in IR were developed as a result of the work of IR theoreticians including Joseph Nye, Robert Keohane, and Immanuel Kant. According to Kant's idea of perpetual peace, which he presented in his essay "Perpetual Peace: A Philosophical Sketch," republican governments should form a federation (world

federation) in order to bring about enduring peace. He also said that democratic states are less prone to go to war with one another. Expanding on these concepts, Keohane and Nye supported liberal institutionalism, the theory that international organisations and regimes can reduce hostilities and encourage collaboration between states¹. Their research on transnational relations and complex interdependence supports the idea that globalisation and interconnection promote shared norms and reciprocal interests, which lessen the likelihood of conflict. In general, liberal concepts that place an emphasis on collaboration, institutionalisation, and the goal of global wealth and collective security have been pushed by researchers of IR.

The importance of international institutions in fostering state cooperation and stability is emphasised by John Ikenberry² and Michael Doyle's³ theories of liberal institutionalism in IR. They contend that because international institutions offer a framework for resolving disputes amicably and furthering shared interests, liberal democracies, in particular, have a stake in their creation and maintenance. The scholars place a strong emphasis on the role that institutions play in influencing state conduct, building confidence, and assisting in the peaceful and diplomatic settlement of conflicts. In general, their research highlights how liberal institutionalism may support collaboration and order in the global system.

In the 20th Century, liberal institutionalism gained prominence as scholars sought to understand and address the challenges of international cooperation in an increasingly interconnected world. Institutions such as the League of Nations and later the United Nations Organisations (UNO) were seen as crucial mechanisms for managing conflict and promoting collective security. Liberal institutionalists argued that these organisations could serve as fora for dialogue, negotiation and conflict resolution among states. Moreover, they believed that by fostering a shared sense of community and common interests, international institutions could help overcome traditional barriers to cooperation and promote stability and prosperity on a global scale.

In the latter half of the 20th Century, liberal institutionalism in IR finds its economic intellectual roots in the works of modern liberal thinkers, among whom Friedrich Hayek and Milton Friedman stand out as influential figures. Hayek, an Austrian economist and Nobel laureate, is renowned for his emphasis on individual liberty and free markets. In "The Road to Serfdom" (1944), Hayek argued against central planning and highlighted the dangers of unchecked government authority⁴. Although his focus was primarily on domestic affairs, his ideas laid the groundwork for liberal institutionalism by championing decentralised decision-making and the importance of institutions that safeguard individual freedoms.

Milton Friedman, another prominent classical liberal economist and Nobel laureate, made significant contributions to the liberal institutionalist framework through his advocacy of free-market capitalism. Friedman's influential book "Capitalism and Freedom" (1962) argued for limited government intervention in the economy and stressed the role of voluntary exchange⁵. His ideas not only contributed to the development of economic liberalism but also influenced the broader liberal institutionalist perspective in IR. Friedman's emphasis on the benefits of free trade and economic openness aligns with the liberal institutionalist belief that cooperative and interconnected economic relations can contribute to global stability and peace.

The post-World War II era saw the practical application of liberal institutionalism in the formation of international organisations and agreements. Classical liberal thinkers like Hayek and Friedman had a significant impact in shaping the intellectual foundations that underpinned these developments. The establishment of organisations like the General Agreement on Tariffs and Trade (GATT) and the UN reflected liberal ideas of international cooperation, collective security and the establishment of rules-based systems. The principles advocated by classical liberal thinkers, especially regarding economic openness and limited government intervention, became integral to the design and functioning of these international institutions.

Liberalism encompasses a diverse array of ideological strands, each with its own distinct focus and principles. Classical liberalism, originating in the Enlightenment era, emphasises individual liberty, limited government intervention and the protection of property rights. Adherents of classical liberalism advocate for free markets, minimal regulation and the rule of law as essential components of a just and prosperous society⁶. Classical liberal thought which commenced with the philosophical ideas of John Locke and Adam Smith continues to influence political and economic discourses to this day.

In fact, modern liberalism, also known as social liberalism, emerged in response to the social and economic challenges of industrialisation and inequality. Modern liberals prioritise the role of the state in addressing social injustices, ensuring social welfare, and promoting equal opportunities for all citizens⁷. Influenced by thinkers like John Stuart Mill and John Maynard Keynes, modern liberalism advocates for government intervention in areas such as healthcare, education and income redistribution to mitigate inequalities and promote the common good. This strand of liberalism emphasises positive liberty, which entails the ability to pursue one's goals and fulfil one's potential with the support of societal resources.

Neoliberalism, another strand of liberalism, represents a more market-oriented strand of liberalism that gained prominence in the latter half of the 20th century, particularly with the rise of globalisation and free-market policies. Neoliberalism advocates for the primacy of free markets, deregulation, privatisation and limited government intervention in economic affairs⁸. Proponents of neoliberalism argue that reducing state involvement in the economy fosters competition, innovation and economic growth, ultimately benefiting society as a whole. However, critics contend that neoliberal policies can exacerbate inequalities, weaken social safety nets and prioritise corporate interests over public welfare. Thus, liberalism encompasses various strands, including classical liberalism, social liberalism, and neoliberalism, each emphasising different aspects of individual freedom, equality, and market dynamics. In contrast, realism prioritises state power, security, and the anarchic

nature of international relations, often advocating for a balance of power among states.

On many fundamental tenets, liberalism differs from realism, one of the most influential theories in IR. These two schools of thinking diverge in a number of ways. To start with, liberalism/pluralism regards non-state players as being crucial to the international system, in contrast to realism, which sees the state as the main actor. It is important to point out that neoclassical realists recognise the influence of non-state actors, but they emphasise that state power and interests remain central in shaping international relations, with non-state actors often operating within the constraints and opportunities defined by the state's objectives and capabilities. Liberals disagree with realism on the state's exclusive importance. Individual and institutional actors are more or less equally important in international relations, even if the state does play a primary role in the international system. In connection with this, liberals, in contrast to realists, also hold that internal politics should not be disregarded. In other words, liberals believe that internal political participants, parties, institutions, and events are equally important in defining the character and operation of the state's external affairs⁹. This underscores the interconnectedness of domestic and foreign policy arenas.

Thus, liberals give precedence to the actions and desires of individuals and collectives, especially those inside a state. As a result, liberalism argues that "domestic state-society relations constitute the central issue of politics"¹⁰. Further, in contrast to realism, which values a person's commitment to the nation-state, liberal theory asserts that individuals' interests can be frequently in conflict with those of the ruling class. As Moravcsik explains, "Private individuals independently calculate personal gains and losses from foreign policy, popular support for foreign policy initiatives, for government institutions and, indeed, for the survival of the state itself, all depend fundamentally on the precise nature of individual preferences and their relation to the international environment"¹¹. Liberal philosophy makes it clear that members of a society may have goals that differ significantly from those of the state leader or

leaders. Thus, a state's ability to maintain a cohesive home front is not easily achieved. As Moravcsik notes, "[F]or Liberals, the foreign policy preferences of governments are directly influenced by the formal representative institutions that link state and society. These domestic "transmission belts" include political parties, electoral systems and bureaucracies"¹². Thus, realist arguments that the state is a single actor are refuted by this argument. Nevertheless, it's important to note that these individual interests don't always align harmoniously. Certain liberals acknowledge the tension arising from the divergent political interests of various actors. In keeping with the idea of numerous actors, liberal institutionalism emphasises the concept of "complex interdependence," which originally was laid out by Keohane and Nye in the early 1970s. They characterised institutionalism to be different from realism in four ways¹³. Firstly, there are several channels for communication between all types of actors that span international boundaries, expanding the channels for communication and linkages between governments and non-state actors. Secondly, in contrast to realism, which places the focus on military security issues, liberal institutionalism allows for equal examination of all issues because high and low politics are not distinguished. Thirdly, in liberal institutionalism, governments try to achieve absolute gains through cooperation rather than conflict which is advocated by realism. States are known for being less concerned with the comparative advantages other states have obtained through cooperative relationships. Fourthly, non-compliance with international standards and laws as promulgated by international organisations like the UN or the World Bank is the main obstacle to collaboration in world affairs. Liberal institutionalism promotes collaboration and soft power through the machinery of collaborative diplomacy, the forms and procedures of international law, and general international organisation in regard to the issue of non-compliance among nations.

However, despite these problems, liberalism promotes the idea that people may work together through democratic institutions to achieve shared purposes and aspirations¹⁴. While realists and liberals both acknowledge that the state is anarchical,

liberals disagree that there is a struggle for control over resources and authority. Instead, in anarchy, governments benefit more through collaboration or dependency than from competition¹⁵. Alternatively put, liberals pay particular attention to interdependence in terms of economic ties of mutual exchange and mutual dependence between peoples and governments.

Moreover, liberalism advocates for the notion that nations can cooperate with each other independently, without the need for a single superpower to orchestrate or enforce such collaboration. Liberal institutionalists interpret this aspect through the lens of global organisations such as the United Nations (UN), World Trade Organisation (WTO), or WHO, as well as the concept of international regulations that govern state behaviour in areas such as peace and security, trade and commerce, or health¹⁶. These sets of rules are also called “regimes”ⁱ. In many cases they go together, the trade regime is for instance shaped primarily by the WTO, or the WHO in the case of health. Liberal Institutionalists thus claim that international institutions help promote cooperation between states. As Scott Burchill explains:

“Anarchy is mitigated by regimes and institutional cooperation which brings higher levels of regularity and predictability to international relations. Regimes constrain state behaviour by formalising the expectations of each party to an agreement where there is a shared interest. Institutions then assume the role of encouraging cooperative habits, monitoring compliance and sanctioning defectors. Regimes also enhance trust, continuity and stability in a world of ungoverned anarchy”¹⁷.

These political institutions might differ in terms of their makeup and character. These institutions may be more centred on the individual human person in certain cases, while in other cases, their purpose may be to build an international institution, such as an international (governmental) organisation made up of states¹⁸. However,

ⁱ James N. Rosenau in *Governance Without Government: Order and Change in World Politics* (1992) describes "regimes" as issue-specific institutional arrangements that bring together states, international organisations, and non-state actors to cooperatively address and manage particular global challenges or problem areas.

through institutions that create and defend standards like individual rights and an open economy, states can collaborate with one another to increase their economic prosperity and, through institutions and cooperation, the security of the state as a whole.

Furthermore, realists and liberals differ on the concepts of relative and absolute power. Liberals place a considerably greater value on absolute power than on relative power¹⁹. Therefore for liberals, regardless of how wealthy or powerful the other state would be as a result of a particular transaction, if two states can come to an agreement and both gain from it, this would be a policy choice worth exploring²⁰. On the other hand, even if both states would profit from an agreement, realists have frequently criticised alliances and trade deals when they make one state stronger than the other. As Burchill states “Liberal institutionalists, on the other hand, believe international relations need not be a zero-sum game, as many states feel secure enough to maximise their own gains regardless of what accrues to others”²¹.

Thus, there is a conviction among liberal thinkers that concepts like absolute advantages, in particular as they pertain to economic interdependence and cooperation, “[F]ree trade has been viewed as a more peaceful means of achieving national wealth, because, according to the theory of comparative advantage, each economy would be materially better off than if it had been pursuing national and self-sufficiency (autarky)”²². Moreover, liberals (like Dale C Copeland) also hold the belief that trade will not only increase a state's economic might but:

“Free trade would also break down the divisions between states and unite individuals everywhere in one community. Artificial barriers to commerce distorted perceptions and relations between individuals, thereby causing international tension. Free trade would expand the range of contacts and levels of understanding between the peoples of the world and encourage international friendship and understanding”²³.

This supports the notion that interdependence encourages nations to avoid war in order to retain economic ties with other states, which would help states refrain from acting aggressively towards one another. As such, liberalism, pluralism, or liberal

institutionalism lays out that actors in the international system can possibly reach a “peaceful world order”, and not one of violence and insecurity that realists propound²⁴. Liberalism posits that humans are not inherently prone to violence toward one another. Instead, it asserts that peace is likely achievable in most circumstances.

Liberal institutionalism is a strand of liberalism that focuses on the role of international institutions and norms in promoting cooperation, peace and stability among states. Liberal institutionalists argue that international organisations, such as the UN, WHO and WTO, and multilateral agreements help mitigate conflicts and facilitate cooperation by providing a framework for resolving disputes and promoting shared interests²⁵. This strand of liberalism emphasises the importance of rules-based international order, collaborative diplomacy, and collective action in addressing global challenges such as climate change, human rights violations, economic disparities and global health.

Liberal institutionalism's approach to global health underscores the significance of international cooperation, institutions and the development of rules and norms in addressing complex health challenges on a global scale. It recognises that health issues, including the spread of diseases, access to healthcare and health equity, transcend national borders, necessitating a multilateral approach. Furthermore, liberal institutionalism promotes the idea that shared values, such as human rights and equitable access to healthcare, should guide global health initiatives. It also emphasises collaborative diplomacy and soft power in resolving health issues and underlines the importance of capacity-building in developing countries to strengthen their healthcare systems. Liberal institutionalism recognises the indispensable role of both state and non-state actors in shaping the landscape of global governance, underscoring the dynamic interplay between governments, international organisations (including intergovernmental organisations), NGOs, and other relevant stakeholders in addressing complex global challenges. In essence, liberal institutionalism offers a framework for fostering international collaboration

and governance to effectively address global health challenges and promote public health worldwide.

Liberal Institutionalism is situated at a vantage position to explain a key issue in global health governance viz.- Universal Health Coverage (UHC). It denotes a system wherein every individual and community can avail themselves of high-quality healthcare services without experiencing financial burdens. It entails ensuring that everyone can obtain the health services they need, including prevention, promotion, treatment, rehabilitation and palliative care, without facing financial hardship. UHC aims to provide access to essential health services for all individuals, regardless of their ability to pay and to protect individuals and families from the risk of impoverishment due to healthcare costs. It encompasses a wide range of health interventions and services, including preventive, curative and palliative care, as well as health promotion and disease prevention activities. UHC is a key component of sustainable development and is essential for achieving health equity and social justice. UHC in the context of liberal institutionalism revolves around the idea that achieving comprehensive health care for all is contingent upon international cooperation, the establishment of robust institutions and the development of shared norms and rules. In the realm of UHC, this perspective suggests that fostering cooperation, building strong global health institutions and setting universally accepted norms are essential for ensuring equitable access to healthcare services worldwide. The emphasis is on creating a framework where nations collaborate to overcome health challenges collectively, reflecting the principles of inclusivity and shared responsibility embedded in liberal institutional thought. Thus, UHC and liberal institutionalism are closely aligned in their shared commitment to promoting global health equity and access to healthcare services for all. Liberal institutionalism's emphasis on international cooperation and the establishment of norms and institutions aligns with the goal of UHC. Liberal institutionalism, by advocating for multilateral approaches and the development of international organisations, supports the creation of global frameworks and agreements that can advance the UHC agenda. It recognises that

addressing health disparities and achieving UHC often require collective action, cooperation among states and non-state actors and the promotion of shared values related to healthcare. Thus, the liberal institutionalist perspective can offer insights into how international institutions and collaborative efforts can be harnessed to progress toward the goal of universal health coverage on a global scale. The multilateral standpoint of liberal institutionalism aligns seamlessly with this perspective, emphasising the pivotal role of international organisations and collaborative endeavours in advancing the global agenda of universal health coverage.

2.3: The Multilateral Stand Point of Liberal Institutionalism

The multilateral standpoint of liberal institutionalism traces its roots to the aftermath of World War II when the international community recognised the need for collaborative institutions to prevent conflict and address global challenges. It emerged as a response to the failures of unilateralism and competitive power politics, promoting collaborative diplomacy, cooperation, and the development of international organisations to foster stability and cooperation on the global stage²⁶. Within the framework of liberal international relations, multilateralism is an important concept. It refers to an alliance or friendly association between multiple countries pursuing common objective(s). Multilateralism has been characterised by Miles Kahler as “international governance” or global governance of the “many”²⁷. Its core concept is to oppose discriminatory bilateral or unilateral decisions and agreements that result in stronger entities having hegemony over weaker ones on the international stage. This, too, in the opinion of liberal institutionalists, may create international conflict²⁸.

Robert Keohane, a noted liberal IR scholar, described multilateralism as “the practice of coordinating national policies in groups of three or more states”²⁹. John Ruggie enhanced the conventional idea of multiple actors forming an alliance to base multilateralism on the principles of ‘indivisibility’ and ‘diffuse reciprocity’ as an

institutional form within international relations. Thus, according to Ruggie multilateralism is that institutional arrangement:

"[...] which coordinates relations among three or more states on the basis of 'generalised' principles of conduct ... which specify appropriate conduct for a class of actions, without regard to particularistic interests of the parties or the strategic exigencies that may exist in any occurrence³⁰."

Membership in international institutions such as the WHO, International Monetary Fund (IMF) and World Bank (WB) encourages multilateralism, which helps weaker states interact with more powerful ones on a more equal footing. It also prevents unilateralism in establishing norms, and gives weaker states and non-state actors a voice and influence that they would not otherwise have³¹. Through group effort, multilateralism seeks to establish stability in the world order and collaboration. However, strong states also find benefits from multilateral accords since they are more resourceful and powerful and may set the rules while still enjoying privileges like veto power and special status within various institutional groupings.

International organisations, such as the UN and the WHO, are multilateral in nature. Multilateralism has historically been mostly backed by economically developed nations that are high income countries / middle powers like Canada, Australia, Switzerland, and the Nordic nations³². Less powerful states hold limited influence within international institutions, though their capabilities vary from country to country. At the same time, the BRICSⁱⁱ, a collective of emerging powers, has its own development bank – New Development Bank which aims to provide aid to the smaller and less developed countries from the global south on better terms and conditions. This trend is contrary to the approach of organisations like the World Bank and International Monetary Fund (IMF) which provide assistance and support on

ⁱⁱ The international economies of Brazil, Russia, India, China, and South Africa collectively make up the BRICS, which was created in 2010 after South Africa joined the BRIC group.

stringent terms and conditions. However, the effectiveness and scale of involvement of the BRICS in development matters is still under evaluation.

Multilateralism, exemplified by entities such as the UN, can entail collaboration among numerous nations, as well as regional or military alliances, pacts, or organisations like the North Atlantic Treaty Organization (NATO)ⁱⁱⁱ. These multilateral organisations were created or adopted by states and are used by states to enhance their ability to pursue their own interests via the coordination of their activities - security, economic and trade, health, environment among other political arenas. Moreover, these frameworks serve as mechanisms to curb opportunistic conduct and encourage coordination by enabling the sharing of information regarding states' actual adherence to different standards, such as trade regulations or health protocols related to anti-tobacco initiatives, to which nations have agreed³³. Regional multilateralism has also been advocated as a strategy to develop answers for current issues that cannot be resolved at the global level but are better handled locally, centred on a specific area or set of nations³⁴. Important regional multilateral organisations that issue guidelines and directives for specific objectives like trade and commerce or development include the European Union, Association of South East Asian Nations (ASEAN), Economic Community of West African States (ECOWAS), Southern African Development Community (SADC), The Pacific Alliance and Mercosur.

In a nutshell, the post-Cold War era has witnessed a substantial growth in multilateralism, marked by an increase in international cooperation, the proliferation of international organisations and a shift towards collaborative approaches to issues in global governance³⁵. The end of the Cold War, with its bipolar power structure, reduced the constraints on international cooperation and allowed for greater flexibility in diplomatic relations. The UN, along with its specialised agencies, gained

ⁱⁱⁱ With 29 European and 2 North American members, the North Atlantic Treaty Organisation, often known as the North Atlantic Alliance, is an intergovernmental military alliance. The North Atlantic Treaty, which was ratified in Washington, D.C., on April 4, 1949, laid the foundation for NATO, a system of collective security, which was developed in the years after the end of World War II.

prominence as platforms for multilateral negotiations and agreements on a wide range of issues, including peacekeeping, climate change and global health³⁶. Additionally, regional organisations, such as the European Union (EU) and the African Union (AU), have expanded their roles in addressing regional and global challenges. The spread of information technology (IT) and global interconnectedness has also facilitated communication and coordination among states and non-state actors. Overall, the post-Cold War era has seen an increased recognition of the importance of multilateralism as a means of addressing complex, transnational issues and promoting international peace and cooperation.

Thus, liberal institutionalism in the realm of global health governance emphasises the significance of international institutions, agreements and norms in addressing global health challenges. It posits that cooperative arrangements and institutional frameworks are essential for effectively managing health issues on a global scale. Liberal institutionalism highlights the role of organisations like the WHO, alongside various state and non-state actors, in setting standards, coordinating responses, and promoting cooperation among nations to tackle health threats such as pandemics, infectious diseases and health inequities. By fostering dialogue, facilitating information sharing and providing platforms for collective action, liberal institutionalism offers a framework for understanding how global health governance operates and how it can be strengthened to better address the diverse and evolving health needs of populations worldwide.

2.4: Criticism of Liberal Institutionalism

As a theoretical framework, liberal institutionalism too has come under a certain degree of criticism. While it offers valuable insights into how international institutions can promote cooperation among states and non-state actors, it has faced several notable challenges from scholars and critics. One of the key criticisms directed at liberal institutionalism is its idealistic nature³⁷. Critics such as Fearon and Walt, among others, argue that the theory tends to overestimate the willingness of states to

cooperate and underestimate the role of power politics in international relations³⁸. In addition, they contend that liberal institutionalism's faith in the ability of international organisations and norms to mitigate conflicts may be overly optimistic and fails to adequately account for instances where states prioritise their national interests over international cooperation.

Furthermore, some critics like Schweller and Priess argue that liberal institutionalism does not adequately address issues related to power imbalances among states³⁹. They point out that the theory assumes a relatively equal distribution of power among actors, which may not hold true in the real world. In cases where one state holds significantly more power than others, liberal institutionalism may not be able to explain or predict how institutions can effectively manage such power disparities. Additionally, some scholars have criticised liberal institutionalism for its limited focus on Western-centric institutions and norms⁴⁰. Critics argue that the theory may not fully account for the diversity of international actors and their varying levels of adherence to liberal principles. This Eurocentric bias can limit the theory's applicability in regions where liberal values may not be as prevalent or influential.

Liberal institutionalism's emphasis on international cooperation and the development of rules and institutions has not always resulted in substantial reforms that effectively address the needs of weaker countries, particularly those from the Global South⁴¹. Persistent power imbalances, vested interests of more influential states, and the challenges of implementing structural changes within international institutions have often limited the ability of liberal institutionalism to create a more equitable and inclusive global governance system. As a result, weaker countries continue to face obstacles in achieving their development goals and securing their interests within the international community, highlighting the complex and ongoing struggles for meaningful reforms in the global governance framework.

From within the perspective of liberal institutionalism, institutions are generally viewed as essential mechanisms for fostering cooperation, stability, and order in the international system. However, there are several critiques of institutions

from within this framework. One criticism is that institutions, particularly large and complex ones like the UN or the WHO, can become inefficient and bureaucratic⁴². Decision-making processes may be slow and cumbersome, hindering effective responses to urgent global challenges. This inefficiency may stem from the need to accommodate diverse interests and negotiate consensus among member states.

A second criticism levelled on liberal institutionalists is that they recognise that institutions rely on voluntary compliance and cooperation among member states⁴³. Nonetheless, critics contend that institutions frequently lack robust enforcement mechanisms to guarantee adherence to international regulations and agreements. Because of absent effective enforcement capabilities, institutions may encounter difficulties in tackling instances of non-compliance or violations efficiently. Another set of criticism is that institutions may reflect and perpetuate existing power imbalances among states⁴⁴. Powerful states may exert disproportionate influence within institutions, shaping agendas and outcomes to serve their own interests. This can lead to unequal treatment of states and undermine the principles of fairness and equality that institutions are intended to uphold. Institutions may also face limitations in addressing complex global challenges that transcend national borders. Critics argue that institutions may be ill-equipped to tackle issues such as climate change, global health pandemics, or transnational terrorism effectively due to their narrow mandates, lack of resources, or divergent priorities among member states⁴⁵. Finally, there are concerns about the legitimacy and democratic deficit within international institutions⁴⁶. Decision-making processes may lack transparency, accountability and inclusivity, leading to perceptions of democratic deficit and a lack of legitimacy among affected populations. This can undermine public trust in institutions and hinder their ability to mobilise support for collective action.

Overall, while liberal institutionalism recognises the importance of institutions in fostering cooperation and order in the international system, these critiques highlight some of the challenges and limitations that institutions may face in addressing global governance issues effectively. Addressing these critiques requires

ongoing efforts to reform and strengthen international institutions, enhance transparency and accountability, and promote greater inclusivity and participation in decision-making processes. Thus, liberal institutionalism emphasises the importance of international cooperation and the role of formal institutions, rules, and norms in addressing global health challenges, providing a framework for understanding how states and non-state actors collaborate within global health governance structures.

2.5: Liberal Institutionalism and Global Health

The study of global health is an increasingly crucial field in IR, with far-reaching implications for the well-being of individuals, communities, and nations. While various theoretical lenses can be employed to analyse global health issues, this study advocates for the use of liberal institutionalism as a valuable and insightful framework. Liberal institutionalism provides a comprehensive perspective that illuminates the complexities of global health governance, cooperation, and the promotion of global public goods. This section elucidates why liberal institutionalism should be employed as a theoretical lens to study global health.

Liberal institutionalism underscores the role of international institutions as key actors in facilitating cooperation among states. In the realm of global health, institutions such as the WHO play a pivotal role in shaping policy, coordinating responses to health crises, and setting norms and standards⁴⁷. Liberal institutionalism offers a lens through which one can analyse how these organisations, with their formal rules and norms, foster collaboration and contribute to the management of global health challenges. Global health governance relies heavily on the setting up and adherence to norms. Liberal institutionalism acknowledges the importance of shared values and norms in shaping state behaviour⁴⁸. In the context of global health, norms related to health equity, access to healthcare, and the importance of international cooperation are critical⁴⁹. Liberal institutionalism provides a framework for analysing how these norms are developed, diffused and embraced by states, influencing their engagement in global health efforts. The WHO plays a pivotal role in shaping global

health governance through the creation of policy frameworks such as Health Sector Reforms (HSRs) and International Health Regulations (IHR). These frameworks serve as standardised guidelines and protocols that member states can adopt and implement within their national health systems. For example, HSRs provide a structured approach to improving healthcare delivery, resource allocation, and service provision within member states, aiming to enhance the overall efficiency and effectiveness of health systems. Similarly, the IHR establish guidelines for the detection, assessment, notification, and response to public health events of international concern, ensuring a coordinated and harmonised approach to managing health emergencies across borders. By providing member states with these policy frameworks, the WHO facilitates cooperation and collaboration among nations, fostering a collective response to global health challenges while promoting equity, transparency, and accountability in health governance.

Global health often involves the provision of global public goods, such as disease surveillance, vaccine development, and pandemic preparedness. Liberal institutionalism's focus on cooperation and collective action is particularly relevant in understanding how states collaborate to provide these public goods⁵⁰. By emphasising the benefits of international cooperation in achieving common goals, liberal institutionalism sheds light on the dynamics of resource allocation, technology transfer, and the distribution of global health benefits.

Global health is not solely the purview of states; non-state actors, including NGOs, philanthropic foundations, and multinational corporations, play a significant role⁵¹. Liberal institutionalism recognises the importance of both state and non-state actors in shaping global governance. It offers a lens through which researchers can examine how these diverse actors interact, collaborate, and influence global health policy and practice.

The COVID-19 pandemic vividly illustrates the need for effective global health governance. The emphasis of liberal institutionalism on institutions, norms, and cooperation gains particular relevance when examining how states respond to such

crises⁵². Researchers can employ this theoretical lens to assess the strengths and weaknesses of existing global health institutions and norms and identify areas for improvement in pandemic preparedness and response.

Thus, liberal institutionalism provides a valuable and comprehensive theoretical framework for studying global health within the realm of IR. By emphasising the role of international institutions, norms, cooperation, non-state actors, and the provision of global public goods, liberal institutionalism allows researchers to gain a deeper understanding of the complex dynamics at play in the field of global health. As global health challenges continue to evolve, the insights provided by liberal institutionalism can guide policymakers and scholars in effectively addressing these critical issues on the global stage.

In sum, liberal institutionalism posits that for global peace to prevail, states must engage in cooperation and be willing to relinquish some degree of sovereignty to foster integrated communities that encourage economic prosperity and address regional and international security concerns. This perspective features prominently in numerous studies focusing on non-state actors, especially in the realm of international relations. *Transnational Relations and World Politics*⁵³, by Robert Keohane and Joseph Nye, challenged the statist realism approach and argued for a new paradigm to study global politics. Keohane and Nye state that world politics can be understood as:

*"...all political interactions between significant actors in a world system where a significant actor is any somewhat autonomous individual or organisation that controls substantial resources and participates in political relationships with other actors across state lines"*⁵⁴.

This formulation made it possible for a wide range of stakeholders, including states, intergovernmental bodies, and NGOs, to take part in and influence global politics at the international level. Thus, this description can apply to MNCs, funding organisations like the Bill and Melinda Gates Foundation (BMGF), religious organisations, as well as a variety of other actors who have the ability to use symbolic

and material resources to persuade other actors to act in ways that are different from how they normally would.

Transnational interactions give rise to international pluralism, exemplified by various institutional frameworks in global governance. Notable examples include the Montreal Protocol on the Ozone Layer (1987), the Forest Stewardship Council (1993), U.N. Framework Convention on Climate Change (1994), the Land Mines Treaty (1997), the Rome Statute establishing the International Criminal Court (1998), and the U.N. Convention on the Rights of Persons with Disabilities (2008). Scholars like Keohane and Nye highlight how transnational relations contribute significantly to this pluralism. They emphasise the expanding influence of non-state actors, such as MNCs, NGOs and global networks, in shaping global affairs. This shift from a state-centric view of international relations to one embracing diverse non-state actors fosters a more pluralistic global landscape.

Consequently, decision-making and policy formulation at the international level no longer remain solely within the purview of states but involve a broad spectrum of actors with distinct interests, agendas and sources of influence. As a result, transnational relations engender a more intricate and pluralistic global order, wherein state sovereignty is not the exclusive determinant of outcomes. This perspective recognises the multifaceted nature of global governance, underscoring the imperative for collaboration and negotiation among diverse actors to effectively address contemporary global challenges.

In the same vein, international pluralism plays a crucial role in shaping the landscape of global health governance. Some examples within the realm of global health include – Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the UHC2030^{iv}, formerly known as the International Health Partnership +, Médecins Sans

^{iv} The global initiative to strengthen health systems for UHC is called UHC2030. Together with advocacy, resources, assistance, expertise and learning, it offers a platform for cooperative high-level events and meetings that foster connections. This encourages all pertinent parties to engage in a more coordinated and efficient manner to assist nations in their pursuit of UHC. The concept is predicated on a common understanding of universally protected health systems and a dedication to never leaving

Frontières, Oxfam, Global Alliance for Vaccines and Immunization (GAVI) and more recently through the COVAX, a multilateral organisation co-led by the Coalition for Epidemic Preparedness Innovations (CEPI). In the realm of global health, international pluralism signifies a dynamic and multifaceted approach to addressing health challenges that extends beyond the traditional boundaries of state-centric diplomacy. It recognises the contributions of a diverse array of actors, including states, international organisations, NGOs, philanthropic foundations, private corporations, and civil society, all of which are engaged in efforts to improve global health. This pluralistic approach fosters collaboration, sharing of resources, and the pooling of expertise from various stakeholders, resulting in a more comprehensive and adaptive response to global health issues. In essence, international pluralism in global health governance acknowledges the interconnectedness of health challenges and the need for a collective, multi-faceted effort to tackle them effectively in an increasingly interdependent world. These structures play a crucial role in addressing a wide spectrum of global concerns, ranging from 'high politics' issues like nuclear proliferation to 'low politics' matters such as health, human rights, and environmental protection. Thus, it enables the reassertion of non-state actors, particularly those at the margins, into the mainstream of international politics.

In addition, regimes and institutions promote the use of multilateralism as a strategy for attracting attention from both states and non-state players on the issue of cooperation. According to Keohane, international regimes should be viewed in the context of issue-areas, and as issue-areas rely on how each player perceives and acts, "their boundaries change gradually over time"⁵⁵. Thus, liberal institutionalists distinguish their theory from the rigid ideas of realism in this regard as well; they contend that institutions can be changed to create new laws and norms that advance

anyone behind. UHC2030 includes a wide range of partners, including philanthropic foundations, governments, international organisations, global health initiatives, civil society and the commercial sector. Additionally, UHC2030 unites networks, collaboratives and partnerships that concentrate on bolstering various facets of health systems and encourages action that reinforces one another as well as the exchange of knowledge, resources and information.

universal health coverage, environmental sustainability, human rights, or economic development as perceptions and behaviour change over time.

While emphasising on global governance and the impact that globalisation has had on IR theory, liberal institutionalists have given more weight to the role of multilateralism and cooperation. The development in globalisation, worries about terrorism, drug trafficking, and pandemics like HIV/AIDS have demonstrated that governments can no longer uphold principles of sovereignty and remain independent of non-state actors in their responses to such challenges. In recent times, liberal institutionalists contend that only regional and international regimes can coordinate policy responses to address such novel security challenges⁵⁶.

However, global health governance as characterised by the rising role of a plurality of actors as per Julio Frenk and Suerie Moon's analysis is in a quagmire of inefficient institutional setups⁵⁷. According to them, three key issues arise as a result of the wide variety of actors engaged in global health governance. First, the vast majority of actors do not represent any one nation-state. They do not neatly fit into one category, falling under the authority of a state since they represent a variety of interests that cut across boundaries. Second, cross-sectoral interconnectedness is becoming a more important lens through which to view health. Without taking into account the various areas that affect health, such as "international trade, migration, and the environment," health cannot be fully comprehended⁵⁸. Finally, they point out the issue of accountability. The new institutional setup of global health governance includes not only the WHO which is "built on the universal membership of all recognised sovereign nation states"⁵⁹, but also multilateral agencies that have an interest in health (e.g. the United Nations Children's Fund (UNICEF), World Bank and regional development banks) as well as innovative and hybrid organisations like the GAVI and GFATM which are private public partnerships and are accountable to their individual board of directors⁶⁰.

2.6: “Statist” and “Globalist” Perspectives on Health Governance

IR, as a discipline, while late in engaging with issues related to health, has since the 1990s witnessed a turnaround on this aspect. This is most notably a reaction, within the realist framework, to the increasing threat to national security posed by HIV/AIDS and other infectious diseases which have the potential to spread across borders⁶¹. Recognising the need for further engagement, scholars such as Andrew Price-Smith⁶² and David Fidler⁶³, approached health through the realist lens. They assume that the state is still the prime actor within the international system. Accordingly, the state is in the best position to address health security issues through national health policies and garnering state resources to stave off such threats.

Within the liberal institutionalist framework, the statist and globalist approaches represent two strands that shape perspectives on global health. The statist approach emphasises the role of states in addressing health challenges, advocating for national sovereignty in determining health policies and interventions. In contrast, the globalist approach emphasises international cooperation and the importance of global institutions and governance structures in tackling health issues that transcend national borders. These strands reflect the tension between state-centric solutions and the recognition of the interconnectedness of health challenges, highlighting the nuanced dynamics within liberal institutionalist thought on global health. In the context of global health, one can emphasise the intricate nature of health governance within the broader framework of IR. Health governance refers to the mechanisms, policies, institutions and strategies put in place to tackle global health issues that transcend national borders. These challenges may include infectious disease outbreaks, health inequalities and the need for coordinated responses to emerging health threats. In relation to global health governance, the "statist" and "globalist" theoretical perspectives underscores the contrasting viewpoints regarding the organisation and management of health governance. The following discussion sets the

stage for an exploration of the theoretical underpinnings that shape discussions and strategies related to global health governance. It provides a deeper examination of how these theoretical perspectives influence the formulation of policies, the role of nation-states and the collaborative efforts required to promote global health and well-being of individuals and communities.

Health governance on the global stage is a complex and critical aspect of international relations, encompassing policies, institutions, and strategies aimed at addressing global health challenges. Two prominent theoretical perspectives, often referred to as "statist" and "globalist," offer distinct viewpoints on how health governance should be structured and managed. These perspectives have a profound impact on international responses to health issues, influencing resource allocation, decision-making processes, and the overall approach to global health governance.

Sara E. Davies, in a seminal article on what IR can contribute to the evolving global health agenda, identifies two key perspectives on the relationship between health and world politics, viz. the "statist" and "globalist" perspectives⁶⁴. Thus in the "statist" formulation the primary referent as well as actor is the state. While there could be other actors that function in responding to the threat posed to the state, their role is relegated to aiding or reducing the ability of the state in responding to a particular threat. Therefore, statist responses are couched within the Realist framework and "typically uses the language of security"⁶⁵. On the contrary, the "globalist" perspective's point of reference starts with the individual. The individual then leads to the constellation of actors involved in promoting health, including the state, international organisations, MNCs and others⁶⁶. It also gives due consideration to the structural factors that contribute to health, e.g. conditions of poverty, level of education, and overarching national health policies adopted by the state. This implies the "globalist" perspective is underpinned by notions from critical and human security theory (broadly part of liberal theoretical debates) which positions health as a human right.

The statist approach within liberal institutionalist framework is characterised by several key principles and approaches. Statists assert that individual nation-states possess the primary responsibility for managing their own health affairs⁶⁷. Central to this perspective is the principle of state sovereignty, which upholds the idea that states have the ultimate authority to make decisions about their domestic health policies, resource allocation, and public health measures. Thus, the WHO, a preeminent international health agency, respects this principle and seeks consent from states before intervening in their internal health matters.

Furthermore, the statist perspective places a strong emphasis on the pursuit of national interests in shaping health policies⁶⁸. States prioritise their security, economic, and political objectives when making decisions about healthcare and health governance. This especially came to the fore during the COVID-19 pandemic⁶⁹. Health policies are often viewed through the lens of how they align with these national interests, sometimes leading to a focus on domestic health issues over global health cooperation. National interests undeniably play a significant role in shaping global health governance. States' security concerns, economic interests, resource access, and pursuit of global influence all impact the global health agenda, resource allocation, and policy priorities⁷⁰. While national interests are essential for states' well-being and economic prosperity, achieving effective global health governance necessitates a delicate balance between these interests and the broader global health goals of equity, access, and health security. This balance requires multilateral cooperation, international organisations, and collaborative diplomacy to ensure that national interests do not undermine global efforts to address pressing health challenges. As the world grapples with ongoing and emerging health crises, the recognition of the interdependence of states' interests and the global health landscape becomes increasingly vital in achieving better health outcomes for all.

In uncovering the threads that bind national security and health, Davies presents three themes which continue to be of relevance to global politics of health in

the present day. Firstly, the language of statist framing particular health issues including the COVID-19 pandemic in the language of traditional security concerns”⁷¹. Echoing Rob Walker’s ideas in *Inside/Outside: International Relations as Political Theory*⁷², Davies points out to how statist see health threats as emerging from the outside and thus requiring protection of the inside⁷³. The statist perspective focuses on protecting the state and its citizens from an external threat which needs to be contained and suppressed. On the contrary, Jeremy Youde’s study of HIV/AIDS in South Africa points to the failure of health security advocates in explicitly linking traditional security studies paradigms and IR theory with the threat of AIDS⁷⁴. According to him, while AIDS did impact the political stability and economy within South Africa, it did not have an impact on South Africa’s neighbours as the rhetoric was.

The second theme, according to Davies, is related to statist’s overriding concern for infectious diseases, “especially HIV/AIDS, MDR TB (multidrug-resistant tuberculosis), pandemic influenza and bioweapon pathogens”⁷⁵. In extending Barry Buzan et al.’s theory of securitisation to the issue of health, the normal routine acts of governance or provision of basic healthcare is side lined in favour of existential threats that require emergency measures to tackle and contain⁷⁶. In such a framework, infectious diseases acquire greater significance requiring short-term measures from the state to address the spread of the disease. This situation has also not led to enhanced allocation of resources by intergovernmental organisations or international institutions like the WHO to strengthen the public health system across developing countries. Further, resources continue to be utilised to protect developed countries from being ‘infected’⁷⁷. Securitisation of health, by dint of requiring an imminent threat, is thus not a comprehensive approach to aid the well-being of an individual or providing long term solutions to health issues which are faced by developing countries.

Davies’ third point with regard to the statist approach is the inherent contradiction in advocates of health security, of simultaneously focusing on the state

as the main actor while acknowledging that infectious diseases can cross boundaries and not be dealt by an individual state alone. In promoting cooperation between states to prevent or contain a disease, as evinced in the revised International Health Regulations (IHR) which were universally passed in the World Health Assembly in 2005⁷⁸. This in turn prompts the states to go beyond the traditional concept of Westphalian sovereignty and join hands in fighting disease which are transnational in nature. While the securitisation logic of the statist approach has brought political attention to certain health issues, viz. infectious diseases and their containment, the socio-political conditions which are at root of many of the negative health conditions – such as poverty, lack of education, political disenfranchisement and socio-economic inequalities continue to be minimally addressed.

Further, statist tend to be cautious about extensive involvement by international organisations in health governance. They generally prefer that such organisations play a supportive role, offering technical assistance and coordination when requested by states. This perspective reflects a belief in state autonomy and self-reliance. Statists, thus advocate for a restrained role for international organisations in global health governance⁷⁹. They view international organisations, such as the WHO, as auxiliary actors that should offer technical expertise, coordination, and support to individual states. These organisations should operate under the authority and direction of member states, respecting the principle of state sovereignty.

The second key approach that Davies writes about is known as the “globalist approach”. This approach is underpinned by two ideas. One, the appropriate referent in studying health and international relations is the individual⁸⁰. And two, the purpose of such an endeavour is to promote health equity, or equal opportunity to access to similar health care and services by an individual across the globe⁸¹. The globalist approach draws its ideas from critical theories of security. In broadening and deepening the scope of security, critical theory focuses on threats posed to the individual rather than the state. In some cases the threat to individuals arises from the

actions of the state action or lack thereof as pointed out by the Human Security Commission led by Sadako Ogata and Amartya Sen⁸². Critical theory analyses security issues as something which is socially constructed. In this analysis security is defined as a result of prioritisation of certain voices and issues over others. Thus, critical security seeks to redress the imbalance by giving voice to the security concerns of those who are marginalised.

In emphasising on the normative values or notions of justice, equity, efficiency and order, critical theory of security often evokes the term “human security”. In discussing human security from a health perspective, authors such as Caroline Thomas, Obijiofor Aginam, Thomas Pogge, Paul Farmer and Solomon Benatar argue that what is needed is not more statist-based global health governance but an attempt to radically rewrite the regulations of the global health governance agenda⁸³. Therefore, these actions include, on the one hand, strengthening local, national, and international organisations to address health concerns, and, on the other hand, instituting fundamental reforms to the current systems that have given rise to such a great deal of health inequity and insecurity.

However, given the potential for change as espoused by the globalist approach, there has not been much development in this area. The reasons can be attributed to primarily pragmatic considerations of the fact that governance ultimately functions through the state⁸⁴. Thus, globalists tend to pursue minor reforms within the health space by engaging with the state and its mechanisms while ensuring the voices of the vulnerable are heard, without falling into the trap of the logic of securitisation.

In contrast to the statist perspective, the globalist viewpoint emphasises the necessity of international cooperation, global governance mechanisms, and shared responsibility in addressing health challenges. Globalists argue that health is a global public good that transcends national borders⁸⁵. Thus, they stress on the interconnectedness of health issues and advocate for collective action to address them.

This perspective aligns with the concept that diseases do not respect borders, and global health challenges necessitate a global response. Globalists support a robust role for international organisations in setting global health norms and standards. The WHO exemplifies this approach, acting as a central coordinating body for international health matters and providing technical guidance and expertise to states.

International organisations play a pivotal role in the development and promotion of norms in global health governance such as human rights and health, intellectual property rules with regard to medicines and clinical developments and access to quality medicines⁸⁶. International organisations engage in extensive research, data collection, and expert consultations to develop comprehensive norms and guidelines. These norms are often informed by scientific evidence and consensus-building processes involving member states, experts, and civil society. Once established, international organisations actively disseminate these norms and advocate for their adoption by member states. They conduct awareness campaigns, provide technical assistance, and encourage policy alignment with global health norms⁸⁷. International organisations monitor the implementation of norms by member states, assessing their adherence to agreed-upon standards. This process often involves periodic reviews, assessments, and reporting mechanisms, which help hold states accountable for meeting their health-related commitments.

Although international organisations play a crucial role in the development and promotion of norms within global health governance, they are not immune to challenges and controversies. Ensuring that member states effectively implement and adhere to global health norms can be challenging⁸⁸. Some states such as developing nations may lack the resources or political will to comply fully with international standards. Controversies may arise when states contest certain norms, either due to differences in priorities, cultural considerations, or perceptions of infringement on sovereignty. Disputes may also arise with reference to trade agreements such as the recent development where states could not come to an agreement on whether the

COVID-19 vaccine should be considered a global public good made available to all irrespective of their ability to pay for it⁸⁹.

In sum, the statist and globalist perspectives represent two distinct but influential approaches to health governance on the global stage. While statist prioritise state sovereignty and national interests, globalists advocate for international cooperation, shared responsibility, and collective action to address global health challenges. The choice between these perspectives often depends on the specific health issue at hand, with some challenges requiring a more statist approach and others necessitating a globalist response. Ultimately, a nuanced and flexible approach that combines elements of both perspectives may offer the best path forward in addressing the complex and interconnected health issues facing the world today.

Thus, the globalist approach to health within liberal institutionalism is increasingly preferred in this study due to the interconnected nature of contemporary health challenges. In an era defined by globalisation, health issues transcend national borders, necessitating coordinated efforts on a global scale. Proponents of the globalist approach argue that collaborative action among nations, international organisations and other stakeholders is essential for effectively addressing complex health issues such as pandemics, infectious diseases, and health inequalities. By advocating for the establishment of global health governance structures and mechanisms, such as the WHO and international health regulations, the globalist approach seeks to pool resources, expertise and efforts to tackle global health challenges comprehensively. However, the statist approach remains important as it underscores the significance of national sovereignty and autonomy in decision-making processes related to health policies and interventions. It ensures that states retain the flexibility to address their unique health needs and contexts while also serving as a check against potential encroachments on state sovereignty by international health institutions. In essence, while the globalist approach promotes international cooperation, the statist approach acknowledges the importance of respecting national autonomy in navigating the

complexities of global health governance. The statist approach to global health governance can effectively address conditions like malnutrition by implementing centralised policies and programmes focused on improving access to nutritious food, healthcare, and sanitation infrastructure within individual nation-states. Conversely, the globalist approach to global health governance is better equipped to tackle issues like pandemics by fostering international cooperation, sharing resources, and coordinating responses across borders to contain the spread of infectious diseases and mitigate their impact on a global scale. Further, non-state actors play a significant role within the globalist approach to global health governance, leveraging their expertise, resources, and networks to contribute to collaborative efforts aimed at addressing health challenges on a global scale.

2.7: Concluding Remarks

Out of the theoretical frameworks employed in the analysis of international relations, realism and liberalism assume paramount significance. Realism, as a theoretical framework in IR, tends to prioritise state-centric power dynamics and security concerns, often overlooking non-traditional security issues such as health. In the context of global health challenges, realism's focus on state interests and military power is inadequate in explaining the complex interdependencies and transnational nature of health threats. Health issues, such as pandemics and infectious diseases, do not respect national borders and require cooperative responses beyond traditional notions of security. Liberal institutionalism, on the other hand, offers a more comprehensive framework for understanding global health governance. By emphasising the role of international institutions, norms and cooperation among states and non-state actors, liberal institutionalism provides insights into how collective action and institutional mechanisms can address health challenges effectively. This approach acknowledges the importance of multilateralism, collaborative diplomacy and shared responsibility in tackling non-traditional security

threats like health, making it better suited for analysing and addressing these issues compared to the limited scope of realism.

Liberal institutionalism's focus on international organisations and international regimes is paramount in the study of international relations and has significant implications for IR theory. Throughout the history of public health, international regimes have played a crucial role. The harmonisation of health guidelines and trade rules under the WHO in relation to the COVID-19 pandemic, international regimes show the relevance of liberal institutionalism in analysing health in international relations. The development of norms and principles such as Universal Health Coverage (UHC) and more recently through the COVAX, a multilateral organisation co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance (GAVI) and the WHO, alongside key delivery partner UNICEF indicate the role of international regimes in building institutional facilitation of communication, information flows and technical cooperation, thus mitigating conflicts. These developments suggest that the role international organisations play in international relations is changing and becoming more significant.

Liberal institutionalism comprises diverse strands of thought within the broader scope of liberalism, each highlighting distinct facets of international relations and governance. One strand, the globalist strand, focuses on international organisations and institutions as key actors in promoting cooperation, peace and stability among states. These institutions, such as the UN, WHO, WTO and IMF, provide platforms for states to negotiate and coordinate on issues ranging from security, health and trade to development and human rights. Another strand emphasises the role of norms and principles in shaping state behaviour and promoting adherence to international rules and agreements. This approach highlights the importance of shared values, such as democracy, human rights and the rule of law, in fostering cooperation and resolving conflicts peacefully. Additionally, liberal

institutionalism encompasses theories of complex interdependence, which emphasise the growing interconnectedness of states through economic, social and cultural ties, leading to mutual dependence and cooperation even in the absence of hierarchical power structures. Overall, liberal institutionalism offers a multifaceted perspective on international relations, highlighting the role of institutions, norms and interdependence in shaping global governance and cooperation.

To sum up, the discussion explored the intricate relationship between liberal institutionalism and the realm of global health. Within the framework of liberal institutionalism, the fundamental assumptions of cooperation, international institutions, and the development of norms and rules have been highlighted as driving forces in addressing global health challenges. The multilateral standpoint of liberal institutionalism underscores the importance of collaborative diplomacy, which has played a pivotal role in managing health crises and advancing health-related norms at the international level. However, one can read into the ongoing debate between statist and globalist perspectives on global health governance. While liberal institutionalism leans toward a more cooperative and internationalist approach, the tension (as well as cooperation) between national sovereignty and global governance remains a central issue in shaping the future of global health initiatives. As one continues to grapple with the complexities of global health in an interconnected world, the insights from liberal institutionalism serve as a valuable lens through which one can analyse and navigate the evolving landscape of global health governance.

Further, within the liberal institutionalist framework of global health, the statist approach emphasises the primacy of national governments and their sovereign control over health policies and interventions. This perspective prioritises state-centric solutions and may be more inclined towards unilateral actions or bilateral agreements. In contrast, the globalist approach underscores the importance of international cooperation, involving not only states but also non-state actors such as international

organisations, NGOs, and private sector entities. The globalist approach recognises that many global health challenges require collaborative efforts across borders, given the transnational nature of issues like pandemics, infectious diseases, and health inequalities. Thus, the globalist approach is perceived to be significant when dealing with non-state actors because it acknowledges their crucial roles in addressing complex health issues affecting nation-states across borders. Non-state actors often possess unique expertise, resources and networks that can complement governmental efforts and fill gaps in healthcare delivery. Moreover, non-state actors may operate more flexibly and innovatively, enabling them to respond rapidly to emerging health threats or reach marginalised populations effectively. By engaging non-state actors in global health governance, the globalist approach harnesses a broader range of perspectives and capabilities, enhancing the overall effectiveness of efforts to improve global health outcomes.

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CHAPTER 3

THE HISTORY OF NOTIONS AND PRACTICES IN GLOBAL HEALTH

3.1: Introduction

The previous chapter framed health as an area of concern in International Relations within the Liberal Institutional perspective. This chapter traces the history of global health from the mid-19th Century to contemporary times. The chapter examines the evolution of global health, beginning with an exploration of its early motives and genesis, tracing back to the roots of colonial medicine and early international health endeavours. The first section delves into the historical contexts and driving forces behind the emergence of global health as a distinct field, highlighting key events that shaped its development. Subsequently, the chapter examines the profound impact of globalisation on health, analysing how interconnected economic, social and political dynamics have influenced health outcomes worldwide. It explores the complexities of global health governance (GHG) in the era of globalisation and addresses transnational health threats. Lastly, the chapter navigates through prominent ideas in global health, unpacking various predominant frameworks and approaches that underpin contemporary global health debates and practice.

Due to globalisation and the deepening interconnection among governments, health has become, apart from ensuring well-being of citizenry, a pivotal concern in foreign policy and diplomacy, impacting aspects such as security, the economy, and international development. The intersection of international relations and health has intensified in recent years, driven by factors such as the engagement of intergovernmental organisations, the impact of transnational epidemics, and the imperative of ensuring drug treatment access for populations in the Global South as a

matter of human rights. Consequently, health has emerged as a pivotal component in international relations, given its profound social, economic, geopolitical, and security implications. To adequately address the significance of health in global politics, there is a need for greater coherence in both domestic and international policies.

In this regard, Colin McInnes and Kelly Lee's main argument in *Global Health and International Relations* is that achieving such a coherence requires a better understanding of the relationship between health and international affairs¹. Unlike the majority of comparable publications on health, which have addressed the subject via the lens of domestic politics and public policy (including matters pertaining to foreign policy), it examines the subject through the lens of international relations. The book's authors fill a vacuum in the literature by exploring both the importance of the issue of health and its function in international relations². The scholars interrogate whether health on the international relations agenda serves any purpose from a social constructivist perspective. McInnes and Lee question as to why health as a subject could not be integrated into the discipline of International Relations, arguing that the field has overlooked health. McInnes and Lee contend from a social constructivist perspective that health was disregarded because governments' interests were not constructed in such a way that they could engage with this subject³.

In recent decades, global health has increasingly garnered attention during conference gatherings of multinational organisations such as the Group of 7 (G7), Group of 8 (G8), and the Group of 20 (G20)⁴. In the realm of health sciences and health policy, the growing political significance of global health and its recognition on a worldwide scale are long-awaited advancements. Yet, the current comprehension of global health faces certain conceptual constraints, as the breadth and depth of the ongoing dialogue often fall short of fully capturing the intricacy of the challenges ahead. In contemporary global health discussions, the assertion of universalism inherent in the term 'global' is often ambiguous⁵. Furthermore, it usually fails to recognise the importance of a comprehensive understanding of health policy that is

both transdisciplinary and multidisciplinary. Global health policy practices and knowledge status are actually quite diverse. In other words, global health policy practices and the state of knowledge in the field of global health vary widely and encompass a broad range of approaches, strategies and levels of understanding. The diversity and complexity within the realm of global health, suggests that there is no one-size-fits-all approach or uniform body of knowledge when it comes to addressing global health challenges.

Over the past 20 years, global health has developed as an important sphere encompassing foreign affairs, security considerations, and development strategies. However, its impact on national health policy discussions within individual countries has remained marginal⁶. Politics of health and foreign policy literature typically use security as a contextual framework, and the securitisation of health is regarded as a crucial aspect of GHG⁷. The quick succession of epidemics like smallpox, measles, and polio, etc., recognised as health emergencies, has fostered the process of framing global health as a matter of security. Such a framework is reinforced by various actors at domestic and global levels working together to tackle health challenges that transcend national boundaries⁸. In practice, acute epidemic occurrences are frequently attributed to globalisation, overshadowing chronic conditions like tuberculosis. Global health initiatives often overlook the structural determinants that perpetuate poor health and health disparities.

Health policy worldwide, in general, predominantly centres on achieving universal health coverage, enhancing access to healthcare in backward areas, health financing reforms and addressing various domestic challenges, owing to the inherent complexities associated with national health systems⁹. But whenever a concern in the shape of a potentially harmful infectious illness materialises (most recently in the form of the COVID-19 pandemic), public knowledge of how global health has developed in the meantime is frequently increased¹⁰. While "killer viruses" and other epidemics were previously believed to be eradicated or at least effectively controlled in Global

North countries, a growing number of life-threatening situations resulting from them have emerged in recent years¹¹. What started with the AIDS pandemic has continued to evolve with the more regular appearance of risky infectious diseases like Severe Acute Respiratory Syndrome (SARS) in Southeast Asia in 2002¹², swine flu in 2010¹³ in multiple regions, Middle-East Respiratory Syndrome (MERS) in 2012¹⁴ in West Asia, and avian influenza in various regions from 2013 onward¹⁵. The Ebola outbreak in Western Africa in 2014, resulting in over 11,000 deaths¹⁶, the subsequent Ebola outbreak in the Eastern Democratic Republic of Congo in 2019¹⁷, the Zika outbreak in Brazil in 2017¹⁸, and with recent developments, the COVID-19 pandemic originating in Wuhan, China and spreading worldwide¹⁹, all received significant media coverage and attention from policymakers around the globe. This wave of continuously occurring epidemic outbreaks referred to as 'health crises' frequently raises public awareness and makes headlines, especially in the Global North but also other Global South countries of the world. Nevertheless, public interest in health concerns affecting other countries and continents often proves sporadic and short-lived. These health-related issues exert a significant impact on countries in the Global South, particularly in Sub-Saharan Africa, where persistent health hazards such as malnutrition and malaria continue to afflict the populace²⁰. In countries of the Global South, especially among the most impoverished populations, infectious diseases persist as a significant risk to public health, with the constant risk of escalating into epidemics and pandemics²¹. However, today's challenges for individuals and healthcare systems in Global South nations go beyond infectious diseases. The disease landscape is expanding due to the epidemiological transition from infectious to chronic and non-communicable diseases. In recent decades, many countries in the Global South have grappled with the challenge of a dual burden of disease, stemming from infectious, viral and bacterial agents on one hand, and lifestyle-related or chronic health issues on the other²². The issue is exacerbated by the coexistence of dietary obesity, undernutrition, as well as malnutrition. Addressing malnutrition is pivotal in global

health efforts, with a significant emphasis placed on reducing inequalities to ensure equitable access to nutritious food and healthcare worldwide.

3.2: Early Motives and Genesis of Global Health

The genesis of global health or its predecessor international health can be seen to go back to the middle of 19th and early 20th centuries when colonial powers began to expand their influence globally, encountering diverse health challenges in their colonies. Initially rooted in the efforts to manage the health of colonial subjects for economic and strategic reasons, early initiatives laid the groundwork for what would evolve into a more interconnected approach to addressing health on a global scale. As global trade and travel accelerated, the recognition of the interconnectedness of health across borders became increasingly apparent, leading to the emergence of international health cooperation and the early foundations of what we now recognise as global health.

In the 19th century, the emergence of modern medicine and the germ theory of disease revolutionised healthcare practices. This period saw the establishment of public health institutions and the development of vaccines, antibiotics and sanitation measures, which significantly improved health outcomes²³. International collaboration in health is often seen as having begun with the International Sanitary Conferences, whose first session took place in 1851²⁴. The meeting was an important step towards addressing international health security problems because of its principal focus on harmonising quarantine regulations in the countries that were historically colonial powers of Europe. The primary focus of the International Sanitary Conferences was to safeguard European economic interest with cross-border diseases being seen as threats to industrialisation and economic growth. In this context, the Spanish delegate, Pedro F. Monlau, opined that quarantine from cholera, then a major health concern, constituted a “loss of time” which invariably led to monetary losses²⁵. Public health, according to him, amounted to loss of valuable resources, associating

the illness with material benefit saying, “Public health is gold” or that material resources should take precedence over health concerns²⁶. The ten rounds of International Sanitary Conferences which were conducted, however, recognised the need for an agreed set of rules and regulations among governments to act as guides for how cross-border diseases could be managed within the home countries²⁷. At the 7th International Sanitary Conference in Venice in 1892, participating nations, despite their differences on how health should be managed, signed the first international treaty relating to health protection²⁸. In the same conference, Egypt was charged with the responsibility of containing plague and yellow fever, diseases whose epidemiology were, hitherto, unknown²⁹. This underlying organisation of how health governance should be carried out finds current reflection in the ways in which global health is viewed in terms of collaborative diplomacy and is intimately related to both health and international security.

The central aim of these sanitary conferences was to protect the wellbeing of European colonial administrators and shield them from the threats posed by diseases from the tropics. Consequently, the field of tropical medicine primarily emerged from this context, closely intertwined with the disciplines of public health and hygiene³⁰. Terms like tropical hygiene and medicine in the tropics were prominent during the start of the 20th century³¹. During this period, tropical institutes began to emerge across the European continent, mainly catering to seafarers arriving at ports. A few of these institutes eventually fell under the authority of Public Health Services, particularly in key port cities like London, Hamburg and Antwerp³². British pathologist and bacteriologist, Harold Scott succinctly captured the prevailing viewpoint of the era. In his examination of tropical medicine more than eight decades ago, he expressed³³:

“We can then trace how improvements have been brought about, usually first with a view to safeguarding the health of officials and European traders, and later undertaking also the treatment of natives by which two purposes would be simultaneously

accomplished - benefit to the health and well-being of the native and further protection of the white man from native-born infection”.

By the mid-19th Century, however, there occurred a transition in the way global health was understood. The period between 1851 and 1920 saw the participation of non-governmental organisations (NGOs) in the policy-making processes of internal health governance, a predecessor to GHGⁱ. Worthy of note are the International Committee of the Red Cross founded in 1863³⁴ and The Rockefeller Foundation’s International Health Foundation set up in 1913³⁵. Other notable NGOs included the League of Red Cross Societies in 1919 and the Save the Children Fund of 1919³⁶. The entry of NGOs into GHG shifted the focus of global health policy from a primarily economic safeguard to one that also incorporated humanitarian concern. An October 11, 1919 bulletin of the League of Red Cross Societies, for instance, declared that the primary aim of the society was to improve sanitary conditions in countries like Poland whose public health had been affected by World War I, with more than 650,000 cases of typhus, a deadly epidemic, recorded in newly independent Poland in 1918 alone³⁷. The spread of typhus in Poland was seen to emerge from Russia and Ukraine, countries that fought against the nations that established the Red Cross Society, viz., Britain, America, France, Japan and Italy³⁸. Thus, it can be observed that political affiliations and propaganda also influenced how a disease was being projected to the international community.

In addition, religious organisations have been pivotal in shaping the management of global health alongside the mentioned NGOs since the mid-19th Century. Medical missions, tasked with evangelical conversions, made their presence felt as far east as China where the first Medical Missionary Society was established in the 1840s³⁹. The diseases in the colonised nations were viewed as punishments meted out to the native population because of their ‘sins’. Colonised regions, especially those

ⁱ Global health governance has been defined as the “rules and procedures by which collective action is taken to achieve agreed goals that protect and promote health within a global context.”

in Africa, were regarded as countries in need of 'saving' from dreaded diseases like cholera, typhus, yellow fever and other epidemics⁴⁰. Between 1851 and 1920, the emphasis was on advocating for a universal healthcare system by endeavouring to involve as many countries as possible in the framework of international governance. This notion of the charitable Global North organisations and governments extended into the later years of the 20th Century.

In the early 20th Century, international health organisations such as the League of Nations Health Organisation, which preceded the World Health Organisation (WHO), and the Pan American Health Organisation (PAHO), established on 2 December, 1902, came into existence⁴¹. These organisations aimed to address health challenges transcending national borders, laying the foundation for GHG. The later years of the 20th century saw a growing acknowledgement of the social determinants of health (SDH) and the requirement for comprehensive approaches to address health disparities. In the post-World War II period, global health initiatives were focused on issues such as immunisation, the health of mothers and children, and the control of infectious diseases⁴². In the current scenario (post 1990s), the evolution of global health continues with an increasing attention on equity, sustainability and multi-sectoral collaboration. The field encompasses a broad range of challenges, including non-communicable diseases, environmental health, and health systems strengthening, reflecting the complex interplay of factors shaping human health on a global scale. The growing political and international significance of global health necessitates more holistic governance approaches. These strategies should encompass organisations and procedures specifically mandated for health (global health governance), in addition to those within global governance structures that explicitly and implicitly influence well-being (global governance for health). Additionally, they should include interstate organisations and instruments established to contribute to guiding global health⁴³.

Despite these additional considerations, the concept of global health expanded to encompass various topics such as political ideologies, research, education, and

healthcare delivery. Its goals include enhancing access to healthcare, improving the quality of care, and promoting overall health worldwide. In the realm of public health, global health includes both individual clinical treatment and population-level efforts as fundamental processes⁴⁴. The approach also entails analysing transnational contexts and considering the economic, political, and social factors that influence health. It involves addressing contemporary health challenges to resolve the issues within these contexts. This is in spite of the complexity and diversity of the interpretations of global health as well as the plurality of stakeholders involved⁴⁵. In essence, the idea of global health encompasses an expansive spectrum of endeavours, ranging from charitable contributions and public-private partnerships to upholding civil liberties and employing health as a means of international and domestic security.

The last twenty years witnessed notable revisions in paradigms concerning the global dimensions and features of health⁴⁶. International health and global healthⁱⁱ have always been closely associated with the defence of domestic populations, corporate interests and objectives of the Global North. For instance, the US Institute of Medicine underscored safeguarding the citizens of the USA, highlighting that 25% of the top drug companies control 40% of the global market⁴⁷. The launch of new medicines in Global South countries provides potentially lucrative sales for the drug and vaccine industry in Global North countries⁴⁸. Similarly, in its first Global Health Strategy in 2018, the German federal government prioritised the safety of the Germans and the welfare of Germany's trade abroad⁴⁹. This suggests that many OECD states continue to prioritise their specific interests and goals. However, there is a growing trend towards prioritising neglected and poverty-driven diseases, with the German

ⁱⁱ Some scholars use the phrases international health and global health interchangeably, whereas others believe that international is a more limited term used to discuss health challenges in the Global South from the Global North's perspective. In other words, international health is the study of health in nations other than one's own, particularly when such countries are from the Global South. On the other hand, global health's stated purpose is to improve health and prevent and treat illnesses for all people in all nations throughout the world. Thus, global health indicates a shift in emphasis towards issues that impact everyone all over the globe. To put it another way, it includes health programmes and initiatives that address health challenges at the local, national, international, and global levels.

Ministry of Education and Research slowly increasing the scope of issues within the context of Global Health Sciences⁵⁰. This underscores the keen interest of states in expanding their global health influence.

The term "global health," as discussed previously, has a relatively recent history, emerging first within the scientific community and later gaining traction in political discourse, as evidenced by relevant literature. The phrase 'global health' has been increasingly used in the literature since the early 2000s, when it began to replace the term 'international health', which had previously been the predominant term⁵¹. The idea of global health did not arise spontaneously; rather, it evolved from a succession of antecedents. It stemmed from colonial medicine during the mid-19th to early 20th centuries, evolving into tropical medicine and international health thereafter⁵². Since that time, the Global North has pushed for the creation of a worldwide system for controlling infectious diseases, largely motivated by their own security concerns.

The notion of international health, an extension of the traditional concept of tropical medicine, gained prominence in the latter half of the 20th Century, principally during the Cold War era. Its main emphasis is on addressing the health challenges and hardships encountered by countries in the Global South. For instance, efforts to prevent and cure infectious illnesses, enhance water quality and sanitation, and advance maternal and infant health were the key priorities⁵³. This concept continues to be extensively employed in universities and other scientific institutions today, albeit with an expanded definition that now encompasses issues such as, injuries, and the enhancement of health systems beyond non-communicable diseases⁵⁴. International health strategies also include international aid dedicated by Global North nations and the international organisations that act as conduits for the Global North countries to alleviate health issues faced in poorer nations⁵⁵. When development assistance first began, it also involved aiding Global South nations in resolving their health issues.

This antecedent to subsequent foreign development aid and present international collaboration can thus be viewed as being fairly paternalistic in nature.

During the same period, the concept of public health, initially developed in the Global North countries following World War II, gained prominence. Public health, rooted in community health, especially sanitation, immunisation, and preventive medicine, differs significantly from personalised medicine in several key aspects. Unlike medical sciences, which focus primarily on personal health issues, public health prioritises the community as a whole. Public health mainly focuses on the SDH, widespread diseases, and health disparities resulting from the inequities in dispersal of economic, social and political circumstances among the population. This understanding of public health has influenced the interpretation of the "global" aspect in global health interventions.

The establishment of the WHO in the 20th century can be traced back to the series of International Sanitary Conferences held in the late 19th century. The realisation that global health challenges required a coordinated, international response led to the establishment of the WHO under the UN initiative in 1948, with its constitution entering into force on 7 April, 1948⁵⁶. Thus, the foundation for the WHO's role in GHG was laid through the gradual evolution of international sanitary conferences and their recognition of the requirement for a unified programme to address health challenges on a global scale.

The WHO, currently composed of 194 nations, established its 'health for all' objective in September 1978 at the International Conference on Primary Health Care held in Alma-Ata, Kazakhstan through the Alma-Ata Declaration⁵⁷. The Alma-Ata Declaration of 1978 was a turning point in 20th Century public health, emphasising primary health care as the cornerstone for achieving the goal of health for all. The proclamation was imbued with three important ideas: pertinent technology, resistance to elitism in health care, and the notion of health as a catalyst for social advancement⁵⁸. With respect to the first idea, the term referred to technologies like

medical diagnostic imaging or machines that pump blood and air, which were either highly advanced or excessively costly for addressing the everyday needs of the poor. It also critiqued the establishment of hospitals in urban areas in Global South countries. Such hospitals were seen as encouraging the idea of reliance on unrequired consumption, benefiting only a minority, and consuming significant funds and healthcare personnel resources while catering to a small fraction of the population who are able to afford treatment. The second main aspect of the declaration, criticism of elitism, implied opposition to overspecialisation of health staff in Global South countries as well as opposition to the advancing of centralised health initiatives. Instead, the focus shifted towards training lay health professionals and involving the community. Finally, the declaration established a relationship between health and development. Health work was viewed as part of a long-term process of improving the quality of life, rather than as a fragmented and temporary intervention. Community care was envisioned as the cornerstone for the promotion of health and the prevention and treatment of disease. This demanded an inter-sectoral initiative, involving the government, corporate organisations and CSOs collaborating on various health issues such as basic sanitation, health education, clean water and adequate housing.

It is important to note that the objective of health for all is included in the field of global health. Yet, the Alma-Ata Declaration faced criticism for its excessive breadth and idealism, along with being faulted for setting an unrealistic timeframe. The tagline 'health for all by 2000' was widely criticised as unrealistic⁵⁹. Following the Alma-Ata Declaration, the Rockefeller Foundation which was concerned with determining the most cost-effective health policies, hosted a conference called "Health and Population in Development" in 1979 in Italy⁶⁰. The meeting was based on Julia Walsh and Kenneth S. Warren's paper "Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries."⁶¹ The meeting sought to identify precise factors contributing to mortality, particularly targeting prevalent ailments afflicting new-

borns in impoverished nations, including diarrhoea and conditions stemming from inadequate immunization⁶². Although refraining from overt criticism of the Alma-Ata Declaration, they proposed an "interim" policy for the advancement of fundamental healthcare. They also stressed the need of realistic goals and cost-effective planning. Thus, the term "selective primary health care" was presented in the paper and at the meeting as the new paradigm. The concept referred to a set of low-cost technological solutions designed to address impoverished nations' major illness issues. Numerous funders, researchers, and organisations supported selective primary health care, viewing it as striking the optimal balance between scarcity and choice⁶³. However, the lack of essential care seems to address illnesses stemming from economic backwardness while avoiding the need to address backwardness itself as a root structural cause of illness⁶⁴. Thus, by focusing solely on treating diseases without addressing poverty itself, there is a risk of only tackling the maladies and not dealing with the source of health disparities. The selective primary health care approach may lead to temporary improvements in health but may ultimately fail to create sustainable and equitable health outcomes, especially for disadvantaged populations. It underscores the importance of addressing poverty as a fundamental determinant of health and advocating for broader social and economic reforms to achieve lasting improvements in population health.

The term "global health" has garnered recognition over last twenty years and has undergone extension and expansion. The health of people all over the world is shaped by a multitude of factors that extend beyond national boundaries in the current highly interconnected globe. These include epidemics, medical patents, and long-term change in the earth's climate, all of which have profound implications for public health on a global scale. The burden of illness has transitioned from communicable diseases to non-communicable diseases (NCDs), prompting increased focus on lifestyle and environmental factors that impact people's health⁶⁵. Cross-border health issues represent just one facet of the broader scope of global health. In

this context, 'global' encompasses a wide array of health issues and transnational factors. These include endeavours like the global eradication of diseases such as polio, challenges like antibiotic resistance, as well as issues like climate change, migration, food security, and urbanisation.

The idea of planetary health, which has gained traction in recent times among scientists but was already under discussion in the 1970s, is significantly broader and more comprehensive. It clearly acknowledges the ramifications on human well-being due to the actions of people on planet earth⁶⁶. Planetary health entails a perspective on life that prioritises people over illnesses, aiming to mitigate health disparities stemming from factors like income, education, gender, and living conditions. Its objective is to ensure that every individual on the planet can access the right to health and welfare, striving to "leave no one behind"⁶⁷. The primary concern of planetary health lies in the impact of environmental changes on health of humans. It concentrates on health of humans within the Anthropocene eraⁱⁱⁱ, addressing the threats posed by climate change and pandemics to human populations and other species. Additionally, it considers the natural habitats supporting these species and the overall health and biodiversity of the biosphere⁶⁸. In other words, by focusing on the impacts of pandemics and climate change on both human and non-human species, as well as their habitats and the overall health of the biosphere, planetary health highlights the complex relationships between human activities and the natural world.

The post-Cold War era witnessed a significant shift in the conceptualisation of well-being on the worldwide stage, transitioning from notions concerning international health to the more encompassing idea of global health. This shift represented a broader recognition that health challenges transcended traditional state boundaries and were shaped by interconnected factors, such as globalisation,

ⁱⁱⁱ The Anthropocene era refers to the current geological epoch characterised by significant human impact on the Earth's geology and ecosystems, primarily through industrialisation, urbanisation, and other activities resulting in environmental changes.

migration and environmental changes⁶⁹. In the aftermath of the Cold War, the world began to grapple with emerging threats like HIV/AIDS, emerging infectious diseases, and the increasing burden of non-communicable diseases, which required collaborative, global responses. The notion of global health emphasised a more integrated and inclusive technique, emphasising health as a global public good and highlighting the need for international cooperation, equity and the recognition that health is not solely a matter of medical interventions but also tied to social, economic, and political determinants. This shift underscored the interdependence of nations in safeguarding global health and paved the way for the development of international health frameworks and organisations focused on addressing these complex and interconnected challenges.

3.3: Globalisation and Global Health

Globalisation^{iv}, a complex phenomenon characterised by heightened interconnectedness and interdependence among nations, carries significant implications for global health. The rapid movement of information technologies, people and goods across borders has diverse effects on health outcomes worldwide, encompassing both beneficial and adverse impacts. Globalisation, a multifaceted process marked by increased interconnectedness and interdependence among nations, has profound implications for global health. The accelerating movement of goods, information, technologies, and people across borders has both positive and negative impacts on health outcomes worldwide. While globalisation facilitates the

^{iv} The intricate phenomena known as globalisation is defined by the growing interdependence and connectivity of economies, cultures, and communities on a global scale. Overcoming national borders, it involves the flow of capital, information, products, and services. Unprecedented levels of global integration have occurred in the modern age, affecting many aspects of human existence. Globalisation has a wide range of repercussions, including geopolitical dynamics, technical breakthroughs, cultural interaction, and economic systems. Globalisation has sparked innovation and economic prosperity, but it has also sparked worries about inequality, cultural uniformity, and issues with global governance. Comprehending the many aspects of globalisation is important in order to effectively navigate its intricacies and capitalise on its prospective advantages while simultaneously alleviating unfavourable outcomes. (Wallerstein, I. (2000). Globalization or the age of transition? A long-term view of the trajectory of the world-system. *International Sociology*, 15(2), 251–267.)

dissemination of medical knowledge, technology and resources, it also contributes to the spread of diseases, health inequalities, and challenges in health governance. Understanding the intricate relationship between globalisation and global health is essential for developing effective strategies to address contemporary health challenges on an international scale.

The dynamic process of growing international interconnectedness in critical spheres of life – including politics, business, culture and environment – commonly known as globalisation, definitely accelerated toward the latter years of the 20th Century. The main preconditions and drivers of globalisation were technological development brought on by improvements in goods and processes, particularly in information communication technologies and transportation thanks to the Internet's widespread use, the significant rise in international air traffic and flexible and more effective methods of moving goods and services. This period of globalisation has been further supported and accelerated by the internationalisation and liberalisation of trade and production, the growth of digitalisation and new communication technologies as well as the increasing pressure on migration brought on by population expansion, prolonged conflicts, and ecological dilemmas.

Increasing Global Health Concerns

The circumstances and outcomes of globalisation, such as the global dispersion of communicable and non-communicable public health issues, have a rising impact on the global burden of disease. In Sub-Saharan Africa, Asia, and Latin America, rural regions are where infectious illnesses are most prevalent. Owing to their disproportionate impact on the most economically disadvantaged populations and contribution to a continuous phase of underdevelopment due to lower output, these illnesses are distributed differently in different regions⁷⁰. Although infectious diseases like malaria, tuberculosis, and HIV still account for the majority of diseases in the most backward regions of the Global South, these countries are also going through a rapid shift in disease patterns that is marked by a change from patterns of disease burden

that are dominated by infectious diseases and paediatric ailments to disease burdens that are increasingly dominated by chronic, non-infectious diseases and accidents⁷¹. In the post COVID-19 times, the significance of pandemics is equally emphasised along with the health concerns mentioned earlier.

Globalisation's frequently abrupt changes in daily living have had noticeable and palpable effects on health, especially mental health, in almost every nation on the planet⁷². For instance, the accelerated pace of daily life puts more individuals under pressure to succeed, causes stress, and exposes many people who are productively engaged to substantial direct and indirect risks. Overurbanisation and changing ways of life, notably tobacco consumption, excessive alcohol use, bad nutrition, sedentary behaviour and air pollution, are strongly linked to current escalating health risks in Global South countries⁷³. Because of the concurrent prevalence of communicable and non-communicable illnesses in many Global South nations, shifts in work and lifestyle habits and the effects they have on one's physical, mental, and social health, such countries are witnessing what is called the 'dual burden of disease'.

In contrast to Global South nations, the Global North is expected to see different repercussions of globalisation. Both communicable and non-communicable diseases are seen to have a greater impact on older populations in the countries of the Global North as compared to countries in the Global South where the younger demographic also contributes to the burden of disease⁷⁴. Data indicates that societal disparities both within and between societies have a significant impact on a population's or demographic groups' level of health⁷⁵. Most cardiovascular diseases, for instance, remain untreated in Global South countries due to the lack of affordable healthcare⁷⁶. Additionally, there are regional and temporal differences in the relationship between socioeconomic status and health risk variables. However, there are significant links between absolute economic poverty and key health factors such as childhood undernutrition, insufficient distribution of potable water and sanitary facilities, and contact with pollutants⁷⁷.

Indeed, when extremely infectious diseases spread globally, they pose a threat to both the Global North and South, underscoring the growing significance of health concerns and challenges⁷⁸. The latest coronavirus epidemic has once again brought attention to how people see global health in terms of health crises. Despite public apprehension stirred by outbreaks of "killer viruses" evoking scenarios of existential threats, chronic diseases, which often necessitate lifelong health care and incur substantial expenses for individuals and healthcare systems, hold greater epidemiological significance⁷⁹. Nevertheless, global financing for non-infectious diseases remains relatively low and lacks effective coordination, with many international stakeholders advocating for greater emphasis on combating rare diseases rather than addressing common chronic illnesses, such as heart disease, stroke and lung cancer⁸⁰. In this scenario, it is crucial to reiterate that despite the increase in global wealth, disparities in access to healthcare are widening rather than narrowing.

Global health encounters substantial hurdles stemming from the disparate dispensation of concerns surrounding well-being and the worldwide disease burden on one side, and the uneven allocation of financial and other resources on the other⁸¹. It encompasses the examination of global, national and local health challenges, factors that affect health, and providing answers to challenges that go beyond multiple sectors explicitly and implicitly related to well-being. This requires interdisciplinary collaboration among society, politics and science to understand their complex interrelationships. The primary objective of global health is to embrace a holistic, integrated, cross-disciplinary, and rights-based method. It amalgamates elements of community well-being, which often lacks a global perspective, with those of international health, which concentrate more on policies for health, preventive healthcare, and aid collaboration. Moreover, it has an explicit political orientation⁸².

Special consideration is given to policy issues and problems to ensure the effective performance of players in the health sector in the larger interest of

populations. This includes directions to be accountable and make effective rules by policy makers. To effectively enhance the efficacy of diverse stakeholders within the healthcare sector and related domains for the betterment of public welfare, a comprehensive focus is placed on governance matters and associated challenges. Governance encompasses the responsible political oversight and regulatory frameworks established by governments and pertinent decision-makers. This includes not only setting policies but also ensuring their implementation and enforcement. For instance, recent data from the economists Martin Roessler and Jochen Schmitt indicates that robust governance mechanisms correlate with improved health outcomes and more efficient healthcare delivery systems⁸³. Additionally, transparency and accountability within governance structures are crucial for fostering trust among stakeholders and optimising resource allocation to address public health needs effectively. The growing health concerns underscore the urgency of addressing issues such as universal healthcare, while also highlighting the risk of privileged healthcare access for the few.

Universal Health or Privileged Healthcare

The journey towards the adoption of Universal Health Coverage (UHC) in GHG has been marked by several key milestones. A pivotal moment in global health history occurred with the Alma-Ata Declaration in 1978, which underscored the significance of primary healthcare as the foundation for achieving health for all. This declaration underscored the need for fair provision to essential health services and advocated for action to address SDH. In 2005, the WHA passed a decision that urged all signatories to the agreement to strengthen health systems towards the goal of UHC. This resolution emphasised the importance of ensuring public health insurance, access to effective patient-centred care as well as equity in health outcomes for all populations. The World Health Report 2010, titled "Health Systems Financing: The Path to Universal Coverage," provided a comprehensive analysis of health funding instruments and highlighted the importance of moving towards UHC. The report

outlined strategies for expanding coverage and improving financial protection, emphasising the role of government leadership and solidarity in achieving UHC. The approval of the SDGs in 2015 further propelled the global agenda towards UHC. SDG 3.8 aims to attain UHC, encompassing public health insurance, provision of effective, safe, and timely health care including vital medication and immunisation for everyone. In 2016, the WHO, along with other key stakeholders, launched the UHC2030 Partnership to accelerate progress towards UHC⁸⁴. This multi-stakeholder platform brings together governments, CSOs, international institutions and the corporate sector to advocate for UHC and assist nations in their endeavours to attain health for all. These milestones reflect a growing global consensus on the importance of UHC as a means to improve health outcomes, promote equity and advance sustainable development. While progress towards UHC remains uneven across countries, these efforts signify a collective commitment to realising health for all.

On the other hand, selective primary health care offers the allure of treating diseases stemming from poverty while overlooking poverty itself as a fundamental structural determinant of illness. The activities of significant global health players today are likewise influenced by this style of thinking. Former Microsoft executive and current leader in funding health initiatives in Global South countries via the Bill and Melinda Gates Foundation (BMGF), Bill Gates has formulated his own vision for what it takes to accomplish global health goals. "But the world didn't have to erase poverty to eradicate smallpox – and we don't have to eradicate poverty before we eradicate malaria,"⁸⁵ he said to the policymakers gathered during the 2005 WHA. He further explained, "A vaccine is necessary, and it will save lives, advance healthcare, and lessen poverty"⁸⁶. This claim, to a large extent, demonstrates the faith in the limitless therapeutic potential of biomedicine. It is also self-evident of the ideological inclinations of one of the world's wealthiest people. Rather than targeting the poor, as emphasised in development efforts at the beginning of the century, poverty alleviation measures should shift focus towards the wealthiest individuals, particularly the top

1% of the global population owning over 50% of global assets. While Bill Gates may not be inclined towards restructuring this status quo, it's crucial to recognise that socioeconomic inequalities undermine public health systems and contribute to escalating poverty levels worldwide.

Approaches to the Tackling of Global Economic Inequality

Addressing global health challenges goes hand in hand with confronting the pervasive issue of global economic inequality. The link between these two concerns is evident in the stark disparities in health outcomes and access to healthcare services among different regions and populations worldwide. According to data from the WHO, these inequalities are explicitly evident in the life expectancy gap, where people in Global North countries can expect to live over 18 years longer than those in Global South countries⁸⁷. According to the United Nations International Children's Emergency Fund (UNICEF), children born into the poorest households face twice the risk of dying before reaching their fifth birthday compared to those from the wealthiest households⁸⁸. Furthermore, access to essential healthcare services remains profoundly unequal. The Lancet Global Health Commission on High-Quality Health Systems reported that only 50% of people across the globe can access vital healthcare services, with multitudes pressed into penury due to out-of-pocket healthcare expenses⁸⁹. These inequalities are not only unjust but also impede global health progress. Tackling global health disparities requires addressing the root causes of global inequality, including poverty, lack of access to education, gender discrimination, and limited access to clean water and sanitation⁹⁰. Achieving equitable health outcomes necessitates a multifaceted approach that focuses on improving SDH, strengthening health systems, and ensuring that healthcare services are accessible and affordable for all, regardless of income or geographic location.

In sum, the fight for global health equity is inextricably related to the fight against global inequality. The data highlights the disparities in health consequences and access to healthcare services that exist between Global North and Global South

nations, as well as within countries. Most of the policy prescriptions on this issue put forth the view that a concerted effort involving appropriate social and economic strategies are required to tackle inequalities, thereby addressing health equity.

3.4: Prominent Ideas in Global Health

The field of global health is marked by a certain set of ideas, policies, and practices aimed at improving health outcomes worldwide. However, within this domain, prominent ideas wield substantial influence, shaping the global health agenda and directing resources and attention to specific health issues. Prominence given to certain ideas or entities over others, often results in the prioritisation of specific interests and approaches to health. The following section explores the concept of prominent ideas in global health, examining their impacts and challenges.

Preponderance of Biomedicine

A predominant notion revolves around the ascendancy of the biomedical framework of health, emphasising clinical methodologies, medical advancements, and interventions tailored to specific diseases. Data highlights this dominance, with global health funding disproportionately allocated to biomedical research and pharmaceutical solutions⁹¹. For instance, a study published in the journal *Health Policy and Planning*⁹² in 2023 found that between 2010 and 2021, less than 2% of global health research and development funding was directed toward health systems strengthening, despite its critical role in achieving equitable health outcomes.

According to many definitions, global health is only an updated version of earlier ideas. Even today, social medicine and the SDH tend to be marginalised by political, medical, and biotechnology actors, who see global health largely as a continuation of international health⁹³. Furthermore, in respect to HIV/AIDS vaccines and other pharmacological remedies, biomedical reductionism^v tends to displace

^v Biomedical reductionist models posit that all diseases stem from biological causes within the body and advocate for treatments primarily based on biological interventions, such as surgery or medication.

interest for broader community-based health initiatives⁹⁴. This perspective is unmistakably influenced by colonialism's legacy and Western culture's predominance in knowledge of the 'tropical' world and its problems⁹⁵. It is generally perceived that, such scientific advancement is seen to privilege health actors of the Global North, leading to skewed knowledge resources where global health is concerned⁹⁶. Following this trajectory, a thorough grasp of economic, political and social circumstances and prerequisites is frequently lacking due to the global health policy's predominant focus on both international health issues and the transmission of hazardous infectious illnesses. The deep-rooted intricacy and completeness of global health (a comprehensive framework comprising health issues of the Global North and the Global South) are frequently absent in policies and health plans, most notably in the wake of the coronavirus epidemic.

Hence, there's a widespread belief that combining political and technological strategies to address both infectious and non-infectious diseases is indeed a sound approach⁹⁷. Effective monitoring and enhanced health care for infectious diseases can improve coaction in halting, monitoring, and treating non-infectious illnesses. Certain scholars propose that insights gained through the scaling up of HIV/AIDS therapies could be effectively employed as well as modified to address non-infectious illnesses including cancer and persistent lung disease⁹⁸. Hence, efforts aimed at breaking down the centralised structures of health initiatives via broadening their scope to encompass illnesses and well-being concerns beyond their initial focus have demonstrated some effectiveness.

However, the concept of integrating strategies for communicable and chronic conditions through the amalgamation of targeted health-in-all policy interventions, currently showing promise in terms of medical efficacy and cost-effectiveness, has not yet received substantial practical validation⁹⁹. These interventions encompass a wide spectrum of actions, including limitations on alcohol and other harmful substance consumption¹⁰⁰, implementation of speed limits, and enforcement of laws mandating

the use of protective equipment like motorcycle helmets and seat belts¹⁰¹. Additionally, interventions involve the implementation of legal regulations to mitigate environmental pollution¹⁰², as well as policy strategies to lessen consumption of possibly harmful ingredients such as trans-fat, sugar and salt¹⁰³. These interventions, which are normally undertaken at the national level, have a very indirect and limited effect on communicable illnesses, and there are still chances for combining methods. This is partly because there's often an assumption that such treatments would seamlessly integrate into global health practices, or at the very least, the political dimension is not thoroughly examined as a genuine issue¹⁰⁴.

Moreover, approaches to implementing health-in-all-policies often take a backseat to biomedical and technical methods, which tend to command more attention in public discourse and political decision-making. The SDH are a recurring theme in nearly all global health literature, yet their thorough consideration and effective implementation often fall short of the aspirations¹⁰⁵. The healthcare industry, by its nature, tends to prioritise specialised professional interests rather than being fully equipped to tackle the present public and global health challenges, which demand inter-sectoral approaches due to their multifaceted nature¹⁰⁶. The economic asymmetries within the healthcare industry are rooted in complex political dynamics that shape the distribution of resources, access to quality care and overall health outcomes. At the core of this issue is the influence of powerful stakeholders, including pharmaceutical companies, insurance providers and healthcare institutions. These entities often wield significant political influence, shaping policies that can either perpetuate or address economic disparities in healthcare.

In many political systems including in India, lobbying (though indirectly) by powerful healthcare interest groups can lead to policies that prioritise profit over equitable healthcare provision. For instance, pharmaceutical companies often engage in aggressive lobbying to protect their patents and maintain high drug prices, limiting

access for vulnerable populations¹⁰⁷. Additionally, the influence of insurance companies in shaping healthcare policies can contribute to a system where coverage is often determined by economic status rather than medical need¹⁰⁸. Political decisions regarding funding allocations for public health initiatives and research also play a crucial role in perpetuating or mitigating economic asymmetries within the healthcare sector.

Moreover, the broader political economy significantly influences healthcare disparities. Societal structures and economic systems can either exacerbate or alleviate health inequalities. In countries with privatised healthcare systems, economic status becomes a determining factor in the quality of healthcare individuals receive. On the other end, countries with robust public healthcare systems tend to provide more equitable access to medical services. Political choices, therefore, play a pivotal role in shaping the economic landscape of healthcare, either reinforcing existing disparities or fostering a more inclusive and accessible system.

Disease-Centric Approach

The disease-centric approach to global health gained prominence during the late 20th and early 21st Centuries, particularly in reaction to significant disease outbreaks such as HIV/AIDS, TB, and malaria. Proponents of this approach include organisations like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), as well as initiatives like the US President's Emergency Plan for AIDS Relief (PEPFAR). These efforts focused on addressing specific diseases through targeted interventions, such as treatment programmes, prevention campaigns and research initiatives. While the disease-centric approach has been effective in mobilising resources and attention towards combating specific health threats, it also highlights broader issues within GHG. This approach has often led to vertical programming, where resources are allocated to specific diseases rather than strengthening health systems more broadly. Critics, like Kurt Stange, argue that this can result in fragmented approaches to healthcare delivery and may neglect underlying health system weaknesses that

contribute to the spread of diseases¹⁰⁹. Moreover, the disease-centric approach can sometimes overshadow other important health issues, leading to gaps in addressing broader health problems including chronic illnesses and health inequalities. As a result, there has been a growing recognition of the requirement for a more comprehensive technique to GHG that considers the interconnectedness of health issues and addresses underlying determinants of health.

Prominent ideas often revolve around the prioritisation of specific diseases or health challenges. For example, data from the Kaiser Family Foundation reveals that in 2020, over 50% of health financing from the US was allocated to combat HIV/AIDS, tuberculosis, and malaria, reflecting the disease-centric approach's influence¹¹⁰. While such a focus has led to progress in controlling these diseases, it has also drawn resources away from addressing broader health system deficiencies and other pressing health issues. The most notable multilateral institutions leading the charge against global health issues, like the GFATM, adopt a vertical strategy, focus particularly on a few key health issues, and employ tools that are tailored to a particular disease, such as HIV/AIDS for the GFATM or vaccine distribution for the Global Alliance for Vaccines and Immunizations (GAVI), or specific demographics like children for UNICEF¹¹¹. They have also not undertaken much to support or enhance health systems, and aside from enhancing healthcare delivery, they haven't undertaken much funding for comprehensive health-related measures¹¹². This mismatch is especially evident in global health programmes like GAVI, which work to increase immunisation access in Global South nations in order to save the lives of children and safeguard the health of populations.

From a community health and global health study perspective, the ongoing coronavirus epidemic has underscored the importance of health policy and governance in a completely novel manner. In the Global North for instance, rather than being seen solely as a measure to shield individuals from the adverse effects of business practices on their health, health security is increasingly regarded as a means

to safeguard industries from the detrimental consequences of widespread illness or poor health outcomes¹¹³. This change suggests a prioritisation of economic interests over public health concerns within the discourse surrounding health security. At the same time, the epidemic is making the contrast between infectious illnesses and health-in-all programmes glaringly obvious. During the heights of the pandemic, discourses were largely controlled by medico-biological and biotechnological concerns, constrained by the proficiency of medical specialists. Their monopoly on opinion influenced political decision-making and the global narrative surrounding the epidemic¹¹⁴. This was evident in the media's attention on policy prescriptions given by public health experts most notably the former Chief Medical Advisor to the President of United States, Anthony Fauci. In the Indian context, public health experts such as K Srinath Reddy, the former President of the Public Health Foundation of India received more space in the media. Due to the overwhelming and pervasive focus on coronavirus policy and media coverage, only a handful of non-mainstream publications delved into the epidemic within the broader context of social, political, and economic factors. This steadfast attention side-lined other policy concerns and reporting¹¹⁵.

Likewise, the large-scale trial initiated by the WHO to expedite research on medications to combat the coronavirus epidemic also reflects the imbalance between biological and biotechnical techniques and initiatives to address the SDH¹¹⁶. Despite the significance of non-medical components, there is presently no corresponding funding visible for researching the economic, political, social and ecological reasons of the pandemic's origin and resolution¹¹⁷. This is notable because the virus's widespread distribution over the world and the extremely diverse regional and national responses to it provide for a perfect testing ground for comparative field studies.

Even while high-quality medical treatment is crucial, people's living, working, environmental, and other factors have a greater influence on their well-being. The

health of the populations across the globe cannot be durably enhanced without taking into account the SDH, the matter of financial assets, environment, schooling, as well as diverse societal concerns¹¹⁸. This vision is absent or inadequate in many health journals, which favour technology solutions above those that aim to eradicate and treat underlying causes¹¹⁹. The German Platform for Global Health, composed of NGOs, civil society and scientific experts, frequently underscores the importance of the SDH and advocates for the increased inclusion of non-medical factors in both national and global health discussions¹²⁰. The primary elements affecting people's health can be managed and affected at the national level alone less and less in the interconnected world of today. However, the following also holds true – national and local health concerns are directly related to global health issues.

Market-Driven Health Developments

Market-driven approaches have gained prominence, with private-sector actors, pharmaceutical companies, and philanthropic organisations significantly shaping global health initiatives. Data from the Global Health Impact Index illustrates this trend, revealing the extensive involvement of private-sector entities in global health projects¹²¹. While their contributions have led to innovations and resource mobilisation, concerns persist about profit-driven motives and their influence on global health agendas, often prioritising market interests over public health priorities.

Growing evidence shows that human actions, especially the unregulated growth of agriculture and the global food industry, are the primary drivers behind the emergence of lethal epidemic diseases triggered by various contagions over the past few decades¹²². The ongoing loss of habitats and accelerated desertification increase the chances of maladies such as coronaviruses, dengue, Zika, Ebola, by bringing humans and animals into closer contact and altering ecosystems to facilitate the spread of these diseases¹²³. Beyond solely relying on biological, therapeutic, or genetic engineering methods, a social-based approach to medicine (linked to SDH) and

healthcare is needed to advance and achieve effective and equitable global health initiatives.

Vertical programmes, which have limited goals and typically only address a portion of the demand, as well as other drawbacks, may be beneficial or lead to the creation of new treatments and vaccines, however, these interventions do not encompass any modifications to the fundamental factors and global health challenges¹²⁴. A comprehensive health-in-all policy must be devised, and global health policy must lead to a fundamental redefinition of how health is perceived. It should also acknowledge the intricate nature of health in all its dimensions and diversity. Only then can global health policy be effective. Centring exclusively on security considerations and framing global health policy as a safeguard for entrenched interests in an unequal society fails to address the present challenges effectively¹²⁵. To attain the goals of global health, it's imperative to prioritise health promotion over disease management, ensure universal access to fair employment and financial opportunities, diminish socioeconomic and health inequalities, advocate for equality, guarantee food sovereignty, enact sustainable environmental policies, and establish inclusive participation, democracy and social security.

To summarise, prominent ideas can mobilise substantial resources and attention toward critical health issues, resulting in progress and innovation. For instance, data from UNAIDS indicates significant advancements in the global response to HIV/AIDS, with the number of new infections declining by 31% since its peak in 1997¹²⁶. On the flip side, the narrow focus of prominent ideas can lead to tunnel vision and competition for limited resources. The Lancet Global Health Commission on High-Quality Health Systems highlights the neglect of broader health system strengthening efforts, which are vital for achieving comprehensive health outcomes¹²⁷.

In sum, prominent ideas wield considerable influence in shaping the global health landscape, as evidenced by data on resource allocation and policy priorities. While they have spurred progress in addressing specific health challenges, they also

pose challenges by diverting attention from broader determinants of health and by promoting particular approaches that may not always align with public health priorities. Achieving health equity and addressing the environmental, political, economic and SDH demand a critical examination of these prominent ideas and a more comprehensive global health approach. From the standpoint of public policy, data highlights the validity of these ideas which in turn can guide efforts to create a more inclusive and equitable vision of health for all.

3.5: Concluding Remarks

The concept of global health is introduced in this chapter, highlighting its emergence and evolution in both scientific and political spheres. It discussed how the term 'global health' replaced 'international health' in the early 2000s and traced its roots to colonial medicine, tropical medicine, and international health. The chapter then emphasised the role of the Global North in addressing health issues in the Global South, primarily motivated by security concerns. The discussions then looked at the transition in ideas from colonial medicine to tropical medicine and later to international health. It discussed how efforts to control infectious diseases, driven by the Global North, led to the establishment of international health as a field primarily focused on addressing health issues in the Global South. The emergence of public health, particularly in the USA and the UK post-World War II, is also explored, highlighting its focus on population health and SDH.

The establishment of the WHO and the Alma-Ata Declaration are key focal points in subsequent discussions. The WHO's role in addressing global health challenges was traced back to the international sanitary conferences, emphasising the need for a coordinated international response to health issues. The Alma-Ata Declaration's emphasis on primary healthcare as a cornerstone for achieving health for all is discussed, highlighting its significance in shaping global health policy. Further discussions underscored the concepts of UHC and selective primary

healthcare. Milestones towards achieving UHC were outlined, contrasting its comprehensive approach with the limitations of selective primary healthcare in addressing poverty as a fundamental determinant of health. The discussion further explored prominent ideas in global health, including the dominance of the biomedical framework, disease-centric approach and market driven strategies to promote global health. The discussions emphasised the necessity for a comprehensive method that considers the environmental, political, economic and SDH influencing health. It reiterated the significance of addressing broader factors that affect health in order to achieve health equity and well-being for all.

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CHAPTER 4

THE POLITICS OF GLOBAL HEALTH AGENDA SETTING AND MULTILATERALISM IN THE GLOBAL SOUTH

4.1 Introduction

The preceding chapter discussed the historical dimensions of global health and global health governance. This chapter examines the global health agenda setting, the process by which global health issues and norms gain the attention of actors who have control over or influence over the distribution of financial, technological, human and other types of resources. These actors include national governments and their populations, international organisations, international non-governmental organisations (NGOs), private foundations, bilateral and multilateral funders, research institutes, businesses, as well as the media.

The politics involved in determining the global health agenda merit consideration. First, due to a lack of resources globally, most notably in the Global South, only a few health conditions are given high-level agenda status. Second, the distribution of resources frequently does not match the prevalence of diseases or the cost-effectiveness of health care, indicating that other variables, such as political ones, drive the global health agenda. This highlights an issue within global health governance where the allocation of resources is not always aligned with the prevalence of diseases or the cost-effectiveness of healthcare interventions. Instead, it suggests that political factors often play a significant role in shaping the global health agenda, influencing resource distribution and priorities in ways that may not always reflect the actual health needs of populations.

This chapter provides an analysis of the roles of actors, ideas, interests, and institutions that influence how the global health agenda is set. The chapter looks at how the global health agenda is determined, with a focus on India, using the Bill and

Melinda Gates Foundation (BMGF) as a case study. The chapter probes what the presence of the BMGF and its counterparts, such as the Global Alliance for Vaccines and Immunization (GAVI), mean for multilateralism in the Global South. The BMGF is taken as a case study on global health agenda setting in the Global South because of its significant influence and involvement in shaping global health priorities and initiatives, particularly in low- and middle-income countries. As one of the largest private philanthropic organizations in the world, the BMGF has played a pivotal role in funding and implementing various health programs and interventions aimed at addressing key global health challenges such as infectious diseases, maternal and child health, and access to healthcare services. In the concluding remarks, important arguments from the analysis are highlighted.

A variety of social and political forums are used to set the agenda for global health. Global decision-making groups including the World Health Assembly (WHA), United Nations Security Council (UNSC), and United Nations General Assembly (UNGA) make pronouncements and pass resolutions. International institutions that facilitate treaty negotiations include the World Health Organisation (WHO), which issues recommendations and offers technical assistance. In the Global North context, donors distribute financial resources for research, projects, and programmes, including the BMGF and the United Kingdom (UK) Department for International Development (DFID). In general, in the Global South, governments continue to be the major contributors to the research, projects and programmes. Similarly, leading media organisations, assign publishing space and advice elites and the general public on which health problems they should focus on. Medical journals examine and distribute the scientific knowledge that research institutes create (via the peer-review process). Standards and norms within the healthcare industry are set by professional organisations such as the Indian Medical Association (IMA) and Indian Council for Medical Research (ICMR). Pharmaceutical corporations make investments in specific goods. One venue could place a topic on the agenda, but not another. This chapter

presents the case that agenda setting in global health disproportionately favours philanthrocapitalists, as argued by Manjari Mahajan, which works to the detriment of multilateral cooperation and democratic principles in the global health arena particularly affecting the Global South.

Philanthrocapitalists refer to individuals or groups who engage in philanthropy with a strategic and business-oriented approach. Some prominent organisations include, the BMGF and the Open Foundation from US and the Wellcome Trust from UK. The term combines "philanthropy" and "capitalism," emphasising the use of business principles, strategies, and market-based approaches to address social issues and promote positive change. Philanthrocapitalists often view their charitable activities through the lens of investment, seeking measurable and sustainable outcomes, akin to the way capitalists approach business ventures. These individuals or entities leverage their financial resources, entrepreneurial skills and business acumen to create social impact. Philanthrocapitalism entails more than traditional charity; it involves applying business-like strategies such as risk-taking, innovation, and scalability to philanthropic endeavours. Philanthrocapitalists may also collaborate with governments, non-profit organisations and other stakeholders to maximise the effectiveness of their philanthropic initiatives. The concept of philanthrocapitalism has gained prominence in discussions about the evolving role of wealth and the private sector in addressing societal challenges, including health. Advocates argue that this approach can bring about innovative solutions and drive systemic change, while critics raise concerns about the potential influence of wealthy individuals on social agendas and the prioritisation of specific issues over others based on donor preferences.

4.2 Actors in Global Health Agenda Setting

In the post-World War II period, the WHO and member states were the key actors involved in the processes of international health cooperation agenda setting¹.

From the 1980s onwards the World Bank and other international financial organisations also became more relevant carving out more dominant roles through the aid and developmental support that they extended². In the present scenario, global health agenda is shaped by a variety of individuals and organisations, both state and non-state.

In the process of global health agenda setting, influential state actors play a critical role in shaping priorities, policies, and resource allocation. These state actors, often represented by government agencies or ministries of health, wield significant power and influence on the international stage. Countries with strong economies, advanced healthcare systems, and political clout, such as the United States, Canada, the United Kingdom, European Union member states, and emerging powers like China, Brazil, South Africa and India, are particularly influential³. They contribute substantial funding to global health initiatives, participate in decision-making forums such as the World Health Assembly, and leverage their diplomatic networks to advance specific health agendas. Through bilateral agreements, multilateral partnerships, and diplomatic negotiations, influential state actors shape the global health agenda by advocating for their interests, mobilising resources, and driving policy priorities that reflect their domestic health concerns and strategic objectives on the international stage.

In the realm of non-state actors, policy entrepreneurs are among individuals who influence policy to a great extent. They highlight issues, connect them to solutions, and engage with political opportunities⁴. Heads of state and international organisations are examples of leaders of remarkable stature who are the subject of entrepreneurial endeavours and occasionally turn into powerful supporters of health causes. A number of global health challenges have seen a tremendous improvement because of such strong leadership. The impact of policy entrepreneurs through strong leadership in addressing global health challenges is exemplified by figures like James Grant, whose tenure as the executive director of UN Children's Fund (UNICEF)

marked a transformative era. For instance, James Grant, the former executive director of the UNICEF, led the Child Survival Revolution in the 1980s, which culminated in the World Summit for Children in 1990 under the UN initiative, where the largest gathering of world leaders met to commit to improving child health and survival⁵. At the close of the 20th century, Secretary General Kofi Annan championed the UN Millennium Declaration and Goals, launching a new overarching standard in development that spurred action on a number of significant global health challenges during the ensuing fifteen years⁶. Following this, several world leaders, including the prime ministers of Norway, the UK, and Canada, as well as UN Secretary General Ban Ki-moon, championed initiatives that attracted about US\$40 billion in financial commitments to improve women's and children's health between 2010 and 2015 as part of efforts to accelerate progress on UN MDGs 4 and 5 (on child and maternal survival)⁷. These collaborations brought together networks of policy entrepreneurs, national leaders, and international organisations united by a common interest in addressing health-related issues.

Policy entrepreneurs, influential political leaders and international organisations collaborate within these global networks due to a shared interest in health-related matters. Experiences highlighted by public policy studies suggest that network and institutional acceptance is a crucial stage in the process of setting the agenda for many topics⁸. The makeup and coherence of networks varies, characteristics that have an impact on how well they form agendas. Regarding addressing health challenges, networks that consist solely of technical specialists from high-income countries often miss out on the advantages enjoyed by more diverse groupings⁹. Six global health networks were examined concurrently, revealing that those which established substantial political coalitions (such as tobacco consumption, TB, and health of mothers) were able to achieve better results in promoting their concerns on the global health policy agenda compared to networks that either postponed extension (such as childhood pneumonia and newborn health) or lacked

diversification extending beyond a core focused solely on health aspects (as seen in alcohol consumption)¹⁰. Consistent findings from studies on the global health agenda for sexually transmitted infections (STIs) and undernourishment point to the facilitative nature of coalition formation while network efficacy is hampered by its reach, excluding a variety of stakeholders¹¹. Disputes regarding how to define problems, prioritise interventions, and advocate tactics within networks focused on advancing global health policy agendas can lead to fragmentation and decreased effectiveness. This contention has hindered the ability to present a cohesive front and communicate a concise message concerning non-communicable diseases and other health conditions¹². However, these dynamics are not fixed. During the MDGs era, the maternal health network, dedicated to reducing maternal mortality globally, experienced enhanced cohesion. This unity contributed to raising awareness of the issue and elevating it on the international development and global health policy agendas¹³. In the 2000s, maternal health garnered unprecedented attention, including from world leaders, and saw substantial resource commitments. For instance, it was one of the issues addressed by the US\$40 billion pledged to the 2010 Global Strategy for Women's and Children's Health under the aegis of the Office of the United Nations High Commissioner for Human Rights¹⁴. Throughout the 2000s, the coalition advocating for integrated community case management (iCCM) of paediatric illnesses strengthened significantly. This enhanced coalition-building facilitated the elevation of paediatric illnesses on the global health policy agenda.

There is also evidence suggesting that an actor's legitimacy plays a key role in shaping their influence on the setting of the global health agenda. For instance, during the WHO-led negotiations on the Framework Convention on Tobacco Control (FCTC), a legally binding international treaty, technical expertise served as a legitimising factor that enabled the involvement of civil society organisations, while actors from the tobacco industry were marginalised¹⁵. Organisations like the Campaign for Tobacco-Free Kids, which possessed in-depth knowledge about the health impacts of

tobacco use, were legitimised as valuable contributors to the treaty negotiation process. Their technical expertise and evidence-based arguments played a crucial role in shaping discussions and influencing policy decisions related to tobacco control measures. On the other end, tobacco industry actors were marginalised due to their conflicting interests with public health goals. The industry's historical role in promoting tobacco use, coupled with evidence of its attempts to manipulate public opinion and undermine health policies, led to their exclusion from discussions within the FCTC framework. The prioritisation of technical expertise over profit-driven motives served as a legitimising factor for the involvement of civil society groups focused on public health. These instances point to the power dynamics of actors including CSOs and networks in their potential to shape the global health agenda.

4.3 Process of Global Health Agenda Setting: Ideas, Interests and Institutions

Throughout the agenda-setting process in global health governance (GHG), ideas that motivate collective action wield considerable influence. These ideas are rooted in universality, implying that concepts applicable in one context hold true across others¹⁶. These ideas are the primary conceptual factors in global health agenda setting. They provide researchers in GHG with frames (theoretical lenses through which issues are seen) and norms (common expectations for the behaviour of actors with a specific identity)¹⁷. Actors within the healthcare system employ ideas to frame and portray issues in specific manners, often to assign blame and responsibility¹⁸. Clear narratives bring people together to blame authorities, but unclear narratives block this process. For example, the FCTC's case was made stronger by years of proof that smoking causes serious illness and death, bringing people together and changing how the problem is seen—from something affecting only individuals to something affecting everyone¹⁹. On the other end, alcohol control faces more challenges in gaining traction on the global health policy agenda because its causal history is more complex compared to tobacco control²⁰. The tobacco control network expanded from

a handful of dedicated individuals to a worldwide alliance of membership-based organisations, whereas the alcohol control network remains a compact group of committed individuals with similar goals. Agenda-setting for other global health issues, such as chronic diseases²¹, mental health²², strengthening of health systems²³, and universal health coverage²⁴, has also been similarly hindered by complicated causal narratives. The difficulty in setting agendas for these global health issues arises from their inherent complexity, interconnectedness, and political nature. Tackling these challenges involves considering diverse viewpoints, recognising power dynamics, and embracing a nuanced understanding of the multifaceted nature of global health.

Agenda-setting is also made easier when issues are seen as serious and capable of being resolved with widely accepted solutions²⁵. The development of global and national agendas for polio²⁶, malaria²⁷, tuberculosis²⁸, maternal health²⁹, newborn survival³⁰, STDs³¹, and nutrition³² has benefited from such processes and ideas. Difficulties in raising awareness of particular issues on the agenda have been hindered by a lack of reliable indicators or the belief that solving problems in resource-limited settings may not be economically viable or lack the necessary technologies for resolution³³. Thus, global health networks face primarily four challenges³⁴. The initial stage involves defining the issue, where consensus is reached on the problem and its solution. Following this is positioning: articulating the issue to inspire action from external audiences. The subsequent step involves forming coalitions with these external actors, especially those beyond the health sector. Finally, governance entails establishing structures and institutions to encourage collaborative efforts.

However, theoretical frames can evolve over time, leading to the promotion of certain issues. For example, in the 1970s, a shift away from vertical and highly medicalised healthcare approaches, which had been emphasised in international health promotion for decades, contributed to the emergence of global backing for primary healthcare. This shift was formalised in the WHO's Alma-Ata Declaration of

1978³⁵. Similarly, in the 2000s, the perception of infant mortality changed from being an unsolvable issue to one that could be successfully addressed with low-cost community-based treatments³⁶. Although the global health agenda initially faced challenges due to the perceived lack of evidence supporting the effectiveness of universal health coverage in enhancing health outcomes, framing it as a solution to the challenges faced by national health systems in the Global South helped to promote the concept³⁷. The discussion of universal health care as a matter of health and human rights affected how the SDGs agenda was negotiated as well³⁸. Therefore, the process of agenda-setting benefits from perceiving issues as significant yet feasible to address with widely acknowledged public policy responses.

A fundamental set of prevailing frameworks can be employed to drive agenda setting and shape policy actions. Scholars examine various health issues through lenses such as evidence-based medicine, security, economics, development, and human rights³⁹. Acquired immunodeficiency syndrome (AIDS) was brought greater attention through security framing, and subsequently AIDS was reframed as a development concern to preserve its importance during the MDGs era⁴⁰. This shift in understanding a disease illustrates the collaboration between security concepts and evidence-based medicine in promoting drug-based and other innovative therapies. To cite an example, in the African context, it was shown how prevalent economic frameworks influenced medication access policies, with human rights-based advocacy for access having lesser impact on the eventual outcomes⁴¹. In summary, the research suggests that different frames are employed, sometimes in competition or in harmony, and they shape the overall response to specific health issues.

In addition, by aligning concerns with existing international regulations, advocacy networks have increased the priority of these issues⁴². It has been noted that the reduction of discriminatory practices against individuals with HIV/AIDS progressed more rapidly when advocates against travel restrictions framed the discussion in the context of human rights. They supported their argument with

references to international standards and specific commitments to prevent discrimination⁴³. Similarly, infant survival moved up the global health agenda in part as a result of concerned parties aligning the problem with the standard for child survival promoted by MDG 4 which stated that lowering neonatal death was required to meet the child survival target⁴⁴. In matters related to maternal survival, adherence to two robust international norms was crucial. One focused on women's rights during the 1990s, while the other aimed at poverty reduction through the MDGs since 2001. These norms provided essential policy support for advancing the agenda⁴⁵.

Researchers exploring global health agenda-setting have highlighted the link between actor behaviour and interests, examining whose interests prevail. Interests represent preferences shaped by the benefits or drawbacks an actor encounters (or expects to encounter) due to specific circumstances. Concurrent with actor behaviour are corporate profit motives, national economic and security concerns, which influence agenda definition. Studies indicate that material interests, including those related to national security and the economy, heavily influence health agenda-setting at both global and national scales⁴⁶. This seems to indicate that if significant actors' interests coincide, a problem is more likely to surface on the global health agenda.

In general, many global health challenges are driven by economic interests. For example, in the late 1970s, when the WHO chose to prioritise essential medications, it issued ambiguous recommendations to accommodate the financial interests of the pharmaceutical sector. This approach helped maintain industry backing for the initiative⁴⁷. In cases involving the availability of the drug praziquantel and universal access to antiretroviral (ARV) medications, actor behaviour was influenced by the economic interests of the pharmaceutical sector and the needs of Global South nations⁴⁸. Pharmaceutical companies doubted the existence of a market for ARVs in Global South nations due to their inability to afford the high prices of ARVs⁴⁹. Consequently, advocacy groups utilised supply and demand dynamics to encourage

drug manufacturers and national governments to become involved in supplying ARVs to underserved populations.

Achieving a balance between national security and health equity amidst infectious diseases requires navigating a fine equilibrium. It's essential to ensure that measures taken to safeguard a nation's security don't disproportionately affect vulnerable populations or undermine the principles of health equity. Health equity, in this context, refers to the fair distribution of healthcare resources, opportunities, and outcomes across different populations. While some studies suggest that health equity and human rights norms may have a lesser impact on shaping the global health agenda compared to considerations of national security and economic interests, comprehensive analyses of various health issues indicate that both sets of factors—health equity and human rights, as well as national security and economic considerations—play crucial roles in influencing and shaping the priorities and strategies within the global health agenda⁵⁰. This nuanced perspective highlights the complex interplay of multiple factors that contribute to the formation and evolution of global health policies. For example, Kapstein and Busby observed that normative commitments were essential alongside changes in material incentive structures in the context of universal access to ARV medications⁵¹. Likewise, several countries lifted travel restrictions on individuals living with HIV/AIDS after being convinced by arguments that these restrictions did not serve their countries' interests. Additionally, they were influenced by local and international principles that prohibited discrimination⁵².

In another instance, the FCTC's guidelines were influenced by civil society groups who utilised concepts of economic growth and moral reasons in their negotiations with the tobacco industry⁵³. In addressing gender-specific health, increased attention to menstrual hygiene management was propelled by several factors. These included business interests in expanding markets, evidence of the health benefits associated with girls completing their education, and ethical concerns

regarding gender disparities in education⁵⁴. Therefore, one can observe that a range of interconnected interests — economic, political, and cultural — contributed to the development of agendas and policies in the global health domain. However, there exists a perception that these considerations would be ineffective without institutions that endorse and validate agendas.

In fact, institutions are "collections of generally long-lasting structures, regulations, and standard operating procedures" that influence the expectations, preferences, and actions of actors⁵⁵. In global health, factors such as aid frameworks, accountability systems, and ethical standards hold significance. Consequently, institutional factors frequently receive focus in analyses when they drive change, while they diminish in importance when they don't. This is because experts in global health agenda setting primarily seek to explain why certain topics gain or lose prominence on policy agendas. Understanding the role of institutions in shaping the global health agenda can be gleaned from examples illustrating the influence of international human rights treaties, regulations governing participation in UN procedures, and trade and patent laws.

Instances demonstrating how institutions shape the agenda can be observed in the regulations governing participation in procedures related to the WHO-sponsored FCTC. Some of these rules were established to incorporate specific stakeholders, while others were designed to exclude them⁵⁶. For instance, initially, the extensive process of acquiring official relations status with the WHO hindered the participation of numerous civil society organisations as efforts to advance the FCTC began in the late 1990s⁵⁷. Member states implemented an expedited and expanded procedure for qualified NGOs to attain official relations and consultative status. This move aimed to mobilise significant additional resources for the FCTC process, intending to bolster political and technical backing for the treaty⁵⁸. The network of actors focused on the adverse effects of tobacco smoking expanded and diversified due to the changes in norms governing consultative relationships. Apart from other efforts, the expanded

network provided delegates with technical information about the proposal, advocated to governments, initiated media campaigns, exposed unethical practices of the tobacco industry, and overcame governmental resistance. These actions elevated the FCTC on both national and international policy agendas⁵⁹. Conversely, industry actors were prohibited by law from engaging in the FCTC negotiating process, limiting their capacity to sway decisions beyond being represented by intermediaries such as "friendly governments"⁶⁰. Moreover, Article 5.3 of the FCTC and its related implementation guidelines assist parties in preventing the tobacco industry from meddling with the policy-making process, as per national regulations⁶¹. However, in numerous countries (including India), the selective adoption of recommendations still provides avenues for industry influence.

To cite another example, the matter of universal access to ARVs exemplifies the institutional influence of trade and patent laws in shaping the global health agenda. One notable obstacle hindering nations and donors from regarding universal access as feasible at the beginning of the 21st Century was the exorbitant cost of ARVs, initially curtailing support for this solution⁶². Low-cost generic drug manufacturing (especially in the Global South countries) had been severely constrained by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) instituted as part of WTO regulations in 1995⁶³. For instance, in India, the TRIPS had significant implications for the pharmaceutical industry⁶⁴. Before India complied with TRIPS, it had a thriving generic drug manufacturing sector. This was aided by the fact that India did not grant product patents for pharmaceuticals. Instead, it followed a process patent regime, which allowed competitors to produce the same drug using a different manufacturing process. Post-TRIPS, the country had to amend its patent laws in 2005, thus impacting the production of low-cost generic drugs. To comply with the TRIPS Agreement, India initially amended its patent laws in 1995 to reintroduce product patents for pharmaceuticals. However, these product patents applied only to new inventions, not existing drugs. In the pre-2005 period, India continued to grant

process patents, allowing companies to produce drugs using different methods than the one patented. During the post-2005 (TRIPS Compliance period), India further amended its patent laws to fully comply with TRIPS, removing the distinction between product and process patents. The new law allowed for the grant of product patents for both new and existing pharmaceutical products. These changes aimed to strike a balance between protecting intellectual property rights (IPR) and ensuring affordable access to medicines. The transition was crucial for India's pharmaceutical industry, known for producing generic versions of essential drugs, and it aligned the country with international intellectual property standards. This change affected the accessibility of affordable medications for various critical health issues, including HIV/AIDS, tuberculosis, and other infectious diseases, highlighting the delicate balance between IPRs and community health priorities.

Policy makers were under pressure to address the issue as a result of public outcry over the Global South's limited access to essential medicines. The Doha Declaration on TRIPS and Public Health 2001, which endorsed member states' rights to safeguard public health and increase access to medications for everyone, was adopted by the WTO in response to this demand⁶⁵. The Doha Declaration and its amendments paved the way for increased generic ARV production and distribution. It also prompted the WHO and the Joint United Nations Programme on HIV and AIDS (UNAIDS) to notably expand the number of individuals utilising ARVs, facilitating the GFATM and the US President's Emergency Plan for AIDS Relief (PEPFAR) in raising additional funds⁶⁶. In the early 2000s, these breakthroughs enabled HIV/AIDS concerns rise to the forefront of the global health agenda. By offering low-cost, high-quality medications, Indian producers of generic ARV drugs encouraged the quick expansion of HIV/AIDS therapy in Global South countries.

Another example is how the formation of the maternal and reproductive health agenda has been supported by international human rights agreements. Emphasising states' obligation to safeguard women's right to health, as guaranteed by specific

international treaties, has been one tactic for increasing awareness of the imperative to decrease maternal mortality⁶⁷. The Committee on the Elimination of Discrimination Against Women (CEDAW), which is responsible for overseeing state adherence to the Convention on the Elimination of All Forms of Discrimination Against Women issued a ruling in 2011 that put these rights into effect⁶⁸. The committee found that "States have a human rights commitment to give women of all ethnic and economic backgrounds timely and non-discriminatory access to suitable maternity health treatments"⁶⁹. Further, a strategy based on human rights also provides a legal framework utilised to reinforce pledges made at notable international gatherings, like the 1994 International Conference on Population and Development. It also serves to validate maternal health programs and guidelines proposed by UN agencies⁷⁰. The UN Millennium and Sustainable Development Goals, normative platforms that are important indicators of global health and international development agendas, were affected by these frameworks, regulations, and pledges in turn. Therefore, within the realm of global health, agenda setting emerges as a pivotal process through which vital health issues are recognised and ranked for international focus and intervention. This process encompasses a diverse range of stakeholders, including governments, international organisations, NGOs, and advocacy groups. While the WHO frequently assumes a central role in agenda setting, the landscape has evolved to encompass a wider spectrum of actors who shape the global prioritisation of health issues and allocation of resources.

Multilateralism is a foundational principle in global health governance, emphasising upon collaboration and coordination among multiple countries and organisations to address common health challenges. Multilateral institutions, such as the UN and its specialised agencies like the WHO, provide a platform for collaborative diplomacy, negotiation, and the development of global health policies and standards. These institutions also facilitate the pooling of resources and expertise to respond effectively to health crises that transcend borders. In tandem with multilateralism,

advocacy networks are instrumental in shaping the global health agenda. These networks often consist of civil society organisations, researchers, healthcare professionals, and grassroots movements that champion specific health issues and advocate for policy changes, funding allocation, and awareness-raising on pressing health matters. They serve as a crucial bridge between the concerns of affected communities and the global system, pressuring governments and international organisations to prioritise certain health issues and adopt various strategies to address them. Thus, global health agenda setting, multilateralism, and advocacy networks are interconnected elements of a dynamic ecosystem dedicated to addressing the world's most pressing health challenges.

The WHO stands as a cornerstone in the multilateral framework addressing global health challenges. Established in 1948, the WHO serves as the UN specialised agency for health, providing leadership on international health matters, shaping the global health agenda and coordinating efforts to combat various health threats. With a membership comprising 194 states, the WHO operates as a platform for cooperation, facilitating collaboration between nations, international organisations, civil society and other stakeholders to address pressing health issues that transcend national borders. One of the WHO's key roles is to provide technical expertise and guidance on a wide range of health topics, including disease prevention, health promotion and healthcare delivery. Through its expert committees, research networks and partnerships, WHO develops guidelines, standards and protocols to guide member states in their efforts to improve health outcomes. Furthermore, the WHO functions as a global surveillance and early warning system for infectious diseases and public health emergencies, facilitating prompt responses to outbreaks and crises. By fostering solidarity and collective action, the WHO is mandated to play a vital role in building resilient health systems and advancing global health equity, ensuring that all people have access to the utmost achievable level of health.

Mainly propelled by significant apprehensions regarding HIV/AIDS, maternal

mortality, and flu pandemics, the last twenty years have seen a remarkable surge in health financing and official development assistance (ODA) estimated at US\$67.4 billion in 2021, 10 times greater than two decades ago⁷¹. This included an unprecedented US\$37.8 billion in development assistance for health towards COVID-19⁷². Scholars working in the intersecting areas of health and international relations such as Devi Sridhar and Ngarie Woods see the past 25 years as being revolutionary in terms of heightened funds and the variety of global health initiatives that have been launched are concerned⁷³. The notable increase in funding from governments and international agencies has coincided with the emergence of novel forms of multi-entity collaboration, exemplified by initiatives like the Global Alliance for Improved Nutrition (GAIN), as well as the establishment of new institutions such as the BMGF, which boasts substantial endowments. The challenge to global health, however, came from neo-liberal economic policies and the utilitarian objectives of philanthrocapitalist organisations. Philanthrocapitalists, positioned mostly in the Global North, with their substantial resources and influence, play a pivotal role in shaping the process of global health agenda setting, especially in the Global South, often directing attention and funding toward specific health issues and initiatives, albeit sometimes with a narrow focus that may not fully address broader determinants of health equity. Following this discussion, the next section analyses the role played by a prominent philanthrocapitalist organisation, the BMGF in the realm of global health. The analysis is undertaken to understand its interventions and implications to multilateralism in the Global South.

4.4 The Bill and Melinda Gates Foundation: Philanthrocapitalism and Challenges to Multilateralism in the Global South

The Bill and Melinda Gates Foundation (BMGF) is one of the largest private philanthropic organisations globally, founded by Microsoft co-founder Bill Gates and his former wife Melinda Gates. With a primary focus on addressing global health issues, the foundation has played a significant role in shaping health initiatives,

particularly in the Global South⁷⁴. Through its substantial funding and strategic partnerships, the foundation has contributed to various health interventions aimed at improving health outcomes and reducing health disparities in the Global South. In the Global South, the BMGF has been instrumental in funding and supporting initiatives to combat infectious diseases, improve maternal and child health, and strengthen healthcare systems⁷⁵. Their efforts have ranged from funding research for developing vaccines and treatments for diseases like HIV/AIDS, malaria, and tuberculosis to supporting programmes aimed at increasing access to essential healthcare services and promoting public health education and awareness. One notable example of the foundation's involvement in the Global South is its role in India. In India, the foundation has partnered with the government, non-governmental organisations, and other stakeholders to address various health challenges prevalent in the country. This includes initiatives to improve immunisation coverage, reduce child mortality rates, and enhance maternal healthcare services⁷⁶. The foundation's investments in India have had a significant impact on public health outcomes, contributing to the country's progress in achieving health-related sustainable development goals. Overall, the BMGF's engagement in global health, particularly in the Global South and countries like India, underscores its commitment to advancing health equity and improving the well-being of communities worldwide through strategic investments, partnerships, and innovative solutions.

In the Indian context, the BMGF opened its offices in 2003 with a purpose to aid the Government of India in its fight against HIV/AIDS⁷⁷. In the early 2000s, the HIV/AIDS epidemic in India was at its highest; its prevalence estimated at 0.55%⁷⁸. The burden of disease from HIV/AIDS has, since then, decreased with a prevalence estimate placed at 0.21% in 2021⁷⁹. Advocates of the BMGF applaud the 'Avahan' project as one of its initial triumphs in India, dubbing it as a "sustainable strategy" aimed at empowering the country to assume responsibility for the disease from 2012 onwards⁸⁰. The programme relied on donor funding, reflecting the approach of the

BMGF in urging America's wealthiest families to contribute a significant portion of their wealth to philanthropic endeavours and charities.

Like most philanthrocapitalist ventures, the BMGF sits on seed money amounting to billions. Warren Buffett, the American business person, is its largest donor contributing US\$ 31 billion to the Foundation. However, similar to the Rockefeller Foundation a century earlier, the BMGF prioritises "strategic investments" intended to foster corporate restructuring, promote economic effectiveness, and draw independent funding to key initiatives⁸¹. The utilisation of these investments influences agenda setting, as the foundation determines agendas based on the diseases it selects to allocate grants to, accountable only to its internal advisory board for such choices. These structural mechanisms ensure that, even in countries in the Global South like India, the notion of "the rich know best" prevails, side-lining welfare-oriented policies that consider the socio-economic and cultural contexts of the population⁸². Furthermore, it complements the technocratic approach to health that is emblematic of projects funded by the BMGF. One of the main concerns a public health researcher at Public Health Foundation of India pointed out was the skewed interest in global health issues which are of the greatest concern to wealthy donors. He pointed out to the issue of sustainability in running of a programme. AIDS could be the priority for one year, and then suddenly the focus would shift on to another health issue which was more conducive for a donor to be involved in.

The BMGF in its public communication states that its interest is in providing 'innovative' and 'data driven' solutions to the health challenges in countries of the Global South, including India⁸³. From 2003, the Foundation extended its portfolio to include sanitation, maternal and child care and food security in backward states in India like Uttar Pradesh and Bihar. Working with Anganwadi personnel and community health workers, the BMGF claims to provide the necessary technological knowledge and support that is lacking from the government⁸⁴. This top-down approach, however, has been criticised for its inability to factor underlying social

variables like gender and caste which determine health outcomes⁸⁵. During a keynote speech to the WHA in May 2005, Bill Gates minimised the significance of socio-economic background as a determining factor in the burden of disease in countries of the Global South. He stated⁸⁶:

“But the world didn’t have to eliminate poverty in order to eliminate smallpox – and we don’t have to eliminate poverty before we reduce malaria. We do need to produce and deliver a vaccine —and the vaccine will save lives, improve health and reduce poverty.”

Additionally, Gates emphasises that countries in the Global South bear a greater burden of disease because their governments are hesitant to eradicate illnesses. This perspective overlooks historical contexts, as many Global South nations were historically subjected to colonialism, which depleted their resources, both material and otherwise. Gates' stance contradicts the purported sympathy he holds for the people in these countries, as he attributes the diseases to them. Furthermore, this approach to Global Health feeds into the celebrity image cultivated by the Foundation and its executive members. Bill Gates and Melinda French apart, a reading of the testimonials on the BMGF India publications, shows a cult of celebrity that is being marketed by the Foundation. Of special note is the testimonial of Dr Naveen Thacker, the President Elect of The International Paediatric Association (IPA), an organisation that works closely with the BGMF to improve and promote child health. Thacker recounts his time as an advocate of polio immunisation in the 1990s when India “accounted for 60% of the world’s polio cases”⁸⁷. The high degree of self-importance being given to these initiatives and individuals can be understood from the following statement:

“With the help of the local Rotary Club, of which I was a member, I became involved in an immunisation program. I began writing small booklets in Gujarati, the local language, explaining how polio was transmitted and the importance of immunisation. With the help of Rotary, these booklets were translated and distributed

*in more and more communities. Eventually, I became so involved that I nearly lost my medical practice! Soon, everybody was calling me 'Mr. Polio'."*⁸⁸

The BMGF provides detailed statements/testimonials of influential people and celebrities regarding the works they undertake in the country. However, some of the key actors such health workers, Anganwadi workers and recipients of the healthcare are generally absent in its public communications. Thus, by sidelining the voices of the majority in favour of executives, the healthcare narrative transitions from being community-centred, as claimed by the BMGF, to being solely about the individual — a marketing tactic that positions the BMGF and its affiliates as critical interventionists in global health⁸⁹. The implementation of market-driven strategies — such as private endowments and funding, technocracy, and the cultivation of celebrity images — holds considerable implications for multilateralism in the global health arena, especially on the issue of deprioritisation of local health realities.

4.5 Changes in Global Health Financing

At first glance, the surge in funding and the diverse array of institutions engaged in global health might suggest a growing endorsement of multilateral collaboration and ODA. Analyses of global health expenditure and development assistance, conducted by organisations such as the Institute for Health Metrics and Evaluation (IHME) and the World Bank, reveal significant growth in both the budgets and commitments of entities like the WHO and World Bank over the past twenty years. Specifically, the WHO's programme budget has more than doubled, while the World Bank's health-related lending has surged by over threefold⁹⁰. Core World Bank funding for the health sector (Health Nutrition and Population programs) increased approximately from \$17.5 billion in 2000 to \$60.9 billion from 2015⁹¹. In 2022, over 240 initiatives were undertaken through the World Bank's \$34 billion global health portfolio which assists nations in taking a comprehensive approach to improving health outcomes⁹². The WHO's programme budget increased from approximately \$2 billion in 2000 to approximately \$4 billion in 2015⁹³. The WHO's current biennium

programme budget for 2022-2023 has been authorised at \$6.72 billion USD⁹⁴. Along with increased financing for global health, the creation of new multi-stakeholder organisations like the GFATM and the GAVI has marked a significant shift in international collaboration. The emergence of these institutions adds certain degree of complexity to the governance of global health, especially in the Global South. The governance structure of the new initiatives distinguishes them from conventional international organisations (such as the WHO and the World Bank) in five significant respects.

The GFATM and GAVI, in contrast to typical international agencies, are managed by boards with representation from civil society, the BMGF, and other private sector interests⁹⁵. Second, unlike the World Bank's and WHO's broad goals to reduce poverty and enhance quality of life and to achieve the best level of health for all people, respectively, the GFATM and GAVI have more specific, problem-focused (disease centric) mandates. Thus, the GFATM aims to 'to attract and disburse additional resources to prevent and treat HIV/AIDS, TB and malaria'⁹⁶, while GAVI's role is limited 'to save children's lives and protect people's health by increasing access to immunisation in poor countries'⁹⁷. The fact that the new multistakeholder projects are completely sponsored by voluntary donations from private citizens, businesses, NGOs, and the foreign assistance departments of several rich nations, most notably the US, the UK, Canada, and Switzerland, is a third feature of these initiatives. Fourth, neither the GFATM nor GAVI work directly in any single country, in contrast to the WHO and World Bank, which collaborate with governmental organisations and have offices and people in recipient nations⁹⁸. Finally, the GFATM and GAVI both get their validity through success in enhancing narrowly specified health results. Comparatively speaking, conventional multilateral organisations focus on state-centric discussion and broader representation of all stakeholders.

The institutional adaptations of emerging global health policy actors represent only the initial phase of examining the increasing international financing for global

health. A change is also evident in how established multilateral organisations like the World Bank and the WHO are funded. In its 2010 report on multilateral assistance, the OECD's Development Assistance Committee highlighted that around 40% of the multilateral funds is distributed through what it refers to as "multi-bi" aid⁹⁹. Funding allocated to multilateral organisations for designated purposes, sectors, regions, or countries, including contributions to trust funds and collaborative initiatives, is termed "multi-bi" aid.¹⁰⁰ In other words, multi-bi aid refers to all designated voluntary donations to multilateral organisations, which are often made through specific trust accounts and fall beyond the core financing.

Such new multi-entity programmes are characterised by four distinct features: a larger group of stakeholders, including non-state organisations; tighter problem-focused mandates; finance based on independent grants; and validity based on economic efficiency, not procedure. This is a problem, particularly in light of the agenda-setting for the advancement of global health in the Global South. The emergence of these new multistakeholder initiatives and their funding structures is constraining opportunities for collaboration among global health policy actors, especially in the Global South. This trend also poses challenges to multilateral initiatives spearheaded by organisations like the WHO and World Bank, which prioritise institutional accountability, broader representation, and state-centric deliberation.¹⁰¹ Additionally, they are limiting the range of participation for a larger coalition of stakeholders, particularly the underrepresented voices that represent the Global South.

The allocation of discretionary funds to programmes at the World Bank and WHO has seen the most dramatic changes in recent years when compared to previous years' funding patterns. The WHO's two-year budget (discretionary/private funding) has increased significantly over the previous ten years, going from US\$1.6 billion in 1998-1999 to US\$4.4 billion in 2016-2017¹⁰². The extra-budgetary financing sector, however, has seen the majority of the expansion. Extra-budgetary funds donated by

affluent countries and organisations surpassed the agency's core budget by 75% over the past ten or so years, balancing off the decline in core financing for the WHO¹⁰³. Looking at each actor's contribution to the overall budget given helps to define their agenda-setting or defining roles. The BMGF and the United States government contributed together for 32% of the WHO's total core and voluntary budget as of 2022¹⁰⁴.

The World Bank has boosted its overall contributions to its health projects, from \$17 billion in 1998–1999 to \$61 billion in 2016¹⁰⁵. However, a significant percentage of this increase is attributable to independent endowments. Much like the independent donations made to the WHO, endowment funds are a sort of financial assistance mechanism created that utilises contributions from one or more contributors. Such endowments are used alone or in conjunction with other programmes, and its geographic scope might be local, global, or national. While both the basic and endowment fund budgets have grown, endowments for health has grown the fastest, going from \$95 million in 2004 to \$5.2 billion in 2021 – a figure that is similar to the basic lending extended by the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA) (\$5 billion)¹⁰⁶. Independent endowments are rising when the basic budgets (contributions from the member states) for the WHO and the World Bank are either stagnating or declining.

A significant portion of the new funding for global health has come from voluntary donors who have control over the quantity of their contribution and the date of payment, as seen by the quantities and changing forms of financing. They also, in a sense, set the agenda by side-lining the broader agendas of the WHO or World Bank for a particular priority they consider as vital, such as the fight against a specific illness perceived as a global issue. In addition, the process of implementing funds from the recognised foreign agencies has been taken over by third party organisations (outside of the host governments) considered unbiased and technically proficient in

project execution. These include private consultants like Health Level Seven International, academic institutions like the George Institute for Global Health and NGOs like Better Care India.

Studies on the WHO's budgetary allocations have critiqued the idea of extra-budgetary funding (mostly by private parties) and its implications for global health development¹⁰⁷. The various mandates for the two sources of funding make this quite evident. The use of core funds is determined by member countries of the WHA, whereas donors determine how to utilise extra-budgetary funding. It clearly shows the preeminent status of donors vis a vis the decision-making pertaining to global health issues. In 2010, 25% of the WHO's annual budget went toward infectious illnesses, 8% went toward non-infectious diseases, and around 5% went for injuries, which closely reflects the global disease burden¹⁰⁸. Contrarily, in 2020, infectious illness has received 60% of the WHO's extra-budgetary financing, compared to 3.9% for non-communicable diseases and 3.4% for injuries¹⁰⁹. It implies the enhanced significance being given to the management of infectious diseases at the global arena.

At the World Bank, the same scenario becomes apparent. Infrastructure in the health sector received the majority of the attention in the basic lending for the health, nutrition, and population sector in 2010, with the top priorities being health systems (34%), water and sanitation (22%), injury (18%), and disease-specific strategies, followed by infectious disease (15%) and non-communicable disease (2%)¹¹⁰. By 2020, the priorities had shifted to specific infectious diseases (33%) and allocations for the promotion of health systems (15%) had been reduced by nearly half as 2010¹¹¹. The Global Partnership to Eradicate Poliomyelitis (polio) and the Global Partnership for TB Control are just a few of the funds among endowments made that are primarily focused on disease-specific initiatives¹¹².

The move toward multi-bi funding most likely reflects the overarching goal of participating countries and other partners, including philanthrocapitalist institutions and NGOs, to more closely manage and oversee multilateral organisations. This has

certain implications for multilateralism around health especially for countries in the Global South. The first consequence of multi-bi funding is that it enables governments and other stakeholders to realign international efforts' goals with their own¹¹³. Individual governments might utilise new financing mechanisms as a tool to declare a separate mission and to advance certain aims rather than utilising the governance available through current organisations. Second, multi-bi funding enables stakeholders like governments to link donations to results. For instance, the GFATM and GAVI expressly relate performance to replenishment and are required to produce outcomes in order to attract the attention of further donors¹¹⁴. Similar discussions on the size and duration of voluntary contributions occur within the World Bank and the WHO, but they happen outside of the formal decision-making processes. Donors may therefore make sure that their money is utilised to affect the organisation's operations and direction by tying their donations to certain departments. Third, when donors delegate tasks to a worldwide fund or agency, multi-bi funding enables patrons to fund and administer aid in a manner that permits tighter supervision. Similarly, while the regional arms of the WHO do not possess sufficient resources and people, the organisations such as the GFATM and GAVI offer comprehensive financial commitments and contributions to address regional level problems.

Further, the emergence of the IHME portends significant changes in how global health indicators are viewed. The IHME, primarily funded by the BMGF, has offered donors a tool to assess numerous health-related SDG indicators and frameworks, aiding in the evaluation of the progress of different countries¹¹⁵. The WHO, which has long been essential to the creation of global health measures, is becoming largely marginalised as seen by the IHME's growing impact¹¹⁶. This change indicates a rising tension between emerging non-state actors' unique methodologies and logical frameworks and the knowledge and standards of national and intergovernmental statistics production on the one hand. The politics and responsibility of knowledge creation connected to the SDGs and development in general are significantly impacted

by these shifts from the international world of statistics to a more plural, global domain of data¹¹⁷. The new data politics may be undermining the ability of poorer governments to understand and address their development challenges on their own terms, even as the SDGs embrace the slogan "no one left behind."

Multi-bi funding for global health governance might have three effects¹¹⁸. First, decisions about prioritising global projects in the field of health will be made outside of the communities that will have to live with these decisions. The agendas of strong governments and organisations could be imposed on weaker countries through this financing structure, according to health ministers from Global South nations¹¹⁹. These populations have little options to hold powerful states and organisations accountable or to change these objectives.

Second, multi-bi funding might develop systems that allow donors to prioritise short-term advantages above long-term objectives for public health. Traditional multilateral organisations have an advantage in that their comparative independence which enables them to take into consideration accountability to contentious decisions. For instance, the WHO was founded to promote enduring collaboration and decision-making on health matters among nations, setting aside short-term differences for long-term benefits. An illustration of this commitment is found in the International Health Regulations (IHR), which require countries to report particular disease outbreaks and public health incidents. The proposed agreement on research and development (R&D) that was considered at the WHA in May 2012 was an initiative that failed in this respect¹²⁰. The document would have specified how to finance and coordinate R&D efforts to combat illnesses that disproportionately impact poor nations and are a shared global responsibility.

Third, multi-bi funding will reduce the world's capacity for information production, collection, and dissemination. Donors still benefit to some extent from a larger, previously acquired technical competence in organisations like the World Bank or the WHO as a result of the several decades of work of core multilateral finance. Yet,

when funding is limited to optional endeavours and support for the core budget diminishes, the capacity for knowledge is likely to decline. In light of financial constraints affecting knowledge capacity, the subsequent dependence on external funding sources, coupled with lobbying efforts by International Non-Governmental Organisations (INGOs) and intergovernmental organisations, introduces a complex dynamic that influences the health policy-making landscape of national governments.

Thus, multi-bi financing in global health can have several negative effects for countries in the Global South. Multi-bi financing often involves multiple donors with varying priorities, procedures, and reporting requirements. This fragmentation can create coordination challenges for recipient countries, leading to inefficiencies, duplication of efforts, and increased administrative burden. Reliance on multiple donors for health financing can increase donor influence over recipient countries' health policies and priorities. Donors may attach conditions to funding, leading to policy distortions or undermining recipient countries' sovereignty and autonomy in decision-making. Fluctuations in funding levels or donor priorities can lead to instability and uncertainty in health financing for recipient countries. Sudden changes in donor funding or the withdrawal of support can disrupt ongoing health programs and jeopardise progress made in improving health outcomes. Managing multiple funding streams from different donors can impose significant transaction costs on recipient countries, including administrative expenses associated with complying with various reporting and accountability requirements. These costs can divert resources away from frontline health services and programs. Donors may prioritise funding for specific disease-focused or vertical programs, such as HIV/AIDS or malaria, over broader health system strengthening initiatives. While vertical programs may address specific health challenges, they can also divert resources and attention away from building resilient health systems capable of addressing a wide range of health issues. Multi-bi financing arrangements may prioritise short-term goals or projects over long-term investments in health system strengthening and

capacity building. This can result in a lack of sustainability and resilience in health systems, making countries vulnerable to future health crises. Overall, while multi-bi financing can provide important resources for addressing health challenges in the Global South, it becomes essential for donors and recipient countries to address the negative effects by promoting coordination, harmonisation, and alignment with national health priorities.

INGOs and intergovernmental organisations exert substantial influence on health policy-making in national governments through lobbying and pressure tactics. In India, their impact is evident in shaping health agendas, steering policy decisions and influencing resource allocation. One prominent example is the role of organisations like the BMGF in shaping India's health policies¹²¹. The foundation's significant financial contributions to health programmes have led to collaborations with the Indian government, influencing policies related to immunisation, maternal and child health and infectious diseases. However, concerns have been raised about the influence of philanthropic organisations on national priorities, as decisions may align more closely with the donors' perspectives than with local needs.

In another example, organisations such as the GFATM among others have impacted India's health policy landscape in recent times¹²². Its funding mechanisms are tied to specific health interventions, influencing the country's approach to managing infectious diseases. While the financial support has been crucial, the conditional nature of the aid can sometimes shape policy decisions in ways that may not entirely align with India's long-term health goals. INGOs operating in India, such as Médecins Sans Frontières (MSF), have been actively involved in advocating for policy changes¹²³. MSF's campaigns have addressed issues like access to essential medicines and affordable treatment, influencing discussions on intellectual property rights and healthcare affordability. Their pressure tactics often involve engaging with policymakers, conducting research and mobilising public opinion to push for policy reforms.

Within the framework of tobacco control, international organisations like the WHO have played a pivotal role in influencing India's policy decisions¹²⁴. The WHO's FCTC has guided India in formulating and implementing anti-tobacco measures, showcasing how global health norms can impact national policies. However, these lobbying efforts are also accompanied with certain challenges. The influence of INGOs and intergovernmental organisations may sometimes be seen as interfering with national sovereignty, raising questions about the alignment of global health goals with India's unique social, cultural and economic contexts. There's a need for a delicate balance between leveraging international expertise and ensuring that health policies are tailored to India's specific needs. Moreover, concerns have been raised about the accountability and transparency of these organisations, emphasising the importance of a collaborative and consultative approach in policy development. The role played by INGOs and intergovernmental organisations in shaping health policies in the Global South states is significant, though dialogue, equality-based partnership and cooperation are somewhat lacking.

4.6 Concluding Remarks

Multilateralism plays a crucial role in global health agenda setting, fostering cooperation among nations to address pressing health challenges collectively. Through multilateral mechanisms such as the WHO, countries have come together to develop strategies, policies, and initiatives to combat diseases, promote public health, and ensure access to essential healthcare services worldwide. The discussion indicated that multilateralism facilitates the pooling of resources, expertise, and knowledge, enabling countries to tackle health issues that transcend national borders effectively. However, the effectiveness of multilateralism in global health agenda setting depends on the commitment of member states to uphold shared values, principles, and goals, as well as the equitable distribution of resources to focus on the requirements of all countries, particularly those in the Global South.

The BMGF has emerged as a significant player in global health, leveraging its immense resources and influence to shape health policies and interventions, including in India. Through partnerships with governments, NGOs, and other stakeholders, the foundation has contributed to significant advancements in areas such as immunisation, infectious disease control, and healthcare delivery in India. However, the foundation's interventions have also raised concerns about the influence of philanthrocapitalist organisations on health priorities, potentially diverting attention and resources away from broader health issues in the Global South as seen in the issue of deprioritisation of local health realities. As such, while the BMGF has made important contributions to improving health outcomes in India, it is essential to critically examine the implications of its actions on health equity and sustainability in the long term.

The discussion highlighted how the prioritisation of health issues by philanthrocapitalist organisations, driven by their particular interests and agendas, can lead to disadvantages for countries in the Global South. While philanthropic initiatives may address specific health challenges effectively, they may also neglect broader systemic issues such as healthcare infrastructure, workforce development, and health governance. Moreover, the influence of philanthrocapitalist organisations on health agenda setting may exacerbate power imbalances and undermine democratic decision-making processes, particularly within countries where they operate. Therefore, while philanthropic contributions can complement government efforts to improve health outcomes, they should be aligned with national priorities and strategies to ensure sustainable and equitable progress.

The funding patterns of the WHO, consisting of core funding and multi-bi funding, explored in the discussions, reflect the evolving landscape of global health financing and governance. Core funding, provided by member states, is crucial for the WHO's autonomy and ability to fulfil its mandate of promoting global health. However, core funding has been declining in recent years, leading to increased

reliance on multi-bi funding from philanthropic organisations, bilateral donors, and other non-state actors. While multi-bi funding can fill gaps and support specific health initiatives, it also raises concerns about the influence of private actors in the agenda-setting process within the WHO. As private actors become more involved in funding and decision-making, questions arise about their accountability, transparency, and alignment with global health priorities. Therefore, it is necessary to finding equilibrium between diverse funding sources while safeguarding the WHO's independence and integrity as the leading global health authority.

In conclusion, the future of global health governance depends on fostering inclusive and equitable partnerships among governments, philanthropic organisations, civil society, and other stakeholders. While multilateralism remains vital for addressing global health challenges collectively, it must be guided by principles of equity, transparency, and accountability. The role of philanthrocapitalist organisations in global health should be critically examined to ensure that their interventions align with national priorities and contribute to sustainable and equitable health outcomes. Similarly, the funding patterns of international organisations like the WHO should be carefully managed to maintain their autonomy and effectiveness in promoting global health. By working together collaboratively and transparently, the global community can advance towards the shared goal of health for all.

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CHAPTER 5

INDIA'S HEALTHCARE SYSTEM SINCE THE 1990S

5.1: Introduction

The 1990s marked a transformative era in the landscape of India's healthcare system, as the nation underwent a series of significant changes that not only reshaped its domestic healthcare policies and infrastructure but also firmly intertwined it with the global forces of economic liberalisation and globalisation. This chapter delves into the evolution of India's healthcare system since the 1990s and its intricate connection to the processes of globalisation over the same period. As the world began to shrink in the wake of economic globalisation, India's healthcare system embarked on a journey of growth, reform and adaptation, ultimately becoming a microcosm of the larger global health paradigm shift. This chapter explores the key factors, challenges and opportunities that have shaped India's healthcare system in the context of globalisation, examining how this nexus has influenced healthcare delivery, policy and the overall health and well-being of the Indian populace. The first section presents a historical perspective on the evolution of India's health policies. The following section deals with the changes in health financing. The subsequent section looks at medical tourism in India in the post 1990s period as a reflection of the increasing effects of globalisation. The ensuing section covers the key phases of health sector reforms in India during the same period. The chapter draws to a close with the concluding remarks highlighting the key arguments made in the chapter.

Since India's economic liberalisation began in 1991, there has been a substantial fall in the government's commitment to public health in terms of public spending. India currently is among those countries that spend the least on public health globally with a current health expenditure (as % of GDP) of 2.96 in 2020 as

compared to 4.03 in 2000¹. Other middle-income countries such as Brazil, South Africa and Bangladesh spent nearly double at 5.62% in 2020². When it comes to the allocation of funds for health in its government budgets (including both union and state governments), India ranks 179th out of 189 nations, according to the Economic Survey, GoI, 2021³. In addition to reducing government health spending, governmental initiatives have promoted the expansion of the private healthcare sector, giving rise to the largest and comparatively least regulated private health care sector in the world⁴. A World Bank study shows that in India, from the 1990s to the 2020s, access to health care in terms of physicians (per 1,000 people) has decreased from 1.2 per 1000 people in 1991 to 0.7 per 1000 people in 2020⁵. Access to public health facilities has been significantly impacted by the policy of user fees, particularly for women and members of underprivileged and disadvantaged populations. Medical expenses have become one of the main sources of debt due to the rapid increase in health care prices, which is something that even the National Health Policy (NHP) 2017 recognises⁶. The discussion in this chapter explores the evolution of healthcare governance in India since the 1990s, emphasising the influence of external factors like multilateral institutions such as the World Bank and International Monetary Fund (IMF). It also discusses the impact of globalisation on India's healthcare system, highlighting both opportunities and challenges. While globalisation has facilitated access to global expertise and innovations, leading to advancements in medical research and infrastructure, it has also brought about health challenges like the spread of infectious diseases and disparities in healthcare access. The influence of multinational corporations (MNCs) and international health organisations has shaped India's health policies, raising concerns about affordability and accessibility. Balancing the benefits of globalisation while addressing its drawbacks remains a key challenge for Indian health policymakers.

Issues pertaining to health of the citizenry of a country is intertwined by the forces from the spheres of the global and local, which sociologists refer to as

glocalisation. The sociologist, Roland Robertson is known for coining the term "glocalisation," highlighting the interconnectedness of global and local forces in shaping contemporary societies and emphasising the mutual influence between the global and the local in the process of globalisation. He defines globalisation as the "compression of the world and the intensification of consciousness of the world as a whole," emphasising the interconnectedness and awareness that characterise the contemporary global condition⁷. Globalisation in general is characterised by greater "exchanges in trade and the greater mobility of information, capital and labour"⁸. In the case of India, globalisation has also resulted in the adoption of neo-liberal policiesⁱ which has had implications for health policies of India's central and state governments⁹. In its health policies, India has consistently followed the models set out by the World Health Organisation (WHO)¹⁰. In the early years of independent India, health policies were significantly shaped by the influence of international organisations, notably the WHO. The WHO played a crucial role in guiding India's efforts to combat communicable diseases and improve public health infrastructure. One notable initiative was the establishment of the National Malaria Control Programme in the 1950s, which aimed to eradicate malaria with WHO's technical assistance. However, the influence of the IMF in the 1990s brought economic reforms that impacted public spending, including health budgets. Structural adjustments and austerity measures recommended by the IMF had implications for healthcare accessibility. For instance, reductions in public spending on health services could limit the availability of essential medicines and infrastructure. The interplay between global health organisations emphasising disease control, and economic institutions advocating for fiscal restraint, created a complex landscape that influenced the trajectory of early health policies in India. This is also consistent with the World Bank's policy of favouring individual needs in health instead of treating health as a

ⁱ The adoption of neoliberal policies in India involved a shift towards market-oriented economic reforms, deregulation and privatisation, aiming to enhance economic growth and reduce the role of the state in various sectors, including healthcare.

public need. In the report, *Raising the Sights: India: Better Health Systems for India's Poor* (2001), the World Bank had argued for a diminished governmental involvement in health policy and funding. Instead of government expenditure, it had advised greater participation of private enterprises in India's healthcare system¹¹. The greater participation of private enterprises in the Indian health system and health financing has led to a dual healthcare system (public and private), with varying access and quality of care, raising questions about equity and the role of for-profit entities in public health. More recently, the NHP 2017 has privileged the role of the individual (ability to pay for healthcare) and private enterprise in healthcare¹². The increasing influence of private enterprise in India's healthcare sector has contributed to a further departure from health being solely perceived as a public need, raising concerns about accessibility, affordability and equity in healthcare services. Against this setting, understanding the historical context is essential for grasping the complexities of the current trajectory of India's healthcare system and its effectiveness in addressing contemporary challenges.

5.2: Major Developments in Health Policy after India's Independence

The healthcare system in post-independent India was shaped by nationalist ideals, advocating for free, basic services accessible to all as part of Nehruvian socialist development objectives, which acknowledged the social determinants of health (SDH)¹³. The ground-breaking suggestions of the Bhore Committee (1946), though its report was submitted a year before independence, were accepted politically and served as the foundation for the development of a publicly funded, all-inclusive healthcare system for curative and preventive purposes. A strong primary healthcare system that is available to everyone, "regardless of their ability to pay," and that is supported by secondary and tertiary levels of care was stressed by the Committee¹⁴. The Bhore Committee Report was thus, a seminal document in the history of India's health system, laying down the foundation for comprehensive

healthcare reforms and the development of a public healthcare infrastructure in the country during the mid-20th century.

The Bhole Committee proposed a three-tiered model aimed at establishing preventive and curative healthcare systems in both rural and urban areas. These recommendations included: 1) the establishment of a public healthcare system, 2) deploying healthcare workers on government payroll, and 3) placing emphasis on reducing the reliance on private practitioners¹⁵. In what is known as the “socialist” phase in health policies in India—in the years prior to 1991—the government virtually controlled all areas of healthcare in the country with the private sector accounting for less than 30 % of health care workers, beds and hospitals¹⁶. The guidelines from the 1946 Health Survey and Development report India's first health committee, the Bhole Committee, established the principles that "nobody should be denied access to health services for his inability to pay," and that the government should bear the primary duty for providing healthcare¹⁷. The idea of a comprehensive (primary) healthcare system in the public sector was also supported by a number of other committees on health, including the Sakhay Sub-Committee in 1948, the Mudaliar Committee in 1962, the Chaddha Committee in 1963, the Kartar Singh Committee in 1974, the Srivastava Committee in 1975, and the Joint Panel of the Indian Council of Medical Research-Indian Council of Social Science Research (ICMR-ICSSR) in 1980¹⁸. The lead-up to India's first National Health Policy in 1983 was characterised by a growing recognition of the need for comprehensive healthcare planning and the establishment of a structured framework to address the country's evolving health challenges.

The Planning Commission of India, established in 1950, played a key role in shaping and implementing the country's health policies for several decades. As a key government body responsible for formulating Five-Year Plans, the Planning Commission was instrumental in allocating resources and setting priorities for the health sector¹⁹. In the initial decades after independence, health policies were closely

aligned with the socioeconomic development goals outlined in these Five-Year Plans. The Planning Commission provided a comprehensive framework for healthcare initiatives, emphasising the establishment of healthcare infrastructure, disease control programs, and the training of healthcare professionals²⁰. The allocation of funds for public health projects and the integration of health objectives into broader development strategies were central to the Planning Commission's approach.

In essence, the Planning Commission of India played a crucial role in shaping health policies until the 1990s, particularly during the era of centralised economic planning. The early plans focused on building essential health infrastructure, expanding medical education and addressing communicable diseases. In general, the Planning Commission's approach reflected the belief that a healthy population was fundamental to achieving broader socio-economic goals. During the Planned-Era, the Planning Commission emphasised the need for preventive and promotive healthcare measures, and accordingly; several initiatives were launched to control diseases such as malaria, tuberculosis and leprosy²¹. Additionally, the establishment of medical colleges, nursing schools, and public health institutions was prioritised to enhance human resources in the public healthcare sector. The Planning Commission's influence was evident in the integration of health objectives with overall developmental goals, emphasising the importance of a well-functioning healthcare system for national progress.

However, by the 1990s, the Planning Commission's role in the Indian economy and policymaking began to shift. Economic liberalisation policies introduced during this period brought about changes in the approach to development planning, marking a departure from the centralised model. While the Planning Commission continued to be involved in health policy, the evolving economic landscape and the emergence of new challenges prompted the national

government to re-evaluate the Commission's role, laying the groundwork for subsequent shifts in governance structures and policy frameworks in the country.

Similarly, in 1983, India introduced its first NHP. The NHP 1983 reaffirmed a commitment to achieving health for all by the year 2000 through the delivery of comprehensive primary healthcare services using a range of diverse approaches. Additionally, it emphasised the importance of ensuring accessibility to these services for all at an affordable cost. However, the policy also required participation from private medical practitioners and volunteer groups to reduce the burden on the government.

During this time, basic healthcare infrastructure and village-level health services underwent significant expansion. However, under the cover of establishing a "selective" primary healthcare system, the government abandoned the fundamental recommendations of the NHP of 1983 due to budgetary cuts and pressure from international developmental assistance organisations like the World Bank and IMF²². Additionally, the private sector expanded unchecked during this time, and medication pricing limits gradually began to disappear²³. Hospitals designated as public trusts were awarded tax advantages and subsidies in 1986, which enabled the industry's phenomenally fast expansion²⁴. The post-1986 period in India witnessed a significant expansion of the private hospital sector, driven by economic liberalisation and increasing demand for advanced healthcare services.

Budgets frequently fell short of the target amount and remained at or near 1.3% of GDP into the 1980s, frustrating the public health agenda time and again²⁵. Furthermore, the upper class dominance of medical education and the medical profession resulted in an elitist bias in urban medical services²⁶. Less than a decade after the Alma-Ata Declaration 1978 and NHP 1983, a solid foundation was established for the extensive reforms that would follow.

To ensure that all Indians have access to primary healthcare by the year 2000, the country's first NHP was created in 1983²⁷. The majority of the principles of Alma Ata which emphasised on primary health care for all were included into India's first NHP in 1983²⁸. A more integrated and thorough health system with a three-tier structure for primary, secondary, and tertiary care services was called for under this agenda. The 1983 NHP was also based on the Bhore Committee's recommendations. By utilising technology and health volunteers, it had given priority to the construction of primary healthcare service networks, resulting in a network of specialty institutions that were interconnected and had a strong referral system²⁹. The private health sector was, at best, “invisible and fragmented” in this initial phase of the country's developing health system³⁰. The period leading up to India's changing health system since the early 1990s was marked by a confluence of economic reforms and a shifting policy landscape, reflecting the country's commitment to adapting to global healthcare trends and challenges.

Health financing, a critical component of health policy, involves the mobilisation, allocation, and utilisation of funds to ensure the availability of essential healthcare services. In the context of India, a rapidly evolving and diverse country, health financing holds immense significance within the broader health policy framework. Historically, India has faced challenges related to inadequate public health infrastructure, a high burden of diseases and significant socio-economic disparities. To address these issues, effective health financing is essential to ensure sufficient resources for the development and maintenance of healthcare facilities, the training of healthcare professionals and the implementation of public health programmes. The importance of health financing in India is underscored by the need to enhance healthcare access, improve the quality of services and achieve universal health coverage. Balancing the allocation of funds between preventive and curative measures, rural and urban healthcare, and primary and tertiary care is a key consideration within India's health policy, reflecting the complex nature of the

country's health landscape. Moreover, as India continues to navigate demographic shifts, emerging health challenges and global health crises, robust health financing mechanisms are critical for building a resilient and sustainable healthcare system. In view of this, the next section discusses major in India's health financing since the 1990s.

5.3: India's Health Financing since the 1990s

It is generally known that the low public investment in health is a major factor in India's high rates of morbidity and death. India's Death Rate stood at 9 (per 1,000 people) for the year 2021³¹. In recognition of this, the NHP 2002 said that "public health investment over the years has been relatively low, and as a percentage of GDP, has declined from 1.3% in 1990 to 0.9% in 1999"³². During this period, expenditure on family welfare increased as a proportion of total plan spending, rising from 0.1% to 1.83%. Conversely, health spending witnessed a decline as a percentage of total plan spending, dropping from 3.3% in the First Five Year Plan (1951-56) to 2.09% in the Tenth Five Year Plan (2002-07)³³. These trends reflect the shifting priorities of the government. According to Deollikar et al., towards the middle of the 1980s, public spending on health in India reached a peak of 4% of the government budget and 1.6% of GDP³⁴. Government health spending fell behind the growing economy in the 1990s; by 2001, it made up 2.7% of the national budget and 0.9% of GDP³⁵. By 2005, these figures had decreased to 2.4% and 0.8%, respectively³⁶. The budget for 2006–2007 saw a gradual reversal of this trend, with increasing funding for social sectors. In 2023, health expenditure stood at 2.1% of the GDP and approximately 2% of the national budget³⁷. Investments (mostly from the private sector) in health have begun to get a higher importance, mostly as a result of the rising acceptance of health as a human right and, to a lesser extent, due to the perception that the working population's health plays a role in accelerating and sustaining economic growth³⁸. Since 2006, India witnessed a notable increase in

health expenditure, reflecting growing recognition of the importance of a well-funded healthcare system to address the diverse health needs of its vast population.

Since the initiation of the National Rural Health Mission (NRHM) in 2005, there has been a gradual increase in per capita public expenditure on health, although at a slow pace stated a public health economist based at the Administrative Staff College of India (ASCI). Research indicates that between 2004-05 and 2010-11, the distribution of public health expenditure between the central and state governments remained relatively consistent, with a ratio of around 40:60³⁹. With India experiencing rapid economic growth, there was a notable expansion in the total share of health spending by 0.2% of GDP in fiscal year 2010-11. This resulted in a significant rise in per capita public health expenditure during the same period⁴⁰. From approximately Rs. 1100 per capita in 2014-15, the country's per-capita public health spending expanded to Rs. 2014 by 2019-20⁴¹.

Further, it is known that private spending makes up the majority of health expenditures in India. From \$101.8 in 2008 to \$199.1 in 2018, India's domestic private health expenditure per capita in purchasing power parity (PPP) terms has almost doubled⁴². Including households, for-profit businesses, and corporations, the domestic private health sector provided 72.1% of India's Current Health Expenditure (CHE) in 2017⁴³. According to data from the National Sample Survey (NSS), 2018, up to 80.9% of persons in urban India and 85.9% of people in rural India do not have any health expense coverage⁴⁴. In India, the total share of private infrastructure in the country's health infrastructure is close to 62%⁴⁵. This is mostly a reflection of the insufficient public investment in health that has been a continuing aspect of India's economic growth over the past several decades. As a result of the increased reliance on private delivery of health infrastructure and health services, citizens generally are socially underprovided by private actors and are further deny the poor proper and quality access to health care. This has negative effects on society as a whole as well as the afflicted population. Current social welfare, worker productivity, and future

chances for growth and development are all negatively impacted as a result of increased illness and affects human development indicators. Because of this, it is necessary to look into the claims that government expenditure on health has declined through the period of economic liberalisation from the early 1990s.

Discussions on health policy in India involve a variety of public health spending indicators. During the 2000s, public health spending, encompassing expenditures by the Ministry of Health and Family Welfare and State Departments of Health and Family Welfare on health, water supply, and sanitation, fluctuated between 1 and 1.2% of GDP, as reported by the Ministry of Finance's Public Finance Statistics (PFS). According to estimates from the National Health Accounts (NHA), public health spending stood at 0.9% of GDP in 2004-05, rose to 1.2% of GDP in 2013-2014, and reached 1.35% of GDP in 2019-20⁴⁶. The NHA figures are slightly lower than the corresponding PFS figures due to the exclusion of spending on water supply and sanitation. However, this difference is partly mitigated by the inclusion of family welfare and health spending by institutions other than the Ministry of Health and Family Welfare and State Departments of Health and Family Welfare.

In 2022, India's health sector was worth more than Rs. 3110340 crores⁴⁷. In 2016–17, India's Total Health Expenditure (THE) was Rs. 581013 crores, or 3.8% of GDP which reduced from 4.2% of the GDP in 2004-05⁴⁸. Per person, it equals Rs. 4381⁴⁹. Government funding (including the national and state share) accounts for 32% of the different sources of funding for health care, with household out-of-pocket spending making up the majority at 63.2%⁵⁰. Less than 1% of revenue came from foreign sources⁵¹. Current Health Expenditure (CHE) accounts for 92.8% of total health expenditures (THE), excluding capital investments⁵². In 2018, the health expenditure through public spending stood at 4.4% of General Government Expenditure (GGE), of which the Union Government accounts for 31.4% and the State Governments for 68.6%⁵³. Nearly all of India's public healthcare delivery system's funding comes from taxes, both at the national and state levels.

In 2011, India's health sector was valued at \$34 billion⁵⁴. This amounted to \$34 per capita, representing 6% of the GDP⁵⁵. Of this, 15% was covered by government funding, 4% by social insurance, 1% by private insurance, and the balance 80% was sourced from user fees, with 85% of these fees directed to the private sector⁵⁶. 90% of the clientele hails from underprivileged regions, with two-thirds of them financing their expenses independently⁵⁷. Similar to the global scenario, in India, those with the means often opt to buy healthcare services privately, while individuals below the poverty line or with meagre incomes often resort to out-of-pocket payments, often leading to significant debt, to access healthcare from private providers⁵⁸. According to the NHA 2018-19, 50% of those in the lower strata of society (in income terms) either sold assets or obtained loans to cover the costs of medical treatment⁵⁹. Hence, it is estimated that asset sales and loans significantly contribute to financing healthcare.

In FY 2019-20, the central government's portion of the Government Health Expenditure (GHE) was 34.3%, while the state governments' share was 65.7%⁶⁰. In 2020, 10% of the total public health budget was funded externally, marking a notable increase from the 1% figure prior to the World Bank's structural adjustment loan and subsequent loans from other institutions in the 1990s⁶¹. Private financing in India often relies on out-of-pocket payments, with a significant portion, especially for hospitalisations, sourced from asset sales, loans and savings rather than current income. Insurance premiums, whether from social insurance schemes or private plans, constitute a relatively small fraction in the Indian context. The relatively low uptake of health insurance in India can be attributed to factors such as low awareness, affordability issues, and the predominance of out-of-pocket healthcare expenses. Financial trends within the Indian health sector must be understood within the context of Indian health policy following the liberalisation of the Indian economy during the 1990s.

5.4: India's Health Policies: Major Developments since 1990s

Following the 1991 economic liberalisation under the unfolding processes of globalisation, significant changes were seen in India's health sector: the marginalisation of the state, the tailoring of health concerns to the demands of the market and the ceding of space to non-governmental organisations (NGOs)⁶². These changes led to the development of the private health industry which has significantly grown since the middle of the 1990s. The changes in India's health policy and implementation can be attributed to the influence of the IMF which, following the economic crisis of mid-1990s, advocated for a cut in public funding in the health sector. The IMF supported instead the incentivisation of private companies by governments to enable the companies to invest and participate in the growth of the health sector. By 2004, the private sector in India had 75% of all specialists (in the country), 85% of all technology in their facilities, 75% of services for non-communicable diseases and 40% of services for communicable diseases⁶³. The important role of the private sector is seen in the fact that private sector providers control over 70% of the hospital market share as of 2020⁶⁴. Alternatively, user fees and service outsourcing were implemented in the public health sector to conform to the private model⁶⁵. For more than 20 years, The World Bank, along with other multilateral and development institutions such as the UK's Department for International Development (DFID), has supported the privatisation of the health sector. The World Bank has primarily endorsed decentralisation, public-private partnerships (PPPs), and the requisite management and legal reforms to implement these policies in the healthcare sector through loans and technical assistance⁶⁶. The influence of the World Bank has played a pivotal role in shaping policies that facilitated the privatisation of healthcare in India, as part of broader economic liberalisation efforts.

The second NHP, introduced in 2002, aimed to expand healthcare services to a wider population through decentralisation, increased involvement of the private sector, and overall enhancement of public healthcare expenditure. This policy built

upon the foundations laid by the NHP of 1983. Moreover, it emphasised the utilisation of non-allopathic treatments such as Ayurveda, Unani, and Siddha, alongside bolstering decentralised decision-making by empowering states with more authority⁶⁷. Focusing on healthcare in five-year plans was a hallmark of earlier health programs, but since the comprehensive execution of NHP 2002, public perceptions of health issues have shifted. The costly healthcare system in India is widely regarded as a significant contributor to poverty, characterised by extensive instances of high expenditure⁶⁸. In its report, the NHP 2002 cites that there is a shortfall of at least 58% of Community Health Centres (CHCs) in the country which provide low-cost healthcare⁶⁹. As a result, the out-of-pocket expenditure for healthcare increased, covering 90% of all private expenditure in health by 2007⁷⁰. At the same time, the quality of health services provided by the private sector is very uneven. It was also noted that private sector healthcare was financially exploitative⁷¹. The exploitative nature of the private health sector in India has often been criticised for its high costs, profit-oriented approach and disparities in access to quality care, raising concerns about equity and affordability in healthcare.

Despite this, however, the NHP 2002 stated that it “welcomes the participation of the private sector in all areas of health”, including giving private establishments the power to provide insurance coverage to the patients who avail of their services⁷². The majority of the major policy recommendations centred on strengthening the private sector and promoting the privatisation of the health care delivery system. The de-regulated nature of private health insurance, however, has been known to exploit patients. Private health insurance policies, working through Third Party Administrators (TPAs), have also been implicated for exploitation of customers where availing of insurance is concerned⁷³. In recent years, the health insurance industry has actively promoted Public Private Partnerships (PPP), with government support, in an effort to increase their market share (especially the ones comprising the lower income groups). PPPs enable the private sector to access public

resources via government-mandated health insurance programs for the underprivileged. Approximately 514 million individuals in India were covered by health insurance in the fiscal year 2021⁷⁴. Most of them were enrolled in government-sponsored health insurance schemes, with a smaller portion covered by individual insurance plans. In 2017-2018, only about 37% of the population had some form of health coverage beyond government assistance⁷⁵. In the fiscal year 2020, the gross direct premium income of the Indian health insurance sector reached approximately Rs. 470 billion. Public health insurance, with over Rs. 225 billion in premium income, accounted for the largest share of premiums written in the western state of Maharashtra⁷⁶. Private sector businesses in FY 2021-22 accounted for 49.31% of the market for general and health insurance, up from 48.03% in FY 2020-21. Six independent, private health insurance businesses saw an increase in gross premium of 66.6%, from Rs. 844.13 crore in May 2021 to Rs 1,406.64 crore in April 2023⁷⁷. The government-sponsored insurance targeted at the poor accounts for more than half of the total business of private banking firms that deal heavily in government programmes, such as the Industrial Credit and Investment Corporation of India (ICICI)⁷⁸. Private health insurance has increased by 25 % per annum in the recent years owing to various circumstances, such as the need for mandatory hospitalisation, while availing state-sponsored health insurance⁷⁹. The Indian health system has witnessed a substantial increase in the presence of private health insurance companies, reflecting a growing awareness of the need for financial protection against rising healthcare costs.

In response to growing health challenges, the Government of India introduced a new health policy. The NHP 2017 was revised and conceptualized, considering both domestic and global conditions at the time. In the interest of providing healthcare to the majority of its citizens, the government stated its purpose to “improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services

provided through the public health sector with focus on quality”⁸⁰. To accomplish this goal, the Government of India resolved to raise its healthcare expenditure to 2.5% of the GDP⁸¹. The policy document is accompanied by a ‘Situation Analysis’ approach to health which claims to address the health concerns of those who are vulnerable and marginalised⁸². However, as Vikas Bajpal points out, this statement does not address the social and economic backgrounds of the marginalised and vulnerable groups, even as it cites a WHO document which demonstrated that health is an outcome of social and economic realities⁸³. As with the NHP 2002, the private sector was called upon to increase their revenue and medical tourism by following “a high degree of associated hospitality arrangements” apart from the specialised care which the corporate hospitals otherwise provide⁸⁴. The NHP 2017 too advocates the same trajectory as medical tourism is concerned. According to a 2022 WHO report, the NHP 2017 “is the most significant health policy step of the Union Government” which follows the High Level Expert Group (HLEG) recommendations on sustainable finance and universal health coverage⁸⁵. The 2022 WHO report on the Indian NHP 2017 served as a critical assessment, offering insights into the policy's implementation and its impact on public health, guiding further refinements in India's healthcare strategy.

Multilateral Development Banks, such as the Asian Development Bank (ADB) and the World Bank in particular, have provided India with significant loans and had a huge impact on its health policy⁸⁶. The World Bank has supported public-private partnerships (PPPs), the privatisation of health services, and restrictions on state spending on healthcare since the 1980s. Although the *World Development Report on Investing in Health* from 1993 is the clearest and most radical exposition of the Bank's philosophy, its first health strategy was created in 1985. The strategy was in favour of a two-tiered health system. In the Global South, publicly supported hospitals and primary healthcare providers were expected to offer a very small number of low-cost, high-return activities, mostly focused on education, though they

were still highly important. Whatever the market would pay for could be provided by the private system⁸⁷. Government involvement in health is reduced as a result of this strategy, which also leads to an increase in private providers and out-of-pocket expenses. The two main methods of obtaining healthcare are private insurance and very limited workplace plans.

At the policy level, the Washington Consensus has significantly influenced the reforms in India's health system, emphasising market-oriented policies, privatisation and reduced state intervention in healthcare delivery and financing. The Washington Consensus—so named because it was developed in Washington at a meeting of the IMF, the World Bank and US Treasury—was widely pronounced by the World Bank to be outdated in the 2000s. However, both the move and any modifications to its broad health objectives have had little practical impact⁸⁸. A fresh emphasis was placed on providing everyone with access to healthcare and providing subsidised aid to the very poor. However, the strategy was still framed by a neoliberal metanarrative that called for cutting back on public health spending and stepping up private service delivery⁸⁹. More focus was placed on creating individualised marketing strategies for health services.

Global health governance witnessed significant changes in the 2000s as a result of the creation of new international health institutions like the Global Vaccine Alliance (GAVI) and the Global Fund to combat AIDS, Tuberculosis and Malaria (GFATM). The Bill and Melinda Gates Foundation (BMGF) had a significant impact on health policy and was for many years the second-largest donor to the WHO⁹⁰. These institutions generally came together to assist programmes for the poor that combat vertical diseases like HIV, malaria, and TB. Additionally, the BMGF promoted private healthcare and a technology-oriented approach to illness priority. At this point, the World Bank started to endorse a sector-wide approach to health⁹¹. This resulted in a more generalised, non-disease-specific approach that combined technical and policy support with financing and strengthening of the health sector

and 'sound' macroeconomic policies. Additionally, unlike in the 1980s, the World Bank was now more focused on expanding out the market than on rolling back the state⁹². Public-private partnerships (PPPs) and Universal Health Coverage (UHC) were its two preferred instruments for this in the health sector. The main gist of the issues which Engel et al., a staunch critic of Fund-Bank institutions go into greater detail on these techniques is on the following lines⁹³.

PPPs are marketed as a method to access the cash and expertise of the private sector to scale up development, but they also have the equally important impact of guaranteeing private profits, which transfers risk and responsibility for private projects to the public sphere. When initiatives don't work out, the government is left to bear the cost, while if they are successful, exorbitant gains are kept by the private sector. PPPs in the healthcare industry result in higher costs, a preference for costlier surgical or pharmacological treatments over primary health care (PHC), and ineffective public-private sector collaboration⁹⁴. For-profit healthcare initiatives have been shown to raise prices and decrease efficiency, but there is no evidence that they enhance healthcare outcomes.

In the case of Universal Health Coverage (UHC), it does not refer to publically funded health systems; rather, it refers to 'reform' of the health sector to increase access and coverage for all socioeconomic groups in a way that is ostensibly fair and financially forward-thinking⁹⁵. Health insurance, on the other hand, takes an individualised and medicalised approach to public health, leaving nearly always substantial gaps in coverage and levels of treatment. Additionally, the UHC strategy disregards the conclusions of the WHO Commission on the Socioeconomic Determinants of Health, which unequivocally shows that tackling greater socioeconomic inequalities is necessary to achieve health for all.

While the National Health Mission (NHM) launched in India in 2005 has contributed significantly to the infrastructural development and financial aid to state governments. The call for universal health coverage was introduced in 2012 as a

result of the UN's resolution on global health and foreign policy which advocated that universal health coverage be included in talks on the post-2015 development agenda⁹⁶. In its effort to provide universal health coverage, the Government of India introduced the Ayushman Bharat Programme in 2018, keeping in mind its promises to do so in the NHP 2017. Under the Ayushman Bharat scheme, the government aimed to increase the number of health and wellness centres (HWCs) to 1,50,000 by 2022 and providing financial protection for secondary and tertiary level hospitalisation as part of the National Health Protection Scheme (renamed the Pradhan Mantri Jan Arogya Yojana (PMJAY)⁹⁷. In their study of the impact of the Ayushman Bharat in a hospital in Mappedu, Tamil Nadu, Vishnu Priya Siree G. V. and G. Rakesh Maiya have noted that at least 42.3% of the households in the entire village were covered under the Ayushman Bharat scheme⁹⁸. Further, that 83.33% of the households from the lower economic background were covered under the scheme during 2021-22. However, the authors also state that the higher percentage of those under the Ayushman Bharat in Tamil Nadu is due to the state government having started a similar scheme in 2014 called the Chief Minister's Comprehensive Health Insurance Scheme which merged with the Pradhan Mantri Jan Arogya Yojana in 2018 (CMCHIS-PMJAY)⁹⁹. What the scholars imply, therefore, is that the groundwork for medical health insurance was already in place before the central government took the initiative to provide one for disadvantaged communities in the country. Further, Shailender Kumar Hooda observes that the universal healthcare coverage promised under the building of HWCs runs contrary to the government's promotion of public-private partnerships (PPPs) in district hospitals which was started under the NITI Aayog a few months before the announcement of the Ayushman Bharat in 2018¹⁰⁰. Thus, the Ayushman Bharat scheme in India has garnered a mixed response, with proponents lauding its efforts to expand healthcare access, while critics expressing concerns about its implementation challenges and the quality of care provided under the programme.

The impact of the NHP 2017 has been observed in the decreasing role of the public healthcare system in providing care and the reduced role of the government in the health sector¹⁰¹. The justification for reducing public investment was advocated by multilateral institutions like the World Bank and IMF. This development is especially observed in the rise of medical tourism in the country which is serviced primarily by the private sector healthcare. Medical tourism has burgeoned in the past decade, driven by economic factors such as cost differentials and accessibility to advanced medical procedures. Private actors, including hospitals, travel agencies, and insurance companies, play a pivotal role in facilitating this industry's growth. They offer tailored packages, streamlined logistics, and specialised services to attract patients seeking healthcare options in India. Additionally, the rise of medical tourism underscores the increasing globalisation of healthcare and highlights the complex interplay between healthcare, economics, and globalisation.

5.5: Medical Tourism in India: Aftereffect of Globalisation on India's Healthcare System

The rise of medical tourism in India is intricately linked to the forces of globalisation. As the world becomes increasingly interconnected, patients are seeking healthcare options beyond their borders, drawn by factors such as shorter waiting times, cost-effectiveness and accessibility to advanced treatments. India, with its well-established medical infrastructure, skilled healthcare professionals, and competitive pricing, has emerged as a key destination for medical tourists. The liberalisation of the Indian economy and the opening up of the healthcare sector to foreign investment have also contributed to the growth of medical tourism. Moreover, advancements in technology and transportation have made it easier for patients to travel long distances for medical treatment. As a result, India's medical tourism industry is thriving, providing a range of specialised services to patients from around the world. An increasing trend, medical tourism has policy

repercussions for healthcare systems, particularly in the nations where it is practised. India's national and state governments, together with private players, are encouraging the medical tourism sector, but it is difficult to ascertain what effect this may have on the country's health systems, particularly in terms of equity in access and availability for the common people. Jonathan N. Goodrich and Grace E. Goodrich define medical tourism as “the attempt on the part of a tourist facility...to attract tourists by deliberately promoting its healthcare facilities, in addition to regular tourist amenities”¹⁰². Thus medical tourism, in the context of India, is reflective of the hospitality services that corporate hospitals are required to make following the NHP 2017¹⁰³. The extension of service industry into the healthcare system is seen as a positive influence on India's GDP¹⁰⁴. In India's case, this focus on medical tourism seems to have produced the desired results, at least economically.

Despite the effects of COVID-19, Indian medical tourism was projected at USD 5 to 6 billion in 2021¹⁰⁵. The growth of medical tourism in the country has been accompanied by changes in India's policies, for instance its consular policies on medical related visas. In 2007, the Ministry of Tourism, GoI introduced medical visas or 'M' visas which allowed foreigners to travel to India for medical purposes. The visas are valid for a year. Similarly, infrastructural changes, such as the improvement of airports, were made to ease the travel of medical tourists¹⁰⁶. India's current medical tourism industry is reflective of a worldwide trend in healthcare. There is, however, a change in the nature of global medical tourism in recent times. While in the 1980s and the early 1990s, medical tourism was a sector that was dominated by the developed nations of the Global North¹⁰⁷, the 2000s saw countries of the Global South (such as India and China) developing their health infrastructure to serve the medical tourism industry¹⁰⁸. Along with countries in South America, India has become a global powerhouse in the medical tourism sector¹⁰⁹. In general, medical tourists to India come from Iran, Pakistan, Bangladesh, Afghanistan, Turkey, Europe, Gulf countries, parts of Africa and the United States of America.

Most of the patients from these countries arrive in India due to the expensive medical care in their home countries or the lack of adequate medical facilities¹¹⁰. The cost of treatment in India is up to one-eighth to one-fifth lower than the same treatment in the Global North regions¹¹¹.

Cultural capital also plays a role in the advancement of the medical tourism industry, particularly, the practice of Ayurveda. In the NHP 2017, the government had promoted health systems other than allopathy such as Ayurveda, Unani and Homeopathy¹¹². Ayurveda and Unani are medical practices that are drawn from centuries-old traditions in India itself and are also associated with spiritual rejuvenation¹¹³. In keeping with the government's objective to promote these traditional healing practices, the Ministry of AYUSH was founded on 9th November 2014. In the FY 2021-22, it was allocated a budget of Rs. 2,970 crore; up by 28.5 % of the budgetary allocation in FY 2020-21¹¹⁴. This was accompanied by extensive advertising of the health benefits of Ayurveda, especially when practised alongside yoga¹¹⁵. In 2023, the Ministry of AYUSH entered into a memorandum of understanding with the India Tourism Development Corporation (ITDC) to launch the Medical Value Travel campaign, aimed at promoting Ayurveda and other traditional healing practices among foreign tourists¹¹⁶. As a result of all these efforts, the AYUSH industry in India was reported to be worth Rs. 151336 crores in 2022¹¹⁷. The growth of medical tourism through AYUSH has also been buttressed by the Make in India policy of the Government of India on the domestic front. Similarly, in the Indian state of Kerala, its economy has especially benefitted from these policies. Foreign tourists from all over the world travel to Kerala for Ayurvedic treatment which also involves recreational activities¹¹⁸. In 2022, the Government of Kerala announced that it would allocate a budget of Rs. 97.77 crore to the AYUSH sector¹¹⁹. What is evident in all these policies is that the medical tourism policies in the country merged with a pan-Indian cultural identity in medical practice. This identity is then commercialised for profit. The AYUSH programme, however, has been

criticised on grounds that it lacks a “scientific approach” to medical care and that it is, at best, “quackery”¹²⁰. Further, in regions where indigenous medical practices (for instance tribal medicines) dominate, the AYUSH programme is seen to be exclusionary and ineffective in dispensing care to the local population.

MNCs in the Global North, acting through the World Bank, the WTO and the WHO, have been active in influencing policies and research relating to health in the India¹²¹. More than 30% of International Finance Corporation’s (IFC, part of the World Bank group) worldwide healthcare investment portfolio is invested in the private healthcare sector in India¹²². It's interesting to note that four hospitals—Apollo, Fortis, Max, and Rockland—prominently appear on the IFC website As beneficiaries of significant loans from the World Bank Group, these four hospitals have collectively received approximately US\$ 320 million (equivalent to about Rs. 2000 crore at the current exchange rate) over the past decade, according to limited investment data available on the IFC website¹²³. Further, Apollo Hospital, for instance, has collaborated with Johns Hopkins University in the US to enable more US patients to access healthcare and health facilities in India. Along with hospitals like Apollo, hotel groups, travel agencies and medical travel planners are involved in the medical tourism industry¹²⁴. The involvement of the service sector in the healthcare system has led many to believe that medical tourism can reduce unemployment and will benefit the country’s economy¹²⁵. The concept of medical tourism in India has received a mixed response, with its potential to boost the country's healthcare sector economically, but concerns persist regarding the impact on domestic healthcare infrastructure and equity in access to medical services.

However, the industry has also faced some criticism. In her study of medical tourism in Kolkata, the geographer, Anu Rai points out that the emphasis of medical tourism on patients who come from abroad has been at the cost of domestic health being neglected in the country. Although the domestic needs surpass those of the medical tourists, patients constituting the former are neglected because they do not

have as much spending power as their international counterparts¹²⁶. It is often pointed out that the commercialisation of health, of which medical tourism is a part, has led to a dwindling concern for the health of the average Indian citizen. There is also a fear that, lured by attractive pay packages, health practitioners will venture into the cities away from the rural areas where healthcare is already under strain¹²⁷. It implies that the focus of medical tourism is on migrant medical patients in urban locations rather than serving the healthcare concerns of rural population.

Medical tourism in India, as a key area of healthcare, emerged following the privatisation of the Indian economy and was looked upon as a valuable resource for the country's GDP¹²⁸. In the wake of the rise of medical tourism in the country, India has seen a decrease in specialist manpower in its Community Health Centres (CHCs) such as obstetricians and gynaecologists (56%), paediatricians (67%), surgeons (56%) and medical specialists (59%)¹²⁹. Economically too, the industry could use its astronomical profit margins to avail more subsidies from the government. This would not only make the private sector richer but also divert public funds away from the public health sector, thus increasing the disparities of resources between the public and private health sectors in the country. In order to better comprehend these changes one must look at the health sector reforms undertaken by the Government of India since the 1990s.

5.6: India Health Sector Reforms (HSR) since 1990s

First Phase of Health Sector Reforms (1991 to 2001)

Since the early 1990s, the private sector has played a pivotal role as the primary driving force behind the changes, having already firmly established itself within the Indian healthcare system prior to the official implementation of economic reforms. With the introduction of economic reforms, industrial policy measures such as subsidising the medical equipment industry and deregulating the pharmaceutical sector further bolstered the momentum towards healthcare privatisation. To a

significant degree, the IMF authored the 1993 World Development Report titled "Investing in Health," which provided the ultimate framework for Health System Reforms (HSRs) in India.¹³⁰ The World Bank had already created a report titled "Financing for India's Health Sector" in 1992, before that¹³¹. Due to the scarcity of public resources, the World Bank's strategy aimed to allocate public funds towards the provision of vital medical services, while delegating non-mandatory services to the private sector¹³².

In fact, the World Bank's position on restricting of public expenditure in the social sector, as well as its opposition to raising taxes on the private sector has aided the private sector in retaining control over the most profitable aspects of healthcare. As healthcare shifted from a public good to a private one, there was a clear push towards favouring the private sector within the context of government austerity measures, tax reductions, trade liberalisation and an overall encouragement of foreign private investment. The World Bank's health plan designated intermittent attempts to manage TB, sexually transmitted diseases, population growth, and other issues as public activities¹³³. During the initial phases of economic reforms, there was a lack of defined standards or specific directives regarding the development of basic facilities or the accreditation of private hospitals and clinics. These shifts were widely interpreted as foreign entities dictating India's health priorities and the scope of its health policies.

The 1990s saw a slowdown in the development of the public health infrastructure as a direct result of inadequate public expenditure. Numerous public primary health care institutions ceased to operate, and what was left had only a skeletal framework due to cutbacks in materials and supplies¹³⁴. Consequently, individuals were forced to choose between paying for public services or receiving private healthcare when the World Bank published a report titled "Better Health Systems for India's Poor" in 2002¹³⁵. Following the recommendations of the World

Bank, even for the most essentially needed health services, the user charge regime was established (in 1997) which continued to operate thereafter.

Between 1980 and 2004, the number of private facilities increased eightfold as the public health system declined. Public amenities barely doubled in quantity.¹³⁶ PPPs were also used during this time to access resources from the private sector for public health. The state, which was severely short on funds, started to give the private sector control of the lucrative secondary and tertiary health care markets, in addition to incentives like tax exemptions and subsidies¹³⁷. By giving away valuable real estate worth Rs. 6.5 billion by the end of the 1990s and relaxing rules, the governments (both central and state) provided the private sector with opportunities for unhindered development¹³⁸. Since the 1990s, the Government of India provided the private health sector with opportunities for significant growth and development, often with a focus on reducing the burden on public healthcare resources while also fostering innovation and competition in the healthcare industry.

This led to an unprecedented expansion of its presence in healthcare, especially in the realm of screening equipment, when combined with the advancements being made in medical technology. Due to the profit motives guiding much of the private sector, healthcare costs have surged to levels that are increasingly unmanageable for the average person. This is evidenced by the significant rise in per capita household expenditure on inpatient treatment between 1986–1987 and 1995–1996, within both public institutions and private ones¹³⁹. As a result, public hospitals were no longer the main providers of inpatient treatment. In the meantime, private players continued to control the majority of outpatient treatment. At about the same time, liberalisation efforts in the insurance industry started¹⁴⁰. Given the escalating expenses, it is not surprising that out of pocket (OOP) health expenditures on an exceptional proportion, particularly in backward regions, contributed to family poverty in the 1990s¹⁴¹. By the 2000s, the problem had gotten worse.

At the time, it was determined to raise public spending on healthcare spending to 2% of the GDP in 2002, the NHP was revised. The intention was to increase the state's commitment to health concerns given that only four of the initial policy's 17 goals had been met thus far with previous health planning methodologies failing to yield the desired results¹⁴². The private sector was given precedence, especially for citizens who could incur the costs of private healthcare treatments. The goal of the strategy was to increase the number of licenced medical practitioners, establish public-private partnerships, decentralise operations through Panchayati Raj Institutions (PRIs), make essential pharmaceuticals accessible at the primary healthcare level, and increase the number of licenced medical practitioners¹⁴³. But when it came to the implementation, the Government of India used extreme discretion¹⁴⁴. The privatisation of the health system in India can be closely linked to the broader shift in global economic settings of the 1990s, marked by increased liberalisation, globalisation and a growing emphasis on market-driven health care solutions.

Second Phase of Health Sector Reforms (2001 to 2010) – Revival of the Public Sector and the Deeper Emphasis of the Private Sector

The National Rural Health Mission (NRHM) was established in 2005, representing an advancement aimed at revitalising the public health system¹⁴⁵. The NRHM aimed to deliver accessible medical services to states and union territories with inadequate medical infrastructure. By leveraging institutions like Primary Health Centres (PHCs), Community Health Centres (CHCs), and Sub-District and District hospitals, the NRHM aimed to propagate Indian Public Health Standards (IPHS) across the nation¹⁴⁶. The IPHS strives to achieve universal health coverage and meet the sustainable development goals within India's healthcare system¹⁴⁷. The mission was instituted in consultation with expert committees consisting of the World Bank, the WHO, United Nations Children's Fund (UNICEF) and the United

Nations Population Fund (UNFPA)¹⁴⁸. Hence, there are multiple interests at play in the development of India's healthcare policy, including those on a multilateral level.

In the focus on PHCs to provide healthcare, the Government of India, under the IPHS, follows the advice of the WHO which advocates that preventive care for non-communicable diseases is best approached through primary healthcare facilities. But while the policy goals maybe positive, the execution of the IPHS policy has fallen short on many fronts. In their study of the implementation of the IPHS in PHCs in rural Uttar Pradesh, Arshiya Masood et al. noted that the buildings themselves had fallen to disrepair and basic services such as sanitation, the provision of medicines and doctors, were low or absent¹⁴⁹. According to the study, these infrastructural impediments are widespread even in states like Rajasthan which boasts of better healthcare facilities and initiatives than Uttar Pradesh, a backward state in terms of its health facilities¹⁵⁰. Masood et al. suggest that the greater involvement of local bodies such as the PRIs and addressing issues like village sanitation may help to alleviate the conditions of the PHCs and maintain accountability in the running of the PHCs¹⁵¹. They suggest, therefore, that the exclusion of local bodies in monitoring the Indian healthcare system, has been a hurdle in the aim to achieve universal healthcare coverage in India. Studies, such as those conducted by Masood et al., show that while multilateral involvement in India's healthcare system has succeeded in providing a vision for the country's public healthcare system, the on-the-ground execution of the programmes has not been too positive. These shortcomings are intertwined with the government's goal of rejuvenating the public health system alongside enhancing private sector involvement in healthcare.

In 2004, with a new government at the helm and amidst shifting political dynamics, efforts were made to rejuvenate the public health system. These changed circumstances prompted a revitalised government endeavour to tackle the fundamental unresolved requirements of citizens¹⁵². As part of a Common Minimum

Programme (CMP), designed by the 20-party United Progressive Alliance (UPA) under Prime Minister, Manmohan Singh, to ease rural misery, public health concerns were put back on the national agenda. It was critical to mitigate the negative impacts of rising costs of health.

As a result of these developments, the NRHM was established and put into action in 2005. It brought forth several novel ideas, such as procuring equipment, infrastructure, and services from the private sector, aiming to promote private interests and management methodologies. This initiative also aimed to shift from comprehensive service delivery at government healthcare facilities to a packaged approach, highlighting corporate governance similar to the private sector. The changed strategy, though with good intentions, to some extent increased disparities in healthcare access¹⁵³. Furthermore, the NRHM received criticism for implementing an IPHS system, which was thought to have some flaws. The endeavours to fulfil objectives were limited in scope and heavily inclined towards reproductive and child health (RCH), despite outlining the minimum human requirements, equipment, and infrastructure necessary to accomplish a broad set of health objectives¹⁵⁴. CHCs, PHCs, and district hospitals all adopted the IPHS. However, rather than enhancing the quality of general service delivery, the emphasis remained on purchasing equipment and meeting infrastructure development targets.

Since 2005, a duality in health reforms has emerged, which is also evident in the governance of health. Although there was a revival in focus on improving government healthcare, policymakers were also concurrently encouraging corporate efforts to enhance availability of beds, diagnostics and other aids through incentives¹⁵⁵. Efforts to enhance the public healthcare system encompassed various initiatives such as bolstering infrastructure, allocating unrestricted funds, providing skill-upgrading training for medical professionals, establishing a cadre of health staff termed Accredited Social Health Activists (ASHAs), and supporting conventional medical knowledge¹⁵⁶. ASHAs play a crucial role in the Indian health system by

acting as a bridge between communities and healthcare services, facilitating outreach, awareness and basic healthcare delivery, particularly in rural and underserved areas.

Meanwhile, the involvement of private entities was being encouraged, although somewhat haphazardly, especially at the secondary and tertiary levels. State governments also endeavoured to incorporate private actors through the Public-Private Partnership (PPP) system¹⁵⁷. Narayana Hrudayalaya (a prominent network of hospitals), in partnership with the Karnataka government and New India Assurance Company, along with other private clinics collaborating with the Andhra Pradesh government, are the significant cases in PPPs in the healthcare sector¹⁵⁸. These collaborations have been noted for their capacity to deliver effective healthcare services by offering expertise, technological resources, and operational efficiency to the people¹⁵⁹. As the government sought to broaden health financing, moving away from its traditional role solely as a healthcare service provider, there have been increased financial involvements from the insurance sector. Initiatives such as the Rashtriya Swasthya Bima Yojana (RSBY) and Janani Suraksha Yojana (Security Scheme for Mothers) have been key initiatives in this regard. With the RCH Programme gaining prominence, these advancements led to infrastructure expansion, including staff recruitment and improved access to health services. This was evidenced by a notable rise in institutional deliveries and outpatient visits¹⁶⁰. However, these advancements have often been dispersed and unequal, especially in relation to the provision of health care facilities in rural and backward regions.

At the beginning of the 2000s, India's rural and urban areas were served by approximately 1.3 million private health practitioners, predominantly consisting of individual doctors and small to medium-sized enterprises¹⁶¹. Private healthcare has undergone significant transformations since then. There has been a prominent increase in corporatisation and consolidation of commercial health firms, particularly in urban areas, giving larger hospitals an advantage. Moreover, medical

expenses have been on the rise due to the healthcare industry's increasing reliance on technology¹⁶². It is reasonable to presume that the private healthcare sector predominantly represents India's health industry, considering the inclination of private enterprises to diversify into new domains.

Health insurance is another sector where private involvement has expanded, and until the mid-2000s, it was primarily dominated by public sector corporations¹⁶³. In a shift in trend, private companies are aggressively promoting insurance as a means to enhance healthcare accessibility for the marginalised. This growth is further supported by the central government and various state governments through their new insurance initiatives, particularly aimed at the low-income segments of the population¹⁶⁴. These initiatives are facilitated through collaborations with a number of approved entities, predominantly private enterprises, and are technically backed by international organisations such as the World Bank and GTZ (German Technical Cooperation). Recipients of the programme are eligible for compensation of family health expenses up to a predetermined limit, typically covering inpatient care, along with the added convenience of cashless transactions¹⁶⁵. The corporatisation of the health sector has, therefore, enabled multilateral agreements at both the economic and policy levels.

Since 2008, there has been a marked increase in the significance of private corporate contributions, with the BMGF taking the lead role, alongside global health initiatives such as GAVI, Global Alliance for Improved Nutrition (GAIN), and the GFATM. These efforts primarily target the containment and mitigation of specific diseases, diverging from the broader strategy of the NRHM¹⁶⁶. During the period from 2001 to 2010, though HSRs tried to enhance the public health system, it inadvertently facilitated the expansion of private sector, thereby perpetuating a certain degree of social inequities.

Developments in Health Sector Reforms (2010 to 2020)

Since 2005, India has been actively endorsing international endeavours aimed at advocating for the significance of universal health coverage (UHC) as a goal, demonstrating a steadfast commitment to the UHC agenda¹⁶⁷. The UHC agenda has been promoted by the WHO and the global movement UHC2030 which seeks to develop more robust health systems for UHC across the globe. Governments, international organisations, global health initiatives, charitable foundations, civil society, and the private sector are just a few of the many partners that UHC2030 brings together¹⁶⁸. Consequently, in 2010, the Planning Commission of India established a High-Level Expert Group, which proposed a holistic framework to accomplish the objective of furnishing comprehensive healthcare to all citizens¹⁶⁹. However, the Twelfth Five Year Plan (2012-17) made only sporadic and weak attempts to implement UHC in India, undermining its purpose. Some efforts, such as the provision of complimentary generic medications via the current state health framework and the enlargement of the states expensive and disjointed health insurance schemes, have been viewed by certain individuals as prioritising voter appeal rather than fulfilling India's pledge to UHC¹⁷⁰. Thus, Government of India's efforts in this regard were not considered to be very effective.

The Twelfth Five Year Plan (2012-17) symbolised a broader trend towards increased private participation in India's healthcare system, resulting in a diminished role for the public sector. The public sector now primarily focuses on providing essential services such as immunisation, antenatal care, and health education, as these services are less lucrative and do not align with the profit-driven goals of the private sector¹⁷¹. Broadening the reach of government-funded insurance schemes such as RSBY led to a fragmented strategy that overly prioritises costly secondary and tertiary healthcare services, in the process neglecting the importance of primary health care¹⁷². It is evident that there is certain hesitancy among policy makers to enhance India's public healthcare system, as seen by the meagre budgetary allocations in the Twelfth Five Year Plan¹⁷³. There has been a consistent

absence of sustained political drive to comprehensively enhance India's healthcare system, leading to challenges in infrastructure development, healthcare funding, and overall public health outcomes. A former Planning Commission official noted that political representatives are sometimes constrained to increase the health care funding due to several structural level factors¹⁷⁴. As a result, essential aspects of public health, such as infrastructure development and healthcare funding, are frequently deemphasised, leading to suboptimal health outcomes for the people. Moreover, the private sector has increasingly filled the gap left by inadequate public healthcare funding, leading to a significant expansion of its role in the Indian healthcare system. This trend highlights the need for stronger public policy interventions that prioritise healthcare funding and strengthen the public health infrastructure to ensure equitable access to quality healthcare for all citizens.

Challenges in Governance in Relation to India's Healthcare Policies and HSRs

India's first NHP was not instituted until 1983, 36 years after gaining independence, primarily focusing on expanding the public health facilities¹⁷⁵. With the institution of the 1st NHP in 1983, there was a boost in state spending in the health sector, reflected in the growth of government expenditure as a percentage of the overall budget¹⁷⁶. While short-term in nature, the trend of increasing public investment in health was evident, between the 1980s-90s¹⁷⁷. Shortly thereafter, India embarked on liberalisation and restructuring of its macroeconomic policies in the early 1990s. Structural Adjustment Programmes (SAPs), mandated by international financing organisations like the IMF and World Bank, emerged as a consequence of this restructuring. The budgetary stringency imposed by the structural adjustment measures had a notable effect on both central and state budgets¹⁷⁸. As of 1990–1991 the central, state, and union territory governments collectively spent Rs. 98,377 million on health care, or Rs 117 per person¹⁷⁹. For FY2022–23, the Ministry of Health and Family Welfare, GoI allocated a budget of Rs 86,201 crore¹⁸⁰. Despite increased budgets for health in India, per capita expenditure has been on a downward trend¹⁸¹.

This decline underscores challenges in effectively allocating resources to meet the healthcare needs of the population.

SAPs compelled the state to alter its spending, aiming to reduce financial deficits by expanding revenue sources, cutting spending, or both¹⁸². Hence, amidst the overhaul, there was a reduction in expenditure on public-service delivery, notably in healthcare, at all levels of governance¹⁸³. The financial crunch starting in the 1990s adversely affected state health financing, and subsequent macroeconomic events like the global financial crisis of 2008-09 and policy measures such as the implementation of the Pay Commissions and the Fiscal Responsibility and Budget Management Act (FRBM) 2003 also influenced central and state spending, further impacting levels of funding by public health expenditure¹⁸⁴. In recent years, there has been a concerning trend of decreasing levels of funding by state governments in India for health, which has posed challenges to the accessibility and quality of healthcare services.

The 2nd NHP 2002 mandated that by 2010, the states' health budget spending was to increase to 8%¹⁸⁵. After the policy announcement, however, there was little indication that state health spending would increase¹⁸⁶. In 2003, shortly after the 2nd NHP was instituted, the Government of India put the FRBM Act into effect. The FRBM Act was crafted to compel both central and state governments to reduce their fiscal and revenue deficits by either boosting their revenue streams or reorganising/reducing their overall public expenditures¹⁸⁷. State governments opted for spending cuts, with the health sector bearing the brunt of these reductions, as the federal structure of the country places the majority of revenue-generating capacity with the central government. With the implementation of the NRHM by the central government in 2005, the health sector underwent an overhaul. Subsequently, the proportion of state health expenditures within the total budget allocation increased¹⁸⁸. Yet, even in recent times, spending on health, a responsibility delegated

to the states in India, has persistently remained lower than the budget allocations they were capable of in the mid-1980s.

HSRs initiated a phase of state disengagement from public healthcare, facilitating rapid and assertive expansion of the private sector in both organising and delivering health services. This shift not only commercialised healthcare but also transferred the burden of healthcare responsibility onto individual users¹⁸⁹. Private interests, operating across various levels and through diverse means, have profoundly altered both public and private healthcare systems, challenging conventional notions of healthcare delivery. Efforts to revitalise public and primary healthcare systems, although sporadic, have proven inadequate in addressing the health needs of the most marginalised populations. In response to substantial budget reductions in the 1990s that disproportionately affected the impoverished, the Government of India endeavoured to strike a balance and soften the impact on vulnerable communities¹⁹⁰. Yet, even these modest efforts to preserve pro-poor policies are being hindered by financial constraints due to inconsistencies in state policy and implementation practices. Moreover, recurrent implementation errors continue to plague the system, perpetuating the longstanding issue of insufficiently allocated funds¹⁹¹. The most concerning policy outcome is the stagnation of public infrastructure alongside a lack of substantial increase in government spending on health.

HSRs diminish the state's role to merely being a regulator, transforming it into a buyer, financier, and guarantor of private care. Through this shift, the private sector continues to benefit significantly from government spending¹⁹². HSRs continuously open up new revenue-generating markets, including the marketisation of government services. The profit motive predominantly drives the private sector, which is often criticised for benefiting from people's illnesses¹⁹³. Both the poor and lower middle classes bear the brunt of privatisation accelerated by HSRs, suffering from the overt commercialisation of healthcare, unethical business practices, and

skyrocketing costs¹⁹⁴. Moreover, public funds and resources are redirected to private entities under the pretext of serving the public good. The NHP 2017, the most recent health policy by the Government of India, seems oriented towards maximising investment opportunities in the health sector. Despite claims of prioritising the strengthening of primary healthcare and decentralising secondary and tertiary care facilities, the current strategy still heavily favours the private system as the primary provider of services¹⁹⁵. Thus, while there are assertions by the Government of India of focusing on enhancing primary healthcare and spreading out secondary and tertiary care facilities, the current policy approach predominantly supports the private sector as the primary source of healthcare services.

5.7: Concluding Remarks

From the preceding discussion, one can infer that India's healthcare system has been shaped by national governance and policies that, by endorsing private involvement in healthcare, implemented measures aligned with global organisations such as the WHO, the IMF, and the World Bank. Moreover, the privatisation of healthcare in India has resulted in healthcare services favouring the affluent while also opening the market to foreign interests, as evidenced by the country's growing medical tourism industry. The transformation of India's healthcare system since the 1990s has been a multifaceted journey, weaving together the intricacies of health financing, policy evolution, the global impact of the medical tourism industry, and extensive HSRs. The discussion highlighted the privatisation of healthcare financing, heightened dependence on the private sector, and the introduction of health insurance schemes like Ayushman Bharat which have profoundly influenced the healthcare landscape. These changes have brought forth both opportunities and challenges, with issues concerning equity, accessibility, and affordability remaining central to ongoing discussions.

Moreover, the influence of globalisation on India's healthcare system is apparent in the rise of the medical tourism sector. India's high-quality medical institutions have drawn patients from across the world, stimulating economic development and encouraging advancements in healthcare offerings. Nonetheless, this trend has prompted inquiries into resource allocation and whether medical services are being prioritised for international patients over domestic requirements.

The NHPs of 1983, 2002, and 2017 have each played a role in shaping the trajectory of healthcare privatisation in India. The 1983 NHP marked a significant shift towards decentralisation and encouraged the growth of private healthcare providers, aiming to improve access to healthcare services. However, this emphasis on private sector involvement laid the groundwork for the expansion of privatisation in subsequent years. The 2002 NHP continued this trend by promoting public-private partnerships (PPPs) as a means to address gaps in healthcare delivery, thus further entrenching the role of the private sector in the healthcare system. The most recent NHP in 2017 continued to prioritise the involvement of the private sector, particularly through initiatives like Ayushman Bharat, which sought to expand health insurance coverage through partnerships with private insurers and providers. While these policies aimed to address gaps in healthcare access, they also contributed to the increasing privatisation of healthcare in India, raising concerns about equity, accessibility, and affordability for marginalised populations.

Finally, in tune with the global trend, the trajectory of healthcare reforms in India since the 1990s has been characterised by a move towards market-driven strategies, decentralisation of healthcare provision, and endeavours to bolster public health infrastructure. Despite these endeavours, inequalities in healthcare accessibility endure, highlighting the imperative for more comprehensive and sustainable reforms. In its pursuit to furnish quality healthcare to its extensive population, India grapples with an intricate interplay of domestic and global forces.

Progress requires a balanced approach, harnessing the strengths of the private sector, ensuring equitable access, and strengthening the public health system.

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CHAPTER 6

GLOBAL HEALTH SECURITY STRUCTURES AND THE CASE OF THE COVID-19 PANDEMIC IN INDIA

6.1: Introduction

The COVID-19 pandemic has underscored the interconnected nature of global health and the vital role that international cooperation and liberal institutionalism play in addressing emergent health threats. As the world grapples with the profound impacts of the virus, examining the dynamics of liberal institutionalism in the context of global health security becomes imperative. This chapter discusses the intricate relationship between liberal institutionalism and the response to the COVID-19 pandemic, shedding light on how international institutions, particularly the World Health Organisation (WHO), have shaped the global health security landscape. The COVID-19 pandemic, with its unprecedented global impact, serves as a case study for assessing the strengths and limitations of liberal institutionalism in the realm of global health security.

Liberal institutionalism, a school of thought within international relations, posits that global cooperation is not only possible but can be achieved through the creation and strengthening of international institutions. These institutions, founded on principles of collaboration, shared norms and collective problem-solving, serve as lynchpins for addressing transnational challenges, including those in the realm of global health. Against this backdrop, this chapter begins by exploring the foundational principles of liberal institutionalism and their application to global health security. It subsequently analyses the role of international organisations in facilitating cooperation among states, promoting a collective response to health crises and establishing norms and standards for pandemic preparedness and response. Following this section, the chapter examines the effectiveness of the WHO and other

global institutions in coordinating a unified international response, disseminating crucial information and facilitating collaborative research and development efforts to combat the virus. Additionally, the chapter critically evaluates the challenges faced by global institutions during the pandemic, such as issues of political manoeuvring, resource disparities (especially in the realm of vaccine allocation) and questions surrounding sovereignty. This is followed by a section that critically examines the existing global health security structures, especially the International Health Regulations (IHR), evaluating their effectiveness, challenges and implications in the context of the COVID-19 pandemic. By dissecting the multifaceted dynamics of international cooperation in the face of a global health crisis, the chapter aims to provide insights into how liberal institutionalism meets the demands of an increasingly interconnected and complex world.

6.2: Global Health Security through the Lens of Liberal Institutionalism

Liberal institutionalism, as a prominent theoretical framework within international relations, rests on several foundational principles that emphasise the potential for cooperation and collaboration among states through the establishment and reinforcement of international institutions¹. These principles, when applied to the realm of global health security, offer a lens through which to examine how international cooperation can effectively address transnational health threats. The WHO defines health security as those “...activities required, both proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries”². Thus, global health security encompasses the collaborative endeavours aimed at preventing, detecting, responding to, and mitigating health hazards capable of traversing national boundaries and endangering populations globally³. These hazards comprise infectious diseases, pandemics, bioterrorism, natural calamities, and various other public health crises.

The concept of global health security is crucial for global health governance for several reasons. Effective global health security measures can prevent outbreaks of infectious diseases from escalating into epidemics or pandemics. By implementing surveillance systems, early detection mechanisms, and rapid response protocols, countries can work together to contain and manage health threats before they spread. Global health security initiatives often involve capacity-building efforts to strengthen health systems in Global South countries⁴. This includes improving infrastructure, training healthcare workers, and enhancing laboratory capabilities, which not only contributes to better responses to health emergencies but also improves overall healthcare delivery. Global health security relies on collaboration and cooperation among countries, international organisations, and other stakeholders⁵. By encouraging partnerships and sharing resources, expertise, and information, the global community can more effectively address health threats that transcend national borders. Health emergencies can have significant economic implications, affecting trade, tourism, and global supply chains. Investing in global health security aids to protect against the economic impacts of outbreaks and ensures the stability of the global economy⁶. Overall, global health security is essential for protecting the health and well-being of populations worldwide, promoting international cooperation, and safeguarding against the threats posed by infectious diseases and other health emergencies.

At its core, liberal institutionalism advocates for the creation of international organisations that act as mediators, facilitating cooperation and coordination among states⁷. In the context of global health security, this principle manifests in institutions like the WHO, which serves as a global platform for states to collaborate on matters of public health. The idea behind such institutionalisation is to provide a neutral space where countries can pool resources, share information and collectively respond to emerging health crises. Another key principle of liberal institutionalism is the establishment of shared norms and values among states. In the realm of global health

security, this involves the development of international agreements and frameworks that guide the behaviour of states in preventing, detecting and responding to health threats⁸. For instance, the IHR, under the auspices of the WHO, sets forth a set of norms and standards to which member states commit in the interest of global health security. Liberal institutionalism places a strong emphasis on collective problem-solving, viewing international institutions as platforms for addressing shared challenges⁹. In the context of global health security, this principle encourages states to work together to find comprehensive solutions to public health crises. Whether through joint research efforts, resource sharing or collaborative response strategies, liberal institutionalism envisions a collective approach to tackling health challenges that transcend national borders.

The principle of reciprocity is also fundamental to liberal institutionalism, suggesting that states engage in mutual cooperation based on the expectation of reciprocal benefits¹⁰. In the realm of global health security, countries engage in international initiatives with the acknowledgment that they can depend on the assistance of the global community during times of crisis¹¹. Reciprocity advances a sense of shared responsibility and encourages states to act in the collective interest of global health. Moreover, liberal institutionalism promotes the idea of institutions as mechanisms for reducing uncertainty and building trust among states. In the context of global health security, this translates to institutions serving as reliable sources of information and coordination during health crises. By providing a platform for transparent communication and data sharing, institutions mitigate uncertainties and contribute to the development of a global health community built on trust.

Lastly, liberal institutionalism recognises the importance of flexibility and adaptability. The global health landscape is dynamic, with new threats constantly emerging. Liberal institutions should, therefore, be capable of evolving to address evolving challenges¹². This adaptability is crucial in responding effectively to novel infectious diseases, as witnessed during the COVID-19 pandemic, where the WHO

had to navigate unprecedented challenges and adjust its strategies in real-time¹³. In essence, the foundational principles of liberal institutionalism offer a robust framework for understanding and analysing the dynamics of international cooperation in the realm of global health security. By promoting collaboration, shared norms, collective problem-solving, reciprocity, trust-building and adaptability, liberal institutionalism provides a theoretical foundation for the development and enhancement of institutions that can effectively address transnational health threats.

6.3: International Organisations and Pandemic Preparedness

International organisations play a pivotal role in facilitating cooperation among states, contributing to a collective response to health crises and establishing norms and standards for pandemic preparedness and response¹⁴. Exemplifying this role, the WHO stands as a prime example of an institution dedicated to global health governance. One primary function of international organisations is to serve as neutral platforms that bring states together to cooperate on matters of shared concern.

International organisations also play a crucial role in strengthening the collective response to health crises. During major outbreaks, such as the H1N1 influenza pandemic in 2009 or the Ebola outbreak in West Africa in 2014, the WHO served as a coordinator, bringing together countries, experts and resources to mount a unified response¹⁵. The collaborative efforts of states, facilitated by international organisations, enhance the effectiveness of responses to emerging health threats. Establishing norms and standards for pandemic preparedness and response is another key role of international organisations¹⁶. The International Health Regulations (IHR), overseen by the WHO, sets out a framework for the coordination of international responses to public health events. By establishing common standards for disease surveillance, reporting and response, the IHR ensures that states adhere to a shared set of norms, enhancing global health security. In addition to the WHO, regional organisations also contribute significantly to international cooperation during health

crises. For instance, the European Centre for Disease Prevention and Control (ECDC) collaborates with European Union member states to strengthen their public health capabilities¹⁷. The ECDC serves as a hub for information exchange, joint risk assessments and coordinated responses to health emergencies in the European region.

Furthermore, at the global level, the Centers for Disease Control and Prevention (CDC) in the United States plays a pivotal role in pandemic preparedness, serving as a leading public health agency with a mandate to protect the nation from health threats¹⁸. The CDC's expertise encompasses a wide range of health issues, and its role in pandemic preparedness is particularly significant. The agency engages in rigorous surveillance and monitoring of global health events, using its extensive network to detect and assess potential threats to public health. By closely collaborating with international partners, the CDC contributes to the early identification of emerging infectious diseases and monitors their progression, enabling timely and informed responses to mitigate the impact of pandemics.

In addition to monitoring, the CDC is instrumental in developing and disseminating guidelines, protocols and recommendations for pandemic preparedness and response. The agency provides evidence-based information to guide public health measures, healthcare practices and community interventions during pandemics¹⁹. The CDC's role extends to facilitating coordination among various stakeholders, including federal, state and local health agencies, as well as international organisations²⁰. By encouraging collaboration and information-sharing, the CDC enhances the overall readiness and resilience of the healthcare system to effectively address the challenges posed by pandemics. Through its comprehensive approach to pandemic preparedness, the CDC plays a central role in safeguarding public health and ensuring a coordinated, science-based response to emerging health threats.

In the context of India, the Ministry of Health and Family Welfare, GoI utilised data and advisories from the CDC for policymaking. One example of this adoption

was the use of CDC guidelines for testing strategies, contact tracing protocols, and vaccination distribution plans. The Ministry of Health and Family Welfare, GoI worked closely with the CDC and other international health organisations to gather insights and recommendations for managing the pandemic effectively in India.

International organisations also further collaboration beyond governmental entities, engaging non-governmental organisations (NGOs) and private sector partners²¹. For example, the Global Vaccine Alliance (GAVI), works with governments, NGOs, and industry partners to improve access to vaccines globally²². GAVI's inclusive approach demonstrates how international organisations can bring together diverse stakeholders to collectively address health challenges. Furthermore, institutions like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) exemplify the importance of international cooperation in resource mobilisation²³. By pooling financial resources from multiple countries and partners, the GFATM supports programs to combat these three major infectious diseases, emphasising the collective responsibility of the international community. In sum, international organisations serve as anchors for global health cooperation, offering neutral platforms for states to collaborate, coordinating collective responses to health crises and establishing norms and standards for pandemic preparedness and response. These organisations play a critical role in assisting a sense of shared responsibility and creating a framework for collective action in the face of global health challenges.

6.4: COVID-19 and the Limits of Liberal Institutionalism

The COVID-19 pandemic served as a compelling case study to analyse the strengths and limitations of liberal institutionalism in the realm of global health security. Examining the response to COVID-19 highlights both the successes and challenges of this approach. Firstly, the pandemic showcased the strength of liberal institutions in providing a forum for international cooperation. The WHO played a crucial role in disseminating information, coordinating global responses and

facilitating collaboration among member states. The WHO's guidance on testing, treatment and vaccine distribution served as a shared framework for countries worldwide, illustrating the importance of a neutral platform for collective action²⁴. However, the COVID-19 response also exposed some limitations of liberal institutionalism. One significant challenge was the politicisation of public health²⁵. National interests and political considerations at times hindered the effectiveness of global cooperation. Nations withdrew into a self-defensive stance, while simultaneously, many participated in a politics of assigning blame. One prime example was of the dispute between the US and China regarding the origins of the virus²⁶. The tension between nations during the early stages of the pandemic, including disputes over information-sharing and resource allocation, highlighted the difficulty in maintaining a purely collaborative approach in the face of geopolitical realities.

The pandemic revealed the need for more robust norms and standards for pandemic preparedness. While the IHR provided a foundational framework, the unprecedented nature of COVID-19 exposed gaps in global health governance. The slow recognition of the virus's airborne transmission and delays in updating guidelines reflected the challenge of adapting established norms to rapidly evolving health threats. Additionally, the reliance on voluntary compliance with international guidelines underscored a limitation in enforcement mechanisms²⁷. Liberal institutionalism often relies on states voluntarily adhering to norms, and the lack of binding enforcement mechanisms can lead to uneven compliance. During the pandemic, some nations deviated from recommended guidelines, impacting the overall effectiveness of global efforts. This was evident in most nations' policy (notably Australia and New Zealand) of closing of borders and restricting air travel to ensure national self-protection in direct contravention of Article 2 of the IHR which states "...provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid

unnecessary interference with international traffic and trade”²⁸. Furthermore, the distribution and access to vaccines revealed disparities in resource allocation²⁹. While international collaborations like the COVID-19 Vaccines Global Access (COVAX) aimed to ensure equitable vaccine access, challenges in production, distribution and vaccine nationalism resulted in unequal vaccine distribution, highlighting the difficulty in achieving truly shared responsibility and resource-sharing.

Global institutions also faced challenges in adapting quickly to the evolving nature of the pandemic. The emergence of new variants and the need for updated strategies showcased the limitations of traditional bureaucratic processes within institutions. The WHO and other global institutions faced criticism for delays in recognising and responding to emerging challenges, revealing the necessity for more agile and adaptive structures³⁰. Despite these challenges, the pandemic emphasised the value of multilateralism in addressing global health threats. Initiatives like COVAX, which aimed to provide vaccines to Global South countries, highlighted the importance of collaborative efforts³¹. The global response to COVID-19 underscored the interconnectedness of nations and the recognition that no single country can effectively combat a pandemic in isolation. To sum up, the COVID-19 pandemic serves as a nuanced case study for evaluating the strengths and limitations of liberal institutionalism in global health security. While liberal institutions like the WHO played a critical role in aiding cooperation and providing guidance, challenges such as politicisation, slow adaptation and disparities in resource allocation revealed areas for improvement.

The collaboration between public and private sectors in developing COVID-19 vaccines has also raised complex ethical considerations³². On the one hand, public-private partnerships (PPPs) have played a crucial role in accelerating vaccine development, leveraging the resources, expertise and innovation capabilities of both sectors. On the other hand, concerns have been raised about equity in vaccine distribution, pricing, and accessibility, with questions arising about the influence of

profit motives and the prioritisation of Global North nations over Global South nations. Pharmaceutical companies invested heavily in research and development, while governments and international organisations provided funding, regulatory support and infrastructure to facilitate vaccine production and distribution. This collaboration led to the rapid development of multiple COVID-19 vaccines, offering hope for controlling the pandemic. For example, mRNA vaccine technology, developed by private companies like Pfizer-BioNTech and Moderna, demonstrated remarkable efficacy in protecting against COVID-19³³. However, ethical concerns have arisen regarding vaccine accessibility, equity and transparency. Despite efforts to ensure widespread vaccine distribution, there has been significant disparity in access between Global North and Global South countries³⁴. Global North countries such as the US and Germany secured the majority of vaccine doses through advance purchase agreements with pharmaceutical companies, leaving many Global South countries struggling to obtain sufficient supplies. This vaccine inequity increased global health disparities and raises questions about fairness and justice in vaccine allocation. Furthermore, the involvement of private sector entities in vaccine development has led to debates about intellectual property rights (IPR) and profit motives³⁵. In general, pharmaceutical companies have faced criticism for prioritising profit margins over global health equity, leading to calls for greater transparency in pricing and licensing agreements.

Additionally, concerns have been raised about the role of pharmaceutical companies in influencing public health policy and decision-making³⁶. The close collaboration between governments and industry stakeholders in vaccine development has raised questions about potential conflicts of interest and the influence of corporate lobbying on public health priorities. Transparency and integrity in decision-making processes are critical for safeguarding public health and ensuring that vaccine development and distribution efforts prioritise the common good over private interests. In general, addressing ethical challenges require a concerted effort

from governments, international organisations, civil society and the private sector. Collaboration and dialogue between stakeholders are essential for developing strategies that promote vaccine equity, transparency, and accessibility while upholding ethical principles of justice, solidarity and public health. It is commonly perceived that, only through collective action and shared commitment, countries can ensure that COVID-19 vaccines are distributed equitably and that the benefits of vaccination are accessible to all.

6.5: International Health Regulations (IHR) and Global Outbreak Alert and Response Network

The IHR constitute a key legal instrument that governs the collective global response to public health emergencies. The IHR's evolution traces back to the mid-19th century, with its modern framework established by the WHO in 1969³⁷. Initially focused on controlling the international spread of diseases like cholera, plague and yellow fever, the IHR underwent revisions to address emerging health challenges. The IHR's evolution took a transformative turn in 2005 after the SARS outbreak in 2003, when the WHO member states adopted a revised version, reflecting a shift towards a more comprehensive and modernised approach³⁸. It emphasised a holistic approach to global health security, considering factors such as environmental events, chemical and radiological incidents and the potential for deliberate releases of pathogens³⁹. A significant breakthrough was the shift from a disease-specific approach to a risk-based framework⁴⁰. The revised IHR acknowledged that health threats could extend beyond known infectious diseases to include chemical, radiological and environmental events⁴¹. This revision expanded the scope of the IHR to cover all public health emergencies of international concern, not just specific diseases. The process of framing and amending the IHR involves collaborative efforts among WHO member states, particularly during sessions of the World Health Assembly (WHA), ensuring a consensus-driven approach that considers diverse perspectives.

The IHR's profound contribution to global health security lies in its framework for enhancing countries' capacities to detect, assess, and respond to public health threats⁴². Mandating core capacities ensures all member states have the necessary infrastructure for effective emergency management, enabling a more strong global health system⁴³. The IHR serves as a critical framework to ensure that all member states possess the necessary infrastructure, capabilities and core capacities to effectively manage public health emergencies, thereby contributing to global health security⁴⁴. The IHR mandates that countries build and maintain specific capacities to detect, assess, notify and respond to potential public health threats⁴⁵. The WHO's strengthened role post-revision underscored its central coordinating authority in global health governance, notably in declaring Public Health Emergencies of International Concern (PHEIC)⁴⁶. Member states commit to building and maintaining core capacities, crucial for effective emergency response. Despite commendable progress, challenges surfaced during the COVID-19 pandemic, highlighting the need for sustained efforts in strengthening public health infrastructure.

The key actors involved in framing and amending the IHR are primarily the member states of the WHO and the WHO itself. The process is a collaborative and inclusive effort where member states, representing the global community, actively participate in discussions and negotiations. The World Health Assembly (WHA), as the highest decision-making body of the WHO, plays a central role in the adoption and amendment of the IHR. During WHA sessions, member states deliberate on proposed changes, share their perspectives, and contribute to shaping the regulations to address evolving global health challenges⁴⁷. The collaborative nature of this process ensures that the IHR reflects a consensus-driven approach, incorporating diverse viewpoints and experiences from countries around the world. Additionally, technical experts, public health professionals and legal advisors also play supportive roles in providing expertise and guidance during the framing and amendment processes. The involvement of these key actors underscores the commitment to multilateralism and

international cooperation in addressing public health emergencies and advancing global health security.

One key aspect of the IHR is its emphasis on the development of core capacities, which encompass a set of essential capabilities needed to respond to public health emergencies. These core capacities include surveillance and reporting, laboratory services, public health infrastructure, emergency response teams and communication systems⁴⁸. By ensuring that each member state establishes and maintains these core capacities, the IHR aims to create a global network of nations capable of promptly identifying and responding to health threats⁴⁹. The IHR's overall contribution to global health security is profound. The regulations provide a framework for enhancing the capacity of countries to detect, assess, notify and respond to potential public health threats. By establishing a set of core capacities, the IHR ensures that all member states have the necessary infrastructure and capabilities to effectively manage public health emergencies. This collective strengthening of global health capacities contributes to a more robust and resilient international health system. Member states commit to developing resilient health systems that can effectively handle a range of emergencies, from infectious disease outbreaks to chemical, radiological and environmental incidents.

India has utilised the IHR framework in various instances to address public health emergencies and thereby enhancing global health security. One notable example is India's response to the COVID-19 pandemic, where the Government of India implemented measures in alignment with IHR guidelines to detect, assess, notify, and respond to the spread of the virus. India's adoption of surveillance, testing, and quarantine protocols exemplifies its commitment to IHR principles in managing the pandemic and minimising its impact domestically and internationally. Furthermore, India has leveraged the IHR framework to address other health threats, such as outbreaks of infectious diseases like the Nipah virus in 2018 and Zika virus in 2023⁵⁰. By collaborating with international partners and adhering to IHR requirements

for information sharing and coordinated response efforts, India has contributed to global efforts to contain and mitigate the spread of these diseases.

Overall, the IHR's emphasis on core capacities, international collaboration, and balanced responses contributes to a more secure global health landscape. Its role in preventing unnecessary trade and travel restrictions during emergencies underscores its importance in maintaining economic stability while addressing health threats. Through a collective effort, the IHR strengthens the resilience of health systems worldwide, ensuring effective response and mitigation of public health emergencies.

Similarly, the Global Outbreak Alert and Response Network (GOARN) was established in 2000 by the WHO as a collaborative platform to enhance global preparedness and response to infectious disease outbreaks⁵¹. GOARN operates as a network of technical institutions, international organisations and experts from around the world, pooling resources and expertise to detect, assess and respond to public health emergencies⁵². GOARN's formation stemmed from the recognition of the need for a coordinated and rapid response mechanism to outbreaks of emerging infectious diseases, following the experiences with outbreaks such as Ebola, SARS and avian influenza. The network was established to facilitate the timely exchange of information, expertise and technical assistance among member institutions and partners, with the goal of improving global health security and reducing the impact of outbreaks on public health and economies.

The working of GOARN is based on a decentralised model, with member institutions and partners collaborating closely with WHO and each other to address specific aspects of outbreak response⁵³. When an outbreak occurs, GOARN mobilizes its network of experts and resources to support affected countries in various areas, including epidemiological investigation, laboratory diagnostics, infection prevention and control, risk communication and medical care⁵⁴. The key actors involved in GOARN include national public health institutes, academic institutions, research organisations, non-governmental organisations (NGOs) and other international

agencies with expertise in infectious disease surveillance and response. These organisations contribute technical expertise, personnel and resources to support outbreak investigations and response efforts, both at the global and country levels. GOARN's operations are guided by a set of core principles, including transparency, accountability, solidarity and respect for national sovereignty. The network operates under the leadership and coordination of WHO, which provides strategic direction, technical guidance, and logistical support to facilitate the collaboration and coordination of member institutions and partners.

Overall, GOARN plays a crucial role in strengthening global health security by boosting collaboration, information sharing and capacity-building among a diverse range of stakeholders involved in outbreak preparedness and response. The network's multidisciplinary approach and global reach enable it to mobilise quickly and effectively to address emerging infectious disease threats, aiding to prevent the spread of outbreaks and save lives.

6.6: India and International Health Regulations

The IHR serve as a guiding framework for health security in India, providing essential principles and standards to enhance the country's preparedness and response to public health emergencies⁵⁵. The IHR's influence is notable in several key aspects of India's health security frameworks. The IHR guides India in establishing and maintaining core capacities for public health emergency management as stated by Anshu Prakash, Former Joint Secretary, Ministry of Health & Family Welfare, GoI. "IHR are an instrument for the world to have a robust protocol for prevention, reporting, information sharing and preparedness"⁵⁶. These capacities include surveillance and reporting systems, laboratory infrastructure and the ability to mount a rapid and effective response. In 2021, the National Health Mission issued the Guidelines on Integrated Public Health Laboratories (IPHLs) to offer direction on standardisation, integration, and enhancement of comprehensive diagnostic,

management, and surveillance facilities at public health laboratories located at district and sub-district levels⁵⁷. Emphasising on the need for India to be IHR compliant, Dr Prakin Suchaxaya, Coordinator-Health Programmes, WHO Country Office for India said, “Building and maintaining IHR core capacities of surveillance, response, laboratory verification, with preparedness, both at national and sub-national level for all hazards, and in particular zoonoses is absolutely critical. This calls for many different agencies and sectors to come together for public health and cannot be done by the health sector alone”⁵⁸. India's health security frameworks align with the IHR's emphasis on building robust health systems that can detect, assess, notify and respond to potential health threats promptly.

The COVID-19 pandemic serves as a compelling example of the IHR's guidance in India. The country implemented surveillance and reporting mechanisms, scaled up testing capacities and mobilised emergency response teams to manage the pandemic's impact⁵⁹. India's response reflected adherence to the IHR's principles, showcasing the practical application of the regulations in the face of a global health crisis. The International Health Division of the Directorate General of Health Services under Director General of Health Services, Ministry of Health & Family Welfare, GoI is tasked with the formulation of technical guidelines, rules, regulations and standard operating procedures for health protocols at points of entry into the country viz. airports, ports and land border crossings⁶⁰. These guidelines adhere to the IHR, as well as comply with the Indian Aircraft (Public Health) Rules and Indian Port Health Rules⁶¹. In addition, the International Health Division coordinates with the various stakeholders i.e Ministry of External Affairs, Ministry of Civil Aviation, Food Safety and Standards Authority of India (FSSAI), Ministry of Home Affairs and Ministry of Shipping. Furthermore, the IHR contributes to shaping India's health security frameworks by emphasising the importance of collaboration and information-sharing⁶². The regulations encourage countries to work together, share data and engage in joint efforts during health emergencies. In line with this guidance, India

collaborates with international partners, neighbouring countries and organisations to promote a collective global response to health threats.

India's health security frameworks are influenced by the IHR's commitment to transparency and accountability. The regulations mandate routine assessments and evaluations, enabling India to continually assess its public health capacities, identify gaps and make informed decisions to strengthen its overall health security⁶³. This commitment to self-assessment aligns with the IHR's emphasis on countries taking ownership of their preparedness and response efforts. The IHR also guides India in preventing unnecessary trade and travel restrictions during public health emergencies. Article 2 of the IHR provides specific guidance on implementing measures that protect public health while minimising disruptions to international trade and travel⁶⁴. India's adherence to these guidelines reflects a balance between safeguarding public health and maintaining economic stability.

The monitoring and evaluation mechanisms established by the IHR contribute to the effectiveness of health security frameworks in India. India is ranked relatively high at 66 out of 195 countries in compliance with the reporting and disaster risk reduction as per the Global Health Security Index 2021⁶⁵. Further, in line with the IHR recommendations, by mid-2024, the NITI Aayog, in collaboration with the Ministry of Health and Family Welfare, GoI and relevant stakeholders, will present a comprehensive program designed to mitigate the spread of any future pandemics⁶⁶. To recapitulate, the IHR play a vital role in guiding health security frameworks in India. The IHR's principles, emphasising core capacities, collaboration, transparency and accountability, shape India's approach to preparedness and response to public health emergencies. The practical application of these principles, especially during the COVID-19 pandemic, highlights the significance of the IHR in contributing to a resilient and effective health security framework in India.

6.7: The Global Health Security Agenda and India

The Global Health Security Agenda (GHSA) is a multilateral initiative aimed at enhancing global health security by strengthening countries' capacities to prevent, detect and respond to infectious disease threats. Launched in 2014, the GHSA is a collaborative effort involving governments, international organisations, non-governmental organisations (NGOs) and other stakeholders⁶⁷. At its core, the GHSA seeks to contribute to a coordinated and comprehensive approach to addressing health security challenges, recognising that infectious diseases can transcend borders and pose significant threats to public health and global stability.

One of the key actors involved in the GHSA is the WHO, which serves as a leading coordinating agency for global health security efforts. The WHO provides technical expertise, guidance and support to countries in implementing the GHSA's objectives, including capacity building, surveillance and response planning⁶⁸. Additionally, the GHSA brings together a coalition of countries known as the GHSA Steering Group, which provides strategic direction and oversight for the initiative's activities. Other important actors in the GHSA include national governments, which play a central role in implementing health security measures within their respective countries. Through national action plans and partnerships with international partners, governments work to strengthen their capacities for disease surveillance, laboratory diagnostics, emergency response and other key areas identified by the GHSA. Non-state actors, such as NGOs, academic institutions and private sector organisations, also contribute expertise, resources and innovation to support GHSA objectives.

In India, the GHSA is operationalised through the Integrated Disease Surveillance Programme (IDSP) and the National Centre for Disease Control (NCDC). The IDSP's mandate encompasses the monitoring and detection of outbreaks of infectious diseases⁶⁹, while the NCDC focuses on disease control and prevention⁷⁰. India has made notable strides in bolstering its health security framework via the GHSA, which includes fortifying its laboratory network and augmenting its ability to respond to infectious diseases⁷¹. India's participation in the GHSA has profound ramifications for

the nation's public health landscape, underscoring its commitment to strengthening health security and addressing global health threats. As a significant player in the South Asian region, India's involvement in the GHSA reflects its recognition of the interconnectedness of health security and the need for collective action to mitigate risks. India's involvement with the GHSA reflects its commitment to strengthening health security both domestically and globally. Since joining the GHSA in 2014, India has actively participated in various initiatives and collaborations aimed at enhancing its capacity to prevent, detect and respond to infectious disease threats⁷².

India has also actively participated in GHSA working groups, policy forums, and advocacy campaigns to shape global health agendas and advocate for resources to support health security initiatives. By contributing its perspectives and expertise to global discussions on health security, India has played a significant role in driving collective action and consensus-building. India has recognised the importance of community engagement in health security efforts and has worked to empower communities to actively participate in disease prevention and response activities. India's focus on strengthening community resilience and capacity at the grassroots level has been instrumental in enhancing its preparedness to tackle global health challenges, particularly evident during the COVID-19 pandemic. Programmes such as the Accredited Social Health Actors (ASHAs) initiative have played a pivotal role in empowering communities with essential health education, services, and support⁷³. These frontline workers have been crucial in disseminating information about COVID-19 prevention measures, conducting screenings, and facilitating access to healthcare services in remote areas. Similarly, the Kudumbasree initiative in Kerala, with its emphasis on women's empowerment and community development, has played a vital role in mobilising local resources and coordinating efforts to combat the pandemic. These grassroots-level initiatives underscore India's commitment to building resilient community structures capable of effectively responding to global health crises like the COVID-19 pandemic. Additionally, the Kudumbasree initiative

in the state of Kerala has been instrumental in promoting women's empowerment and community development, thereby improving access to healthcare and enhancing resilience to health crises⁷⁴. These grassroots-level efforts highlight India's commitment to building robust community structures capable of effectively responding to global health emergencies.

6.8: COVID-19 and Challenges for India's Health Security

The COVID-19 pandemic presented unprecedented challenges for India's health security, exposing limitations in the country's healthcare infrastructure, governance systems and pandemic preparedness efforts. In general, India's healthcare system struggled to cope with the surge in COVID-19 cases, particularly during the devastating second wave in 2021. Hospitals were overwhelmed with patients, leading to acute shortages of beds, medical oxygen and critical care facilities. The inadequacy of healthcare infrastructure, especially in rural areas, posed challenges in providing timely and adequate medical care to those in need⁷⁵. India faced challenges in scaling up testing and surveillance capacities to match the escalating caseload. Delays in test results, inadequacies in contact tracing and disparities in testing accessibility between urban and rural areas hindered efforts to curb transmission. The limited testing infrastructure and lack of widespread surveillance systems made it difficult to accurately track the spread of the virus and implement targeted containment measures.

Despite being one of the world's largest vaccine producers, India encountered logistical challenges in rolling out its COVID-19 vaccination campaign⁷⁶. Issues such as vaccine shortages, supply chain disruptions, and logistical bottlenecks in distribution slowed down the pace of vaccination, delaying the achievement of herd immunity and hindering efforts to control the spread of the virus⁷⁷. India also grappled with widespread misinformation and vaccine hesitancy, undermining efforts to promote vaccination and build public trust in the healthcare system.

Misinformation campaigns circulated widely on social media platforms, leading to scepticism and reluctance among certain segments of the population to get vaccinated or adhere to public health guidelines⁷⁸. The pandemic exacerbated pre-existing social and economic disparities in India, disproportionately affecting vulnerable populations such as migrant workers, daily wage earners and marginalised communities. Lockdowns and mobility restrictions resulted in job losses, food insecurity and disruptions to essential services, exacerbating poverty and widening existing inequalities in access to healthcare and social protection.

India faced challenges in governance and coordination at both the central and state levels, leading to inconsistencies in pandemic response strategies and implementation. Coordination gaps between different government agencies, lack of transparency in decision-making, and bureaucratic hurdles hindered the effectiveness of pandemic management efforts, contributing to confusion and chaos. India's response to the pandemic was also shaped by global solidarity and equity concerns, particularly regarding access to vaccines and medical supplies. The country faced criticism for prioritising its domestic vaccine rollout over sharing doses with lower-income countries facing vaccine shortages⁷⁹. The need for equitable access to vaccines and support for global vaccination efforts emerged as key challenges in India's pandemic response.

6.9 COVID-19 and Securitisation of Health in India

The emergence of COVID-19 in late 2019 posed a significant challenge to global health security, and India was no exception. This section explores the intricate relationship between the pandemic, India's pre-existing health security vulnerabilities and the processes of securitisation employed to contain the outbreak. Before the COVID-19 pandemic, India faced several pre-existing health security vulnerabilities that exacerbated the challenges posed by the outbreak. Firstly, India's healthcare infrastructure was inadequate and fragmented, with significant disparities between

urban and rural areas. While major cities boasted advanced medical facilities, rural regions often lacked access to basic healthcare services, including hospitals, clinics and trained medical professionals⁸⁰. This disparity in healthcare infrastructure contributed to unequal healthcare outcomes and hindered the country's ability to respond effectively to public health emergencies like COVID-19. India, also, struggled with a high burden of communicable diseases, including tuberculosis, malaria, and dengue fever, which strained the healthcare system and diverted resources away from pandemic preparedness efforts⁸¹. The prevalence of these diseases highlighted underlying weaknesses in India's public health surveillance and response capabilities, making it challenging to detect and contain emerging infectious diseases before they spread widely.

India's densely populated urban areas, particularly in slums and informal settlements, posed significant challenges for disease control and prevention. Overcrowded living conditions, poor sanitation infrastructure, and limited access to clean water made it difficult to implement effective infection control measures and heightened the risk of disease transmission⁸². These urban health vulnerabilities compounded the spread of COVID-19 within communities and presented formidable challenges for containment efforts⁸³. India's large population, with its diverse socio-economic and cultural landscape, presented unique challenges for public health interventions. Socio-economic disparities, including income inequality, limited access to education and inadequate healthcare coverage, contributed to disparities in health outcomes and hindered efforts to implement equitable and inclusive health policies⁸⁴. These disparities amplified the impact of COVID-19 on vulnerable populations, including marginalised communities, migrants and informal workers.

In addition, India's healthcare financing faced significant challenges, with limited public investment in healthcare infrastructure and a heavy reliance on out-of-pocket expenditure for health services⁸⁵. This lack of financial protection left many individuals and families vulnerable to exorbitant health expenditures and reduced

their ability to access essential healthcare services, including COVID-19 testing, treatment, and vaccination. India's health workforce was stretched thin, with shortages of doctors, nurses and other healthcare professionals, particularly in rural and underserved areas in terms of health facilities⁸⁶. This shortage of trained personnel limited the country's capacity to respond effectively to public health emergencies like the COVID-19 pandemic and underscored the need for investments in health workforce development and retention strategies.

Furthermore, India's vulnerability to emerging infectious diseases was exacerbated by environmental factors, including rapid urbanisation, deforestation and climate change. These environmental changes (for instance, different kinds of pollution) created favourable conditions for the spread of vector-borne diseases and zoonotic (animal to human) infections, increasing the risk of pandemics like COVID-19⁸⁷. Addressing these environmental health challenges required a multi-sectoral approach that integrated public health, environmental conservation and climate adaptation efforts. India's weak public health governance and institutional capacity hindered the country's ability to mount an effective response to public health emergencies. Fragmented governance structures, bureaucratic shortcomings, and limited coordination between different levels of government affected the implementation of timely and coordinated public health interventions⁸⁸. Strengthening public health governance and building institutional capacity were essential for enhancing India's preparedness and response to future health security threats, including pandemics like COVID-19.

COVID-19 in India- A Background

In India the southern state of Kerala reported the country's first COVID-19 case towards the end of January 2020⁸⁹. The Government of India's initial approach was to issue warnings and keep surveillance on foreign arrivals (through the major international airports in the country)⁹⁰. Throughout February, there were very few cases reported in the nation, but in March, it became clearer that the pandemic was

present in India. Kerala and a few other states had started to establish social distance standards and regulations in the meanwhile, but enforcement was patchy⁹¹. After there were 100 confirmed cases, on March 14th, the central government proclaimed a national health emergency⁹². On 22 March, a curfew was imposed, and on 24 March, a total lockdown was declared with only a few hours' notice⁹³. This move eventually brought an end to international passenger flights as well as nearly all commercial activity and transportation of any type, including domestic road, rail, and air travel. Governmental response systems for diseases and catastrophes of every sort were in place, and both the centre and the states were operating within those frameworks. The lockdown and subsequent restrictions were implemented by invoking two important central government acts - the Epidemic Diseases Act of 1897 (EDA)⁹⁴ and the Disaster Management Act of 2005 (DMA)⁹⁵. These acts served as crucial emergency response mechanisms in India, emphasising the state's responsibility for public health under constitutional obligations. These laws grant the central government to take decisive actions during health crises, superseding state actions to ensure a coordinated and effective national response to epidemics and disasters.

There were barely 500 instances of viral infection at the time of the initial lockdown, and the number of illnesses and deaths stayed low for some weeks after that⁹⁶. The original lockdown lasted for three weeks but was gradually extended up to the last week of May 2020, at which point a progressive relaxation was allowed⁹⁷. The initial lockdown had been uniformly severe, but at this point, the states had been granted a little more latitude, especially over the timing and specifics of their 'unlocking'. Additionally, regular meetings between the Prime Minister, Narendra Modi and Chief Ministers of various states gave the states more influence over the decision to keep the lockdown in place after the initial phase. Case counts and fatalities started to increase as the restrictions began to loosen, starting a little in late May but, more so, in June⁹⁸. These trends initially followed exponential curves, but in July and August they started to flatten, and in September cases and fatalities peaked⁹⁹. From

that point on, they started to decline, eventually reaching relatively low levels by the start of 2021. By this time, several COVID vaccines had been developed including Covishield and Covaxin and began to be used in India like many other nations¹⁰⁰.

India had an edge over many other developing nations because of its capacity to research and produce vaccines at home, and the Government of India even started making commitments to export vaccine doses to other countries through the 'Vaccine Maitri' initiative¹⁰¹. A new variant of the coronavirus that caused a considerably more abrupt spike in cases and fatalities, beginning in March 2021 and peaking in May, led to the questioning of the existing COVID management policies by many public health experts¹⁰². These peaks were in excess of four times as high as the peak in 2020, and it is possible that the strain on the healthcare system at this time resulted in an undercounting of illnesses and fatalities¹⁰³. Despite the second wave's far higher intensity, there was no national lockdown, and state and municipal control through curfews, travel restrictions, and other social distancing tactics was much more heavily relied upon.

COVID-19 and its variable impact on states within India

According to the Seventh Schedule of the Constitution of India, state governments are primarily responsible for enhancing public health and is empowered to legislate on matters concerning public health and sanitation¹⁰⁴. Additionally, both the central and state governments share concurrent powers in certain health-related domains, including preventive detention for maintaining public order, such as imposing quarantines during disease outbreaks, and regulating the movement of people, animals, and goods within and between states¹⁰⁵. India's health allocations have been chronically low and this is also evident in the status of its health indicators. Despite several centre-sponsored initiatives and insurance plans, the government's spending on health during 2019-21 ranged from 1.2% to 1.6% of GDP¹⁰⁶. In the Annual Budget for 2020-21 the actual allocation under the Ministry for Health and Family Welfare, GoI was Rs. 80,694 crores, roughly 2.3 % of the entire budgetary allocations¹⁰⁷.

India witnessed an overall growth in public health spending, which went from 0.9% of GDP in 2015–16 to 1.1% of GDP in 2020–21¹⁰⁸. According to the GoI's Economic Survey 2020–21, India is 179th out of 189 nations in terms of how much of the government budget is allocated to healthcare¹⁰⁹. The National Health Policy (NHP) 2017 states that by 2025, public health spending is to reach a level of 2.5% of GDP¹¹⁰. Achieving this target would likely require increased government investment in healthcare and could have significant implications for healthcare delivery and outcomes in the country.

States also receive funds from the central government to maintain and operate surveillance systems and enhance health capacities and infrastructure. The reporting and notification of the data from such surveillance is however voluntary and not obligatory under the central law¹¹¹. In India, the National Surveillance Program for Communicable Diseases set up in 1997 was transformed into the NCDC and is mandated to undertake disease surveillance through the IDSP which started in November 2004 with World Bank financing to detect and respond to illness outbreaks swiftly¹¹². While over the years, the IDSP has been reporting on and recommending measures to tackle the country's disease burden, the reporting has been inconsistent. The NCDC's performance in fulfilling its mandated duties was deficient during the COVID-19 outbreak¹¹³.

Similarly, the overburdening of health care workers and weak institutional capacity to bear the impact of the burgeoning cases of COVID-19 was visible across states with several implications on the varied nature of socio-economic development of states in India. This also underscores the importance of state-run health care facilities in India. In terms of capacity reflected in number of employees and size of infrastructure, India has one of the largest public sector health systems in the world¹¹⁴. Despite the size of the health system, India's density of skilled health workforce is among the lowest across the globe. A study by a team of researchers from the Indian Institute of Public Health estimated that India had an average of 20.6 (based on

National Sample Survey data) and 26.7 (based on professional association registry data) doctors and nurses per 10,000 population in 2019 against the WHO's recommended minimum threshold of 22.8 per 10,000 population¹¹⁵. Many states in the eastern and north-eastern parts of India, as well as rural areas across almost all states, face a greater shortage of trained doctors and nurses. It is pertinent to note that the India State-Level Disease Burden Initiative Collaborators led by Lalit Dandona, Distinguished Research Professor and a public health expert, in a long term study of Global Burden of Disease Study from 1990-2016 pointed to subnational variations within India emphasising that the, "...magnitude and causes of disease burden and the [associated] risk factors vary greatly between the states"¹¹⁶.

India's healthcare system is pluralistic, characterised by a mix of the public sector and the private sector. Public hospitals mostly financed by state governments account for only 10 percent of hospitals in the country¹¹⁷. In such a situation many states aimed at improving capacity to manage the healthcare needs in the wake of the pandemic, by allowing private hospitals, clinics and, in some states, the private hotel industry too, to provide treatment and paid quarantine facilities¹¹⁸. The inadequate infrastructure and facilities within the public health sector affected the management of pandemic, especially the health concerns of lower strata and marginalised communities.

During the second wave of COVID-19 in India, there was a sudden surge in the demand for liquid medical oxygen (LMO) with frequent reports of shortages across the country. In order to mitigate the situation, the central government responded by airlifting a great number of tankers from overseas. Other innovations included liquid argon and nitrogen tankers being adapted to transport oxygen, and the railways innovated by introducing special Oxygen Express trains¹¹⁹. Provision of medical oxygen was sped up by the government, along with the purchase and distribution of oxygen concentrators. Through the PM Cares Fund, the central government funded the setting up of 1,222 PSA plants, which generate 1,750 metric tonnes of captive

oxygen every day¹²⁰. In addition, a large number of plants have been established in states, as a result of government initiatives and business support.

The COVID-19 has had significant negative health and economic effects on India, with considerable regional variations. The strain on state healthcare facilities was all the more prominent with many of the migrant labour force from cities returning to their homes in villages and rural areas of north Indian states such as Uttar Pradesh, Rajasthan and Haryana; Orissa, Bihar, Jharkhand and to a certain extent West Bengal and Assam in eastern India¹²¹. A majority of the labour force, who returned in trying conditions of travel as a result of the national lockdown, were engaged in the development of cities and contributed to the informal sectors of economic activity in cities in more developed states in the west and south including Maharashtra, Gujarat, Karnataka, Kerala, Telangana, Andhra Pradesh and Tamil Nadu. Without a safety net, the situation led to severe economic implications including lack of livelihoods and decrease in income for migrant workers.

According to a state-level empirical study, social distancing and confinement strategies significantly decreased the number of cases, albeit at a significant financial expense¹²². The necessity of sufficient social expenditures, a well-developed health care system, and social safety nets were highlighted by the fact that state characteristics, such as the proportion of services in the economy and the health care infrastructure, have a significant impact on the economic and health results.

State responses and 'securitising' of health

Securitising health in states across India was in conformance with regulatory orders from the centre. The EDA 1897¹²³ and the DMA 2005¹²⁴ were used to implement the comprehensive lockdown in India. The former gives the state the authority to take action to ensure public safety and prevent the development of any deadly epidemic illness. It was originally passed during the colonial era in Bombay, in what was then British India, to combat the bubonic plague¹²⁵. The latter, which is more recent,

requires the state to establish a three-tier catastrophe management authority at the national, state, and district levels in order to create a comprehensive strategy to reduce hazards, prioritise preparedness, and increase capacity in the event of a catastrophe.

To mitigate the spread of the novel Corona virus and deaths in its wake, state authorities had instituted measures that severely affected citizens' freedoms, starting with restricting their freedom of movement. Restrictions on movement except for emergency purposes put most people under various socio-economic and psychological pressures during the 68-day national lockdown between March 25 and May 31, 2020¹²⁶. Multiple states continued to keep partial lockdowns in areas with an increased prevalence of positive cases during different waves of the pandemic in India.

In fact, India was not the only country from the Global South that used harsh measures against people's critical responses to COVID-management. Similar procedures had been utilised in Kenya, South Africa, Philippines and many other countries¹²⁷. The government's responses to the critical views on COVID-management raised several questions on ethical and normative values associated with India's public policy management (which the country followed over a period of time). In the second wave of securitisation measures, journalists and other activists were targeted for uncovering data errors in the government's figures on the number of infections and deaths¹²⁸. As it turned out, the pandemic presented the state with an easy justification to interfere with democratic processes with minimal resistance; a state of exception in demanding such actions, ostensibly for the benefit of people.

The DMA 2005, enacted by the Indian government, was crafted with considerations that align with guidelines and advisories issued by the WHO. The act aims to provide a comprehensive framework for disaster preparedness, response, and mitigation, encompassing various types of emergencies, including public health crises like pandemics. In this regard, the DMA laid out protocols and procedures for

managing disasters, including the coordination of efforts between central and state authorities, resource mobilisation, and the establishment of response mechanisms.

However, despite its alignment with WHO guidelines, the implementation of the DMA during the COVID-19 pandemic witnessed a degree of unilateral action by both central and state governments. While the DMA provided a legal framework for managing the spread of infection and maintaining public order, its execution varied across different regions of the country. Some state governments utilised the DMA to impose strict lockdowns, travel restrictions, and quarantine measures, while others adopted more lenient approaches, leading to disparities in response strategies and outcomes.

Numerous studies and commentaries have scrutinised the application of the DMA by central and state governments during the COVID-19 crisis. For example, analyses have focused on the effectiveness of lockdown measures¹²⁹, the impact on vulnerable populations¹³⁰, and the balance between public health imperatives and civil liberties¹³¹. Additionally, scholars have examined the role of DMA provisions in facilitating or hindering the pandemic response, highlighting areas for improvement in disaster preparedness and governance structures¹³². Overall, the utilisation of the DMA during the COVID-19 pandemic reflects the complex interplay between legal frameworks, public health strategies, and governance dynamics in India's response to health emergencies. Enforcing the EDA and DMA affected people's lives in multiple ways. Some of the ill effects included restriction on movement which affected people's livelihoods and their ability to earn, especially migrant workers and members of marginalised communities. Other ill effects included mandatory quarantine and stringent surveillance measures using contact tracing applications which infringed upon people's right to privacy.

6.10 Concluding Remarks

Global health security frameworks play a vital role in guiding countries' preparedness and response efforts to infectious disease threats like the COVID-19 pandemic. These frameworks, exemplified by the IHR and initiatives like the GHSA, emphasise principles such as surveillance, collaboration, and transparency to enhance collective action against health emergencies. However, the effectiveness of these frameworks relies heavily on countries' capacity to implement and adhere to the regulations, which can vary significantly due to factors like healthcare infrastructure, governance structures, and regional disparities. As demonstrated by India's experience, while adherence to global health security frameworks can bolster a nation's resilience and response capabilities, addressing systemic challenges and vulnerabilities is essential for ensuring effective preparedness and response to future health threats. Therefore, continued efforts to strengthen health systems, enhance collaboration between countries, and promote equitable access to healthcare are crucial for achieving global health security goals and mitigating the impact of infectious diseases on public health and socio-economic stability worldwide.

The discussion examined India's health security structures and responses to the COVID-19 pandemic within the context of global health security frameworks. It highlighted the influence of the IHR in guiding India's preparedness and response efforts, emphasising the importance of surveillance, collaboration, and transparency. India's adherence to the IHR principles during the pandemic, including implementing surveillance mechanisms, scaling up testing capacities, and collaborating with international partners, demonstrated the practical application of these regulations in addressing global health crises.

Despite India's efforts to align with global health security frameworks, the discussion identified several challenges and vulnerabilities in the country's health security system. Shortages of healthcare professionals, weak public health governance, environmental factors like rapid urbanisation and climate change, and fragmented governance structures hindered India's ability to mount an effective

response to the pandemic. The discussion underscored the need for investments in workforce development, multi-sectoral approaches, and strengthening institutional capacity to address these challenges and enhance India's resilience to future health threats.

Furthermore, the discussion examined the varied impact of COVID-19 on different states within India, highlighting regional disparities in healthcare infrastructure, economic impact, and social responses. It emphasised the importance of state-level interventions, social expenditures, and well-developed healthcare systems in mitigating the spread of the virus and addressing the socio-economic implications. Additionally, it scrutinised the implementation of regulatory orders like the EDA 1897 and the DMA 2005, raising ethical and normative questions about the government's responses to the pandemic and the balance between public health imperatives and civil liberties. Overall, the discussion provided an analysis of India's health security structures and responses to the COVID-19 pandemic, offering insights into strengths, weaknesses, and areas for improvement in the country's approach to global health security.

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CHAPTER 7

CONCLUSION

The study explored the evolving role of health within the realm of International Relations (IR), with a specific focus on changes in how issues of health are analysed, particularly in the Indian context since the 1990s. It examined the transition of health from an individual concern to a global issue influenced by state and non-state actors in an interconnected world under deepening processes of globalisation. The study examined how states, particularly those from the Global South like India, have adapted their health policies in response to increased economic globalisation post-Cold War (since 1990s). It examined the shifting dynamics of state involvement in health policy implementation at the national level, considering the impact of global interdependence on policymaking. The analysis highlighted the influence of external ideas and institutions on national health policies, underscoring the interconnectedness of global governance and policymaking in shaping health outcomes.

This study posed two central research questions. They included: (1) How do political, social, economic and historical factors shape global health governance and its dynamics in the contemporary era characterised by globalisation, a plurality of actors, and the presence of diverse institutions and processes?, and (2) How do such factors affect the way policy decisions related to health are made and implemented in countries in the Global South, with particular reference to India in the post 1990s? The study had a few pertinent objectives. They included: to study the evolution of global health governance in relation to major milestones in the area of health at the global level; to examine the nature and preponderance of multilateral institutions which includes philanthrocapitalist initiatives within global health governance; to understand the processes of agenda setting in global health governance including ideas, institutions and interests; to analyse how the nuanced connections between the private sector/market and policy makers affects health and health governance in the

countries of the Global South such as India; and to understand the nature and involvement of global institutions in the securitisation of health in the context of new pandemics such as COVID-19.

The study adopted a theoretical framework - liberal institutionalism to analyse the evolving dynamics of global health governance. Liberal institutionalism, derived from liberal political theory, argues that international cooperation and governance are best facilitated through the establishment of formal institutions, rules, and norms. In the context of global health, this perspective underscores the significance of institutions such as international organisations like the World Health Organisation (WHO) and its specific legal and regulatory frameworks such as declarations like the Alma-Ata Declaration 1978, and agreements like the International Health Regulations (IHR) in shaping health policies and responses to global health challenges. Through a liberal institutionalist perspective, it was revealed that while multilateral organisations such as the WHO play a central role, the governance landscape is characterised by the involvement of diverse actors, including non-state entities like the Bill and Melinda Gates Foundation (BMGF), the Global Vaccine Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). By applying liberal institutionalism, this study aimed to explore how the formal and informal structures influence the behaviour of both state and non-state actors, shape decision-making processes, and ultimately affect the effectiveness of global health governance in addressing critical health issues since the 1990s.

The study consists of seven chapters. Chapter 1 provided an overarching context for the research and examined the topic under investigation. Chapter 2 established the theoretical framework for the study, focusing on the politics of global health governance from a liberal institutionalist perspective. Chapter 3 offered an overview of the historical developments leading to the emergence of global health governance and analysed how certain discourses have been privileged within the discipline over time. Chapter 4 explored the nature of negotiations and shifts in the

politics of global health agenda setting, including the roles of key actors and their influence over the allocation of resources to address global health challenges. Chapter 5 evaluated India's health system since the 1990s, tracing the evolution of its health policies, financing, and health sector reforms stemming from the country's economic reforms beginning in the early 1990s. Chapter 6 discussed the development of global health security structures, particularly the IHR, and examined the securitisation of the COVID-19 pandemic in India. Finally, Chapter 7 presents the summary of the main findings.

The study employed a methodology that draws on a range of primary and secondary sources. Empirical evidence was gathered using both analytical and empirical approaches, which encompass qualitative and quantitative research methods. Qualitative data was obtained through documentary analysis and informed discussions with key public health experts, while quantitative data was sourced from statistical reports, surveys, and databases. Primary sources included intergovernmental documents from the WHO, government documents from the Ministry of Health and Family Welfare, Government of India, and policy documents from NITI Aayog, providing insights into national health policies, strategies, and initiatives. Technical reports and official records from multilateral organisations, government agencies, and non-state actors also contributed to the dataset, offering nuanced perspectives on global health governance dynamics. Additionally, secondary data sources such as books, academic articles and news reports available in the public domain through various media outlets were analysed. A key aspect of the methodology involves conducting a detailed case study analysis of the Indian health system.

Chapter 1 of the study laid down the background to the study including the research questions, as well as the research objectives that shaped this study viz. – to investigate the prevalence of philanthrocapitalist initiatives in global health governance, assess the prevalence of top-down donor-driven projects measuring

impact through biomedical and clinical solutions, and analyse the influence of connections between large business conglomerates and policymakers on health governance in the Global South, especially India.

The study (Chapter 2) further discussed the liberal institutionalist view of global health governance which emphasises the importance of international institutions and cooperation in addressing global health challenges. Theoretical framework of the study, liberal institutionalism, highlighted the role of norms, rules and cooperative interactions among states, intergovernmental organisations and non-state actors in promoting effective and equitable health governance. The two strands that shape perspectives on global health within the liberal institutionalist framework – viz. statist vs globalist interpretations of issues of health investigated how these approaches facilitate or constrain certain health policy actions. The statist approach prioritises the involvement of individual states in tackling health challenges, advocating for national sovereignty in dictating health policies and interventions. Conversely, the globalist approach highlights the significance of international collaboration and the role of global institutions and governance frameworks in addressing health concerns that extend beyond national boundaries. In this study, the globalist perspective on health, as viewed through the lens of liberal institutionalism, was favoured due to the interconnected nature of modern health challenges. Nevertheless, the study highlighted the imperative for a nuanced examination and assessment of power structures and vested interests within liberal institutionalist framework, aiming to enhance fairness and just health outcomes for every individual.

Historical factors, such as colonial legacies, global inequalities and the legacy of past health crises, also influence the current landscape of global health governance. These as well as other historical aspects such as the 19th Century International Sanitary Conferences to deal with human disease epidemics and the development of the WHO in the post-World War II era were reviewed in Chapter 3. The chapter argued that public health concerns shifted from one of a horizontal approach advocating primary

healthcare for all at the Alma Ata Conference 1978 to that of a vertical approach in tackling individual types of diseases such as malaria, tuberculosis, HIV/AIDS, etc. during the post-Cold War period starting in the late 1980s.

Through an analysis of existing literature, policy documents, and empirical data, this study shed light on critical aspects of the politics of global health governance and agenda setting. The arguments, as elaborated in Chapter 4, reveal that philanthrocapitalist initiatives have become increasingly prevalent in shaping global health governance, with influential actors from the private sector blending philanthropy and capitalism to influence health policies and interventions. The study further argued that such a phenomenon has raised concerns regarding accountability, transparency and the influence of corporate interests on global health agendas. Furthermore, the chapter highlighted the dominance of top-down global donor-driven projects that prioritise approaches which centre on biomedical and clinical interventions. While these approaches have delivered measurable outcomes in certain contexts, their limitations and potential unintended consequences should be carefully considered. The chapter put forth the view that there is a need to balance the evidence-based approach with a comprehensive understanding of local contexts, social determinants of health (SDH) and the involvement of civil society actors in building sustainable and inclusive health systems. In addition, the chapter examined the role of multilateralism in the Global South through the issue of multi-bi financing – i.e. financial contributions directed to multilateral organisations for a designated purpose, sector, region, or country, including allocations to trust funds and collaborative programmes. As the study pointed, multi-bi aid – donor contributions, mainly from philanthrocapitalist organisations (such as BMGF) and private bodies, to multilateral organisations earmarked for specific purposes – has increasingly become an important channel for financing health development. The Organisation for Economic Co-operation and Development's Development Assistance Committee noted in its 2010 report on multilateral aid that approximately 40% of multilateral funds are allocated

through multi-bi aid. However, multi-bi aid presents challenges for countries in the Global South including adhering to certain conditional requirements to avail funding, fragmentation of the aid and higher transaction costs. The chapter argued that certain reforms with the aid arrangements especially aligning interests of the recipient countries national health policies, can help multi-bi assistance become more effective and efficient while also appearing more legitimate to recipients, especially countries in the Global South.

Chapter 5 examined the evolution of India's healthcare system since the 1990s, highlighting a multifaceted journey shaped by health financing, policy evolution and the burgeoning medical tourism industry. It outlined the significant role played by the privatisation of healthcare financing, increased reliance on the private sector, and the implementation of health insurance schemes like Ayushman Bharat. The important role of the private sector is seen in the fact that private sector providers control over 70% of the hospital market share as of 2020. These changes presented both opportunities and challenges, with issues of equity, accessibility and affordability remaining central to the discourse. Despite efforts to enhance public health infrastructure and decentralise healthcare delivery, persistent disparities in healthcare access underscored the need for more inclusive and sustainable reform. Furthermore, the impact of globalisation on India's healthcare system was explored through the emergence of the medical tourism industry, which attracted patients from around the world, driving economic growth and fostering innovation in healthcare services. However, questions arose regarding resource distribution and the prioritisation of medical care for foreign patients over national needs for health care. In summary, the chapter emphasised the ongoing quest for quality healthcare in India, calling for a delicate balance between harnessing the potential of the private sector, ensuring equitable access and strengthening public health systems. While acknowledging the progress made in healthcare reforms, it underscored the need for more inclusive and sustainable approaches to address persistent disparities in access and quality of care.

The narrative reflected a dynamic landscape where domestic and global forces intersected, shaping the trajectory of India's healthcare system in the 21st Century.

Against this setting, the study focussed on through the discussion in Chapter 6 on the COVID-19 pandemic within the context of global health security structures. The study specifically pointed out the role of international organisations such as the WHO and the Centers for Disease Control and Prevention (CDC) from states like the US in coordinating responses to public health emergencies. It underscored the importance of collaboration among nations to address emerging infectious diseases and pandemics. Liberal institutionalism's strengths and limitations were examined, revealing both successes, such as the WHO's coordination efforts, and challenges, including politicisation and slow adaptation to evolving health threats. Furthermore, the chapter explored India's experience with the COVID-19 pandemic, exposing pre-existing vulnerabilities in its healthcare infrastructure and governance mechanisms. The study highlighted the issues such as disparities in access to healthcare, misinformation and logistical challenges in vaccine distribution in the management of the pandemic. The securitisation measures employed by the Government of India, including lockdowns and regulatory actions, were analysed, shedding light on their impact on certain political values, for instance free movement, access to livelihoods, etc. and impact on marginalised communities during the crisis. The chapter emphasised the need for a comprehensive and integrated approach to global health security. It called for strengthening healthcare infrastructure, enhancing public health surveillance, addressing socio-economic disparities and improving governance capacity. The pandemic served as a warning for greater collaboration, investment and multi-stakeholder engagement to build resilient health systems and mitigate the impact of future health emergencies on a global scale.

This research sought to contribute in a modest fashion to the growing body of literature on global health governance through empirical analysis coupled with the use of the theoretical framework of liberal institutionalism. The research findings offer

certain insights across theoretical, empirical, and policy domains. Firstly, by adopting a liberal institutionalist framework, it offered an analytical perspective that elucidates the role of institutions, norms and actors in shaping global health policies and outcomes. Secondly, through its empirical analysis and case studies, it provided insights into the dynamics of multilateralism, agenda setting and policy implementation in the realm of global health. Additionally, by focusing on India's healthcare trajectory and the COVID-19 pandemic, the study threw light on the diverse challenges and opportunities inherent in global health governance.

The study suggests that since the 1990s, global health governance has witnessed a complex interplay of influence and cooperation among both state and non-state actors. Moreover, the Indian healthcare system has experienced significant influence from multilateral institutions, as well as national governance and policies that have facilitated the entry of private entities into the healthcare sector. Consequently, the privatisation of healthcare in India has led to greater accessibility for the affluent section than the lower strata of the society, diverging from the principles of equity and inclusivity, core values advocated by the liberal institutionalist/globalist approach. Furthermore, these developments present challenges concerning equity, accessibility, and affordability in healthcare delivery.

Global health governance through international institutions and private actors like philanthrocapitalist organisations significantly influences the health sector in India across multiple dimensions. These actors allocate significant amount of resources, shape policies, and provide technical assistance, impacting the focus areas of health interventions, policy priorities, and capacity-building efforts. Their influence extends to innovation, technology transfer, and the promotion of public-private partnerships (PPPs), which can enhance healthcare delivery and outcomes. However, their involvement also raises concerns about accountability, transparency, and the potential prioritisation of profit motives over public health objectives. In fact, the balance between the contributions of philanthrocapitalist organisations and national

health priorities is critical for ensuring equitable health outcomes and addressing disparities within the country.

The impact of global health governance through international institutions and private actors like philanthrocapitalist organisations can be viewed through the framework of liberal institutionalism, which emphasises the role of formal institutions, rules, and norms in promoting international cooperation and governance. Within this framework, these actors contribute to the establishment and functioning of global health institutions and agreements. They contribute to shaping the criteria and regulations that govern global health, impacting policy determinations and the distribution of resources. Furthermore, liberal institutionalism also highlights the importance of transparency, accountability, and collective action, which are essential for effective global health governance. However, it also raises questions about power dynamics and the potential for unequal influence among different actors – international organisations, corporate entities, national governments, as well as concerns about the extent to which these institutions truly serve the interests of all member states, particularly those in the Global South like India. Thus, while liberal institutionalism provides a framework for understanding the mechanisms through which global health governance operates, it also highlights the need for critical analysis of the distribution of power and resources within these institutions and the implications for health outcomes.

Based on the conclusions stated above, one can infer that future studies may be required to examine the role of the Global South in shaping global health agendas. Additionally, such studies positioned within IR, may investigate the impact of private sector engagement on health outcomes and the effectiveness of international organisations and their processes, such as health financing mechanisms and policy interventions in countries like India, in achieving equitable health outcomes.

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Annexures

1. WHO – Country Cooperation Strategy at a Glance: India. World Health Organisation (2018). Retrieved on April 17, 2024, from <https://www.who.int/publications/i/item/WHO-CCU-18.02-India>

India



<http://www.who.int/countries/en/>

(Disclaimer: This map is an approximation of actual country borders. The boundaries and names shown on this map do not imply official endorsement or acceptance by the World Health Organization)

Key indicators: India	
WHO region	South-East Asia
Child health	
Infants exclusively breastfed for the first six months of life (%) (2013)	64.9
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	88
Demographic and socioeconomic statistics	
Poverty headcount ratio at \$1.25 a day (PPP) (% of population) (2010)	32.7
Gender inequality index rank (2014)	130
Human development index rank (2014)	130
Health financing	
Total expenditure on health as a percentage of gross domestic product (2014)	4.69 (India note)
Private expenditure on health as a percentage of total expenditure on health (2014)	69.96 (India note)
General government expenditure on health as a percentage of total government expenditure (2014)	5.05 (India note)
Health systems	
Physicians density (per 1000 population) (2014)	0.725
Nursing and midwifery personnel density (per 1000 population) (2013)	2.049
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2016)	25.4 [22.6-28.4]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016)	43.0 [38.8-47.3]
Maternal mortality ratio (per 100 000 live births) (2015)	174 [139 - 217]
Sustainable development goals	
Life expectancy at birth (years) (2015)	69.9 (Female)
	66.9 (Male)
	68.3 (Both sexes)
Births attended by skilled health personnel (%) (2013)	81.1
World Health Statistics	
Population (in thousands) total (2015)	1.30E+06
Population proportion under 15 (%) (2015)	28.8
Population proportion over 60 (%) (2015)	8.9

Sources of data:
Global Health Observatory May 2017
<http://apps.who.int/gho/data/node.cco>

HEALTH SITUATION

- Polio has been eliminated. Yaws, guinea worm and maternal and neonatal tetanus have been eliminated. Leprosy stands eliminated at the national level and the country is rapidly moving ahead to eliminate kala-azar, lymphatic filariasis, leprosy and malaria.
- India has a high burden of communicable, including NTDs, maternal and neonatal conditions and a rising burden of NCDs, mental health and injuries.
- Premature mortality from NCDs accounts for 57% of total mortality among 30-69 years old.
- While India recorded an impressive 70% reduction in maternal deaths and 66% reduction in deaths of children under-five years of age between 1990 and 2015, the maternal mortality ratio (MMR) of 167 and infant mortality rate (IMR) of 43 is still high.
- Immunization coverage in 2015 was 62% among 12-23 months old, (NFHS-4). Coverage rates have improved in 2016 and are further improving with Intensified Mission Indradanush, which aims to reach 90% by end of 2018.
- Revised TB incidence from 2.2 to 2.8 million/year and TB mortality from 220 000 to 480 000 per year indicate that India has 27% of global TB burden and 34% of TB mortality.
- India has the third highest malaria burden in the world with 1.16 million cases in 2015.
- Wide health inequity exists within and among states. For example, MMR in Kerala was 61 compared to 300 in Assam (2013), and girls in India have higher prevalence of undernourishment than boys.
- The country has a high proportion of sex selective abortion. In 2016, India ranked 125th in gender equality, with a Gender Equality Index of 0.530

HEALTH POLICIES AND SYSTEMS

- India is a fast growing economy. GDP doubled between 2000 to 2014 with a projected growth of over 7% for this fiscal year.
- Rural population is 67% (2015), urbanization is fast increasing with 2.4% annual growth.
- A 'demographic dividend' of 65% of under 35 years is challenged by a growing population of elderly – 8% of total population.
- India has made great progress in health. It became polio free in 2014, eliminated guinea worm (2000), yaws and maternal and neonatal tetanus in 2016. Life expectancy is now 68 years; it was 33 in 1947
- Government expenditure on health is around 1% of GDP. This has resulted in:
 - Inadequate financial protection in health and high out of pocket (OOP) - more than 62% of spending on health by Indians represents OOP and around 60 million people are pushed into poverty due to OOP.
 - Relative low health outcomes with high burden of communicable diseases, including neglected tropical diseases, TB and a high risk of premature death due to NCDs.
 - Weak public health system and sub-optimal capacities in surveillance and infection control.
- Inequity in socioeconomic dimensions is a challenge to India's development.
- Air pollution is a rising concern.
- Health is now higher on the political agenda.
- India has become the "pharmacy of the world", contributing to access to good quality and affordable medical products for India itself and beyond its borders. It is consistent with the PM initiative "Make in India".
- The National Health Policy 2017, approved by Cabinet and Prime Minister, aims for health expenditure by government to 2.5% by 2025 and achieve universal access to good quality health care services.
- Union Budget 2018-19 brought health centre-stage. The Ayushman* Bharat programme, a landmark initiative, has two components (1) the National Health Protection Scheme, providing financial protection to 0.5 billion and (2) Health & Wellness Centres, which brings health services closer to people

COOPERATION FOR HEALTH

- A multisectoral approach is key to effective CCS implementation. As the lead UN agency for health, one of WHO's important role is to lead collaborations and partnerships with a range of health and non-health partners to maximize synergies and ensure health goals are at the forefront.
- WHO works closely with UN agencies within and outside the country such as UNAIDS, UNICEF, United Nations Development Programme, and United Nations Population Fund.
- WHO will use its convening power to promote the coordination of partners with the Government
- WHO will actively seek new partnerships to leverage the health agenda and will work with civil society to ensure public participation.
- WHO will continue to support the government on the health agenda and effectively build partnerships with other UN agencies, educational and research institutes, WHO CC and the private sector

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2018–2021)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Advance UHC and SDGs agenda through improved health service delivery, financial protection, population coverage	1. Strengthen initiatives to equitably improve social and economic access to health services 2. Enhance equitable coverage of person centric services through public and private systems 3. Strengthen governance and regulation, human resources for health, essential drugs and other medical products, health information systems
STRATEGIC PRIORITY 2: Respond to the challenge of NCDs, including mental health and road traffic injuries, and mitigate health impacts of environmental risks	1. Promote multi-sectoral approach to prevent risk factors of NCDs and road traffic injuries 2. Strengthen quality of service delivery for NCDs, mental health and related comorbidities at primary care level 3. Strengthen evidence generation, institutional framework and capacity building to mitigate the health impacts of air pollution, unsafe water and sanitation and climate change
STRATEGIC PRIORITY 3: End epidemics of key communicable diseases and accelerate reduction of maternal and newborn deaths improve health of women and children and end epidemics of key communicable diseases	1. Accelerate actions for ending epidemics of NTDs, TB, AIDS, malaria and combating hepatitis, water-borne and other communicable and vaccine preventable diseases with enhanced disease surveillance system and response plans 2. Implement polio end game strategies and successfully transition to National Public Health Surveillance Project to address public health agenda 3. Promote maternal, newborn, child and adolescent health through quality facility and community care
STRATEGIC PRIORITY 4: Enhance systems strengthening to address global health security threats	1. Implement and monitor IHR (2005) and strengthen disease surveillance to prevent, detect and respond to emerging public health threats 2. Scale-up capacity for disaster risk reduction, and health emergency preparedness and response 3. Prevent and control AMR through surveillance, anti-microbial stewardship, and infection prevention and control
STRATEGIC PRIORITY 5: Advance India's leadership in health globally, by leveraging its strengths in medical products, health technologies and services	1. Strengthen country regulatory capacity and quality assurance in pharmaceuticals, vaccines, medical devices, diagnostics and laboratories 2. Advance bilateral and multilateral cooperation including South-South cooperation and other collaborations for promoting access to medical product 3. Promote research and innovation in health and share best practices.

Annexures

2. Government of India: Approach on WHO Reforms. Ministry of Health & Family Welfare. Government of India. (2020). Retrieved on April 17, 2024, from <https://main.mohfw.gov.in/?q=newshighlights-29>



Government of India

Approach on WHO Reforms

Health Emergencies and public health threats, particularly those at the level of epidemics and pandemics, have become a global challenge requiring a coordinated and prompt global response. It is important to ensure that the global health governance and support structures with the WHO at its core are robust and suited to deal with such emerging challenges as COVID 19 pandemic. The COVID Pandemic is not only an unprecedented challenge confronting the world with its socio-economic impact beyond the health sector but also a historic opportunity to build a new global partnership with reformed and effective multilateralism.

- 1. Strengthening the Public Health Emergency of International Concern (PHEIC) declaration process:** Currently the decision making is primarily on the recommendation of International Health Regulations (IHR) Emergency Committee.

Recommendation: It is important to devise objective criteria with clear parameters for declaring PHEIC. It should also be possible for DG WHO to declare a PHEIC if in his/her assessment there is a broad agreement, though not a consensus, within the IHR Emergency Committee and not to wait for a consensus to emerge. The emphasis must be on transparency and promptness in the declaration process.

- 2. Funding:** Most of the financing for Programmatic Activities of the WHO comes from extra budgetary contributions, which though voluntary in nature, are normally earmarked. The WHO enjoys very little flexibility in use of these funds. Assessed contributions comprise less than one-fifth of the WHO's Budget. Even the Health Emergencies Programme is not fully funded from the regular budget. There are also many important non-Governmental organisations in global health architecture, with budgets significantly larger than that of the WHO, such as Global Fund, UNAIDS, GAVI and UNITAID.

Recommendation: There is a need to ensure that extra budgetary or voluntary contributions are unearmarked to ensure that the WHO has necessary flexibility for its usage in areas where they are required the most. There is also a need to look at increasing the regular budget of the WHO so that most of the core activities of the WHO are financed from it, without putting an overwhelming financial burden on developing countries.

3. Ensuring transparency of funding mechanism and accountability framework:

Presently, only broad-based priorities are discussed with member states and in respect of selection of activities, their expenditure and concurrent monitoring, there is no regular and institutional mechanism involving the member states. There is no collaborative mechanism wherein the actual projects and activities are decided in consultation with member states, there is no review with respect to value for money and whether projects are being done as per the member states priorities or if there are abnormal delays. Without the same, the technical assistance to member states primarily is neither transparent nor adding the required value to the member states.

There is an urgent need for effective involvement of Member States in discussions on budget implementation and spending. This is imperative to strengthen efforts towards enhancing cost efficiencies and value for money proposition.

Recommendation: Establishing strong and robust financial accountability frameworks will enable maintaining integrity in financial flows. It is also crucial to establish significant amount of transparency with respect to data reporting and disbursement of funds for increased accountability. It is also important to strengthen the effectiveness, and efficiency of various funding mechanisms e.g. WHO Solidarity Response Fund, WHO Foundation and Strategic Preparedness and Response Plan (SPRP). There is no framework or mechanism to ensure that the details on funding & financing are disclosed at a micro level which is a crucial element. There should be a quarterly review of ongoing WHO activities in the country by Member States with the WHO Country Office so as to align expenditure by WHO in consonance with country priorities.

4. Enhancement of the response capacities of the WHO and Member States:

Implementation of the IHR 2005 has highlighted critical gaps in the basic health infrastructure of member States. This has become more evident in their dealing with COVID 19 pandemic.

Recommendation: It is important that the programmatic activities carried out by the WHO, under its General Programme of Work, should focus on building and strengthening capacities in member states as required under IHR 2005, which are found lacking or deficient on the basis of the self-reporting on IHR 2005 done by the Member States. WHO may support creation of IHR technical and core competencies in each country so as to facilitate broad uniformity in country responses.

- 5. Improvement of the WHO's governance structure:** The two policy making organs of the WHO i.e. the World Health Assembly and the Executive Board are currently playing a peripheral role. (This is more pronounced in case of the Executive Board). Being a technical Organisation, most of the work in WHO is done in Technical Committees composed of independent experts. Moreover, in light of the growing risks associated with emergence of disease outbreaks the role of the Independent Oversight and Advisory Committee (IOAC), responsible for the performance of the WHO Health Emergencies Programme (WHE), becomes extremely crucial. It is necessary for this oversight mechanism to be strengthened and the inputs of Member States to be integrated. These inputs need not only be taken during EB or WHA but there should be a mechanism for concurrent and regular coordination of IOAC with member states.

Recommendation: It is important that the member States have a greater say in the functioning of the WHO, given that it is the States which are responsible for implementation on ground of the technical advice and recommendations coming from the WHO. There is a need to devise specific mechanisms like a Standing Committee of the Executive Board to ensure effective supervision by member States. There is also a need to including look at the functioning and composition of various technical committees to make them more effective and responsive to the priorities and recommendations of the Member States.

The Pandemic laid bare various gaps in the preparedness of healthcare systems across the globe, which could have been reviewed & strengthened in a timely manner. Thus, there is a need to facilitate and strengthen the role and functioning of bodies such as the Independent Oversight and Advisory Committee (IOAC), which is a legitimate oversight body for the WHE programme. Additionally, there is a need of effective representation of the developing nations and the high disease burden countries on different decision-making processes in WHO's Technical Committees. WHO should also consider actively leveraging the support of experts, academicians and policy makers from the high disease burden nations in the decision making and policy formulation processes.

A proper review of the format & functioning of Executive Board & World Health Assembly should also to be taken up for them to be an effective engagement tools with the Member States instead of the present set up where in the format of Executive Board & World Health Assembly are repetitive. There must be an accountability mechanism to indicate what follow up action on the interventions of member states in EB and WHA has been initiated by WHO Head Quarter, Regional Office and Country Office.

- 6. Improvement in IHR Implementation:** The Member States have a self-reporting obligation under IHR 2005. However, review of IHR implementation is voluntary. It has been proposed by some States that peer review of the IHR implementation should be made mandatory, like the review of the human rights through the UPR mechanism through an intergovernmental peer review process. It has also been proposed that the WHO should be given necessary tools to ensure compliance with the IHR.

Recommendation: The public health infrastructure in developing countries is still being developed and many of them do not have the necessary means to ensure the IHR's full implementation. Therefore, the review of the IHR implementation should continue to be on a voluntary basis. The current COVID 19 crises has shown that the public health systems, even in the developed countries, were unable to cope up with the COVID 19 surge, It is therefore critical to accord priority to enhance international cooperation, which should be directed at providing assistance to developing countries in areas which they have been identified as lacking the necessary capacity to implement the IHR. It is important that public health is considered a global good.

In light of the Pandemic and the circumstances preceding it, IHR should have a robust mechanism to assess risks early and initiate subsequent steps. This principle should also be incorporated on a regional level where there needs to be an effective system facilitating regional declaration of health emergencies. This is imperative for effectively mitigating the risks of any health emergency transforming into a pandemic in the future.

Also, for the process of expediting the initial response to be more effective, a paradigm needs to be created where the Member States of WHO should be encouraged to notify the WHO of significant information including pathogen samples in the early stages of an outbreak.

7. **Access to therapeutics, vaccines and diagnostics:** It has been felt that the TRIPS flexibilities provided for public health, under Doha Declaration, may not be sufficient to deal with crises such as COVID 19 pandemic. There have been instances of restrictions on trade in public health goods in the initial phase of COVID 19. Also, as a reflection of vaccine nationalism, some developed countries have been signing bilateral agreements with vaccine manufacturers, leaving very little space for developing countries to get fair, affordable and equitable access to the same. India and South Africa have moved a proposal at the WTO for a COVID 19 specific waiver of some of the provisions of TRIPS Agreement. Lack of awareness of TRIPS flexibilities and an enabling national mechanism has made it difficult for the developing countries to benefit from these provisions.

Recommendation: It is important to ensure fair, affordable, and equitable access to all tools for combating COVID 19 pandemic and, therefore, the need to build a framework for their allocation. The WHO is working in this direction and its work should be supported. The tools for COVID 19 pandemic such as vaccines are a global public good and TRIPS waiver as proposed by India and South Africa would go a long way in effective international and national response to COVID 19 pandemic. It is also important to develop a global framework or specialised protocols for benefit sharing for non-influenza pandemics on the lines of PIP Framework consistent with the objectives of the CBD and its Nagoya Protocol.

- 8. Creation of Global Framework for Management of Infectious Diseases & Pandemics:** There is a need to create a monitoring mechanism and support to member states on International Health Regulations, preparedness of infrastructure, human resources and relevant health systems capacities such as testing and surveillance systems.

Recommendation: Enhancement of capacities of countries in preparation for and response to infectious diseases of pandemic potential, including guidance on effective public health and economic measures for health emergencies by leveraging a multidisciplinary approach which includes social science alongside health and natural sciences. There is an integral need to establish a system facilitating **pan world surveillance** by leveraging innovating ICT tools.

- 9. Role of Hosted Partnerships in pandemic management:** The risks imposed on humankind, by new influenza viruses causing more disease outbreaks are very real. There is an urgent need for the global community to address this issue by making bold efforts and ensuring vigilance and preparedness in our healthcare systems. The current Pandemic management systems may be proving to be insufficient in enabling agile and robust responses with respect to protecting global citizens against disease outbreaks.

Recommendation: The primary objective should be to improve capacity for global pandemic prevention, preparedness, and response, and strengthening our ability to fight back any such pandemic in future. For undertaking required agile and prompt action besides the existing Department or Division approach there is a need for initiating Hosted Partnerships on this key agenda of Pandemic Management. WHO can leverage the support of academia, technical experts and most importantly Member States in terms of policies, advocacy & implementation.

Any pandemic management requires effective data driven insights and hence need to integrate digital health agenda also as a priority area along with pandemic management. It is therefore proposed to have two hosted partnerships – one for Pandemic Management & other for Digital Health under the aegis of WHO.

Climate Change and Global Health Governance in Relation to the Global South and the Global North

*Vivek Nenmini Dileep**

Abstract

This essay attempts to piece together the main trajectories of climate change and global health governance starting with the historical connectedness of the idea of the global. While the Global South and the Global North constitute key concepts in the approach to global governance of key issues such as climate change and health governance, this essay attempts to locate the historical course undertaken by both concepts within the context of colonialism and postcolonialism in the unequal exchanges between these geopolitical entities. The essay argues that the hegemonic relationship between the Global North and South is traceable to colonialism and its epistemic vestiges (manifest, for instance, through state laws and concerns of security) that have an adverse impact on the countries of the Global South where health and climate change governance is concerned. The essay suggests that the majority of the socioeconomic issues currently plaguing the Global South can be attributed to colonialism and imperialism, which were supported in many parts of the world in the 19th and 20th centuries, as well as to the neocolonial and commercial strategies of extractive and exploitative capitalism of the 21st century. The costs of these changes must be considered in the context of a long-standing theme of the Global North's exploitation of the environment and the people of the Global South, particularly in terms of heritage loss, loss of biodiversity, extreme weather conditions, and even health emergencies like the COVID-19 pandemic. The essay concludes by advocating for a greater inclusion of the Global South in the governance of climate change through hybrid institutional complexes (HICs) in governing the global commons.

Keywords: Climate Change – Colonialism – Global Health Governance – Politics of Global Health.

CONTENTS: 1. Introduction. 2. Overview of Literature. 3. Global North/South, Legacies of Colonialism and the Politics of Climate Change. 4. State and Security in the Global South. 5. Conclusion.

* PhD Candidate at the Department of Political Science, University of Hyderabad. The author wishes to thank the editorial team at NAD and two anonymous referees for their helpful suggestions on the essay. The essay was submitted to double blind peer-review. Member of the Editorial Team who oversaw the essay: Laura Corti.

1. Introduction

In November 2021, in a mid-term evaluation for an introductory course on “Fundamentals of Political Science” that I teach to undergraduate students of law, one of the questions I had posed was the following: explain the heavy “luggage” carried by the Global South in the context of a cartoon by Rohan Chakravarty in his comic-strip *Green Humour*¹. The Global South, represented by a dark-skinned lady in a traditional flowery *gomesi* (full length colorful garment worn by women in sub-Saharan Africa), is shown carrying a huge rucksack with the words “climate change, droughts, floods, livelihood loss, social injustices, heritage loss and biodiversity loss” emblazoned on it. As she awaits at the entrance for delegates, she is accosted by the Global North, represented by a spry white man with a light suitcase on wheels that has the words “The 1.5°C Challenge” embossed on it. He goes on to state, «Oh, I always travel light»². This cartoon appeared as part of a series by the cartoonist on the 26th United Nations Climate Change Conference of the Parties (COP26), held between October 31st and November 13th, 2021, in Glasgow, Scotland.

One of the students (of nearly half of the class who attempted the question), explained the cartoon in simple terms: «The cartoon depicts the amount of issues that we have in the world and the leaders who hardly make any effort to solve them». Another student opined that the “luggage” reflects the «problems faced by countries in the Global South due to climate and ecological factors, with these countries bearing the brunt of the problems while the Global North is singularly focused on reducing global temperatures by 1.5°C, without bearing any responsibility». Yet another student noted, «problems that are unattended to by society, problems which they carry with them, things which happened in the past». The students’ statements suggest how the adverse effects of climate change, that are becoming more evident on the socioeconomic structures and systems which regulate life on our planet, are continuing to be ignored by our political leaders. They also reflect how the Global North’s target of mitigating global warming through technocratic solutions that reduce global temperatures by 1.5°C will, in all likelihood, ignore the costs of the multi-dimensional issues the Global South faces (as is evident in the heavy luggage in the cartoon). Many of these multi-dimensional issues are broadly a result of the continuing effects of colonialism in postcolonial countries of the Global South. Along with war and violence, climate-induced migration, as a result of human insecurity, has led to 40.5 million people being internally displaced in 2020³. Further, an unending COVID-19 pandemic, increased conditions of planetary stress, escalating cases of non-communicable diseases (NCDs), and multiple other vector-borne diseases have severely strained health systems across the globe. To this effect, climate change will only exacerbate the existent inequities in health systems in a colossal manner, further compounding and altering existing socioeconomic inequalities. In this regard, the idea of reducing global temperatures by 1.5°C can only be seen as a temporary solution which aids the position of the industrialized Global North. It is my argument that the

¹ R. Chakravarty, *Green Humour*, Cartoons on COP 26, October 28th, 2021, greenhumour.com/2021/10/cartoons-on-cop-26.html.

² *Ibidem*.

³ Internal Displacement Monitoring Center (IDMC), *Global Report on Internal Displacement*, 2020, internal-displacement.org/sites/default/files/publications/documents/grid2021_idmc.pdf.

Vivek N. D. <viveknenmini@gmail.com>

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This letter confirms that **Vivek N D** attended Dublin City University's 5th Annual South Asia Conference organised by the Ireland India Institute. The conference took place virtually from April 26 - 29, 2022.

Thank you for participating and presenting your paper titled '*Rule of/by Law, COVID-19 Policy Measures and Political Implications in India*'.

We look forward to your further participation in the years to come.

Yours Sincerely,

Jivanta Schottli

Dr Jivanta Schottli

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