REVIEW ESSAY

The Global Politics of Health Security before, during, and after COVID-19

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Security and Public Health, Simon Rushton (Cambridge, U.K.: Polity, 2019), 240 pp., $64.95 cloth, $22.95 paper, $18.99 eBook.

Feminist Global Health Security, Clare Wenham (Oxford: Oxford University Press, 2021), 296 pp., $74.00 cloth, $72.99 eBook.

Globalization & Health, Jeremy Youde (Lanham, Md.: Rowman & Littlefield, 2019), 252 pp., $89.00 cloth, $34.00 paper, $32.00 eBook.

The first eighteen months of the COVID-19 pandemic felt simultaneously truncated and elongated, the time warped by the ennui of lockdowns; the devastating experiences of loss (of life, livelihoods, routines, connections, and enjoyment); and living through the many phases of the pandemic. A retrospective of the global politics of these eighteen months underlines just how much happened in that period. The negotiations over access to Wuhan for the World Health Organization (WHO) teams. The declaration of a public health emergency of international concern (PHEIC) and later of a pandemic by the WHO, and the downplaying of the risk of COVID-19 by many states despite these declarations. The increasing dread that was felt watching surveillance dashboards as case and fatality numbers increased and the red circles that represented them grew in size and spread worldwide. The stockpiling of nonperishable food and other essentials as the collective imagination of contagion and disease kicked

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in. The increased stigma and fear of the Other that led to anti-Asian racist attacks worldwide. The closings of schools, shops, and borders, stranding people far away from home. The rumors about the origin of the SARS-CoV-2 virus that causes COVID-19,[1] and the recriminations between China, the United States, and the WHO about those origins. The subsequent U.S. withdrawal from the WHO as the failure to control the virus domestically had President Donald Trump casting about for a scapegoat. The responses (or nonresponses) to the virus of leaders at opposing ends of the political spectrum. And, above all, the long-standing inequities and injustices that led to unequal burdens due to the disease, caring responsibilities, and lockdown measures—inequities that have only been further entrenched by the pandemic.

Three books written respectively by Jeremy Youde, Simon Rushton, and Clare Wenham (published in 2019, 2019, and 2021) provide insights into the politics of global health, and can help us make some sense of the processes and dynamics that shaped the unfolding of the COVID-19 pandemic and the national and international responses to it. The fact that these were all written before the onset of the pandemic tells us that much of what has unfolded is predictable and unsurprising —the result of decades (even centuries) of social, economic, and political dynamics that have shaped national and international (health) politics, governance mechanisms, global inequities, and our concepts of both "global" and "health." Yet COVID-19 has also shed light on issues that have not figured as prominently in prior analyses of global health politics but should have, such as the hierarchies of international order, race and racism, border practices, and the relationships between these issues.

I begin this review essay by outlining the key arguments of the three books before exploring what they can individually and collectively tell us about the politics we have seen unfold during the COVID-19 pandemic. In the second half of the essay, I explore aspects of the pandemic that have illuminated the politics of global health and health security that are less evident in the three books and require us to go beyond their analyses as we try to make sense of the pandemic and where we might be headed afterward.

COVID-19 and the Politics of Global Health

Jeremy Youde's *Globalization & Health* is the most expansive of the works considered here; it gives a broad-stroke—though empirically rich and detailed—overview

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of the myriad ways in which globalization shapes global health and the politics of health, and indeed how health influences globalization. Youde elucidates the manifold connections between globalization and health through chapters that respectively explore, inter alia, the eradication of smallpox, the severe acute respiratory syndrome (SARS) epidemic, key global health governance institutions (both public and private, formal and informal), transnational health activism, and the role that surveillance plays in the governance of disease outbreaks. He concludes with a discussion of three areas of connection between globalization and health that have received insufficient attention in the literature: namely, gender, the environment, and populist nationalism. Throughout, Youde argues that globalization has not only made us more susceptible to illness and disease but also, at times, made us better able to address the causes of ill health through transnational action; for example, through eradication programs such as those against smallpox, or activism around access to antiretroviral medication for people living with HIV/AIDS.

Importantly, Youde bookends his argument with the prescient warning that "[we] know that there will be disease outbreaks in the future, but we do not know where they will occur, when they will happen, or what will cause them" (p. 189). With respect to COVID-19, we have answers to two of those questions—the where and when—while the politicized debate over cause is likely to rumble on, given the Biden administration's suggestion in May 2021 that it was reopening investigations into whether the COVID-19 outbreak was caused by a laboratory leak.[2] It remains the case that for the *next* pandemic, "we will be utterly ill-equipped to present an effective response" if we do not also develop "an understanding of the dynamics of globalization" (p. 189). Youde's book helps lay the foundations for that understanding. Indeed, with this bookending, he articulates a central premise of global health security: Future disease outbreaks *will* happen, so how do we prepare for and respond to them?

The fear of outbreaks, Simon Rushton argues in the thought-provoking *Security and Public Health*, has become a central national security concern for most states; any debate over whether or not health *should* be framed as a security concern has already been pushed aside by policy-makers. He takes as his starting point that "the securitization ship has already sailed" (p. 2), as most (Western) states have firmly identified disease outbreaks as a key threat to be addressed in their security policies and agendas, and have begun implementing surveillance, detection, containment, and response mechanisms as a result. Though Rushton does identify the downsides of bringing security logics to bear on health issues, he does not

fundamentally challenge this approach, arguing that it is here to stay. What he does is probe the limits of health security and elucidate the politics of securitization and its outcomes so that "security-driven objectives can be reconciled with other important and desirable goals" (p. 3).

Rushton analyzes various disease outbreaks and the responses to them—notably, the H1N1 swine flu virus, SARS, Ebola, and the global HIV/AIDS epidemic (this last case is different than the others because it, and the disease itself, was and continues to be longer term, slower to progress, and the magnitude of its scale is much larger). He also surveys the risks (real and perceived) associated with biological research and the possibility of weaponizing bioagents. In doing so, he explores a number of issues related to securitization, including the unintended or negative consequences that result from the securitization of health; how other nonsecurity interests gain traction relative to security interests; what the trade-offs are between security and nonsecurity interests and how these trade-offs impact rights, justice, and equity; and, finally, how securitization is challenged from above, within, and below the level of the state, and how these challenges mitigate the negatives of securitization. All of this leads Rushton to identify three key questions about health security: "How much security do we feel we need from disease threats? What are we prepared to sacrifice to achieve that level of security? And, what are the conditions under which security logics prevail in guiding responses to perceived disease threats?" (p. 29).

In *Feminist Global Health Security*, Wenham examines the Zika epidemic that occurred in Latin America from 2015 to 2017 to explore some of these questions through a feminist lens. Based on extensive policy analysis and primary data collection, Wenham presents compelling evidence that the burden of the Zika epidemic was disproportionately borne by women, especially poorer women of color in the northeast of Brazil (the main country of focus). She draws on the feminist concepts of in/visibility, social and stratified reproduction, structural violence, and everyday crises to demonstrate how gender norms around work and care responsibilities left poor women especially susceptible to bites from the Aedes mosquito, which transmits the Zika virus. Moreover, while Zika typically causes a relatively mild illness, it can cause severe complications for pregnant women and their fetuses. Women who give birth to children with congenital Zika syndrome then bear additional care burdens, caring for children with birth defects like microcephaly and brain malformations. In response to the risk, governments in many Latin American countries essentially advised women to, in Wenham's words,

"clean your house and don't get pregnant" (p. 107). This advice both masked the gendered power dynamics that mean pregnancy is a decision women are not always given the choice to make *and* placed the responsibility on women to enact national health security within their own homes (yet another example of informal and unpaid labor burdens placed on women).

Wenham situates the response in Latin America in a wider context, including the backdrop of the global spectacle of the Olympics taking place in Rio de Janeiro in 2016. She argues that the response to Zika demonstrates that global health security is gender blind, which, in practice, means it is blind to the impact of gender on health policy outcomes. While global health security policy purports to be gender neutral, it fails to recognize or address the gendered implications of diseases and of disease surveillance, prevention, and response. Moreover, state-centric conceptions of security inevitably cause this blind spot since the state and policy-making within it are shaped by patriarchal power relations. Thus, global health security policy and outbreak control have failed to account for the overwhelming evidence that gender is a significant contributing factor to an individual's risk of infection in disease outbreaks, as well as to wider health inequities in access to services, burden of caring roles, and health policy-making. This leads Wenham to call for a feminist conception of global health security that shifts the referent object of security to "those most affected by global health emergencies: women" (p. 5).

Individually and collectively, these three books can tell us much about the world we now inhabit, the ways in which states have responded to COVID-19, and the effects the pandemic has had on different populations. Wenham's book is the only one to have been published since the start of the pandemic. In an epilogue chapter, she shows that many of the gendered inequities experienced during the Zika epidemic have been replicated over the course of the COVID-19 pandemic. Wenham notes how some forms of care work have been made visible and recognized through superficial gestures (like the Thursday-evening "Clap for Our Carers" applause for healthcare workers that took place in the U.K. and similar responses in many other countries), but without any accompanying material support in care systems that are undercut by austerity. In fact, social reproduction burdens have increased during the pandemic as a result of the lockdowns, and yet the domestic work and childcare burdens disproportionately fell on women. Women also experienced reduced access to sexual and reproductive health services—for example, due to disruptions in the production and provision of contraceptives—which

has entrenched the stratification of reproduction whereby "some people's reproduction is encouraged and other's stigmatized and punished" (p. 110). In addition, the everyday crises of deprivation, structural racism, and other socioeconomic determinants have made women and other vulnerable populations more susceptible to catching COVID-19 and becoming severely ill from it. One thing that *is* new, Wenham notes, is the increased public discourse around the gendered impacts of outbreaks, which acknowledges the ways in which these impacts have been manifested during the COVID-19 pandemic—this is not least *because* of the work of Wenham (my words, not hers) and other feminist academics, advocacy groups, and practitioners[3]—even if this recognition is yet to translate into meaningful policy change.

The inequities Wenham outlines have been reproduced across multiple different axes during the COVID-19 pandemic. Exposure to COVID-19 has been shaped by many things, including forms of employment, precarity, the (in)ability to work remotely, living conditions, and the material support available to those forced to self-isolate, while susceptibility to severe illness from the virus is shaped by underlying health conditions, which are in turn often socioeconomically determined.[4] As Youde points out, these socioeconomic determinants are also global in scope, as trade policies, consumerism, and environmental degradation shape our health.

Despite these obvious inequities in risk, both Wenham and Rushton note that at the heart of the global health security *narrative* is a conception of shared vulnerability to infectious diseases. Writes Wenham: "This vulnerability is framed as universal through expressions such as 'diseases know no borders' and 'global health security is only as good as its weakest link', whereas in reality the vulnerability to a highly pathogenic virus is neither universal nor global" (p. 35). Indeed, Rushton argues that the risks of diseases and the ability to access treatment for those diseases are both highly unequal among populations, and security practices intersect with these inequities to further entrench them—for example, by stigmatizing and vilifying perceived carriers of disease and by the attendant practices aimed at protecting the wider population from these carriers—while security discourses obfuscate or underplay these inequities.

Moreover, Rushton reminds us, pathogens themselves are not exogenous but rather products of human behavior, such as our interaction with nature at the local, national, and international levels. As a result, pathogen transmissions are certainly not inevitable natural occurrences despite this being a central premise

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of much health security policy-making. This false premise also leads policy-makers to neglect the global dynamics that drive the emergence and proliferation of pathogens, and instead view them as emerging from specific locations "with a strong (although often unstated) belief that the source of the risk to that [global] community emanates mainly from the global poor" (p. 137). Meanwhile, Rushton notes, "The involvement of the rich in creating the global inequalities and in driving the political and economic processes that exacerbated disease emergence are rarely if ever acknowledged in policy documents and statements" (p. 137).

These premises and assumptions, in turn, lead to health security policies that aim to contain pathogens in certain locales. At the heart of this health security regime sits an ever expanding surveillance network aimed at identifying health risks as they emerge. During COVID-19, this was brought into the public consciousness by the numerous dashboards to which our eyes were collectively glued in the first months of the pandemic as case numbers rose in various hot spots. Youde highlights through the experience of H1N1 that "surveillance is not apolitical; instead, its use and interpretation is invariably connected with larger economic, political and social issues" (p. 152). Certainly the public imagination of—and response to—COVID-19 was shaped by these methods of surveillance and representation of case numbers. Furthermore, Youde notes how disease surveillance has become a national security issue and become linked to other domestic and international policy areas, expanding the ways in which abuses of surveillance can occur.

Once an outbreak has begun, the logics of global health security also engender certain types of containment and response strategies that may involve unequal responsibilities and consequences for different populations. For example, Wenham demonstrates how the security logics that governed the response to Zika led to a short-term focus on vector (mosquito) control and shifted part of the burden of that response onto women. Policy-makers neglected to implement longer-term structural reforms that would address underlying inequities, ones that made poor women of color both more susceptible to the effects of the epidemic and to the secondary effects of policies aimed at securing the state. Similarly, Rushton notes that even though the surveillance and containment practices at the heart of global health security may be important in their own right, they do not address any of the underpinning inequalities or everyday insecurities experienced by the majority of the world. Instead, these practices often negatively impact the security of these same populations. This way of acting is an "emergency mode

of operation" (p. 132), which is chosen because the alternative—a preventive mode that would require significant resource redistributions—has been "deemed unacceptable" (p. 132) by health security policy-makers from the Global North.

Wenham also situates the response to Zika within the wider "medicalisation of insecurity," a concept first identified by Stefan Elbe.[5] This notion has led to a focus on pharmaceutical innovation as *the* response to health security threats, exemplified during the Zika epidemic by a rush to develop vaccines and to genetically modify mosquitoes to limit their reproduction. While these forms of countermeasures can form a key part of disease response, they do not address the vulnerabilities caused by inadequate housing, sanitation, and social protection mechanisms, for example, or indeed underlying local and global inequities. Importantly, across all three books it is apparent that this focus on short-term technical innovation is a result of the interplay between the neoliberalization of domestic and global health policy; the attendant influx of nonstate actors—especially private philanthrocapitalist organizations like the Bill and Melinda Gates Foundation[6]—participating in the financing, design, and delivery of health policy; and the global health epistemic communities that work within this neoliberal landscape.

The global response to COVID-19 has demonstrated that these technical short-term fixes mean little without political leadership and governance at the local, national, and global levels. At the global level, we have seen the authority of the WHO questioned and undermined repeatedly, not least by the Trump administration and its (now reversed) decision to withdraw the United States from the organization. Youde's discussion of China's response to SARS shows us that this (un)willingness to engage in global cooperation is not a new phenomenon and that the ability of the WHO to act will remain constrained by its most powerful member states. Moreover, the medical nationalism—in the form of stockpiling medication, personal protective equipment, and vaccines—that we have seen since the start of the pandemic confirms Rushton's point that "it is one thing for governments to agree in the abstract about the desirability of global cooperation in times of crisis .... But when a possible future outbreak becomes a real present-day crisis, the political calculation can shift dramatically" (p. 46).

Nationally, we have seen how countries that might be expected to respond assuredly to a pandemic—because of their compliance with the International Health Regulations or their rankings in the Global Health Security Index[7]—have failed miserably to do so. Rushton points out that state compliance is dependent on "the politics of bureaucratization and routinization" (p. 51) of obligations,

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and those politics are clearly affected by years of neoliberal austerity and the hollowing out of the state.[8] Wenham makes a similar point, contrasting Brazil's rights-based approach to ensuring access to antiretroviral medication for people living with HIV/AIDS and its resistance in the mid-2000s to using security terminology in health policy with the country's securitized response to Zika in light of a distinct neoliberal shift in Brazilian politics. Youde, for his part, notes the effects that populism and nationalism can have on a state's internal response to diseases, and also on its willingness to engage in multilateral cooperation. The response to COVID-19 in the United States, India, Brazil, and the United Kingdom, to name a few, suggests that an analysis of populism (and medical populism)[9] must sit at the heart of future work that straddles the disciplines of international relations and global health.

Security Hierarchies, Borders, and Racism during COVID-19

In short, these three engaging and enlightening books will help any reader—whether new to global health politics or a seasoned observer—make sense of some of the events of the first eighteen months of the pandemic. But COVID-19 will inevitably push the theory and practice of global health and global health security in new directions as well. While the analyses in these three books lay the foundations for some of this rethinking, there are certainly new perspectives and areas of inquiry to consider. As a springboard into a discussion of what we might add to the analysis of Rushton's, Wenham's, and Youde's books in light of COVID-19, I want to begin by outlining some of their normative prescriptions for addressing global health governance and security. The events of the first eighteen months of the pandemic compel us to engage with these normative questions about the future direction of global health politics and go beyond the analyses provided by the three books.

As noted, Rushton thinks the securitization ship has sailed (a point echoed by Wenham) and that we must therefore engage with the existing realities of the global health security regime, despite its shortcomings. Rushton is acutely aware that "security"—and the trade-offs made to achieve it—tends to mean security for some at the expense of others. He conceptualizes this tension as a set of competing rights claims—often between the individual and the collective when it comes to public health measures, such as quarantines—and argues that this

tension "requires a broader set of political debates around power, justice and inequality, asking whose rights are being breached, and in the name of whose security" (p. 127). To engage in these debates, Rushton calls for a "pro-health politics" that does not just rely on "narrow medico-pharmaceutical 'war' against microbes," given that "too often . . . the primary interest of powerful states has been in combating individual 'threatening' microbes rather than grappling with the deeper structural causes of health insecurity" (p. 17). A pro-health politics "would take seriously public health efforts to understand health risks at different scales, from the individual right up to the global, and to engage in preventive measures rather than reactive crisis management" (p. 27), and this would entail engaging with social, political, and economic determinants of health and centering the concepts of dignity and solidarity.

Wenham's conception of a feminist health security bears many similarities to Rushton's proposal, as she views it "as an emancipatory vision of (health) security which goes beyond state-centrism to recognize the everyday needs of individuals" (p. 32). To actualize this emancipatory vision, Wenham argues, requires making women the referent object of security in order to examine how outbreaks and the responses to them are gendered, and mainstreaming feminist knowledge into policy-making in order to address "underlying issues of hierarchy, power relations and systematic exclusion" (p. 15). Admittedly, she recognizes that reshaping health security in this way is complex due to the state being a nonneutral guarantor of security. Youde makes fewer normative claims in his book, but nonetheless argues that "global health is specifically premised on an outward-focused, interconnected framework" (p. 188) and that "globalization may contain emancipatory possibilities in the health realm, too" by introducing "a sense of obligation to the equation" (p. 20) as we become more aware of the near and distant connections that shape our health.

The experiences of 2020 and 2021 compel us to revisit this faith in the possibility of an emancipatory conception of security (even if not conceived of as state-centric) and the possibilities of global solidarity as applied to global health issues. Here, I note four areas of focus that challenge the normative assumptions and proposals of the three authors. First, the ongoing pandemic raises questions about global health hierarchies. While global inequities are, of course, acknowledged and addressed to varying degrees in the three books, all three nonetheless characterize the international order as one of equally sovereign states. Yet, as Adom Getachew (among others) has shown, the global order is better characterized as

hierarchical and unequally integrated, with some states more sovereign than others.[10] These postcolonial hierarchies have become painfully apparent during COVID-19 in the ways that states have been able to engage with or have been excluded from the governance of the pandemic. This can be seen most starkly but not solely in the inequities in vaccine distribution and the control of the means of vaccine production. While Europe, North America, and select states in other parts of the world forge ahead with vaccinating their populations, those same regions and states are preventing the production of vaccines in others. This is a result of both intellectual property legislation—the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), for one—and the long-standing resistance to the type of technological and resource transfers that would enable local production of vaccines. Even if there are signs that some states are loosening their commitment to TRIPS and willing to implement waivers in light of activism by other states and nonstate actors, the current state of affairs is still representative of an emergency and security mode of governance that sustains inequities in access to medicines in the long term. COVID-19–specific waivers become the exception that confirms the rule.

What's more, the focus on biomedical and technical solutions within global health security policy has been reinforced during the COVID-19 response and further embeds these hierarchies. The rapid creation of COVID-19 vaccines might be an impressive feat of biomedical research and essential to stem the tide of the pandemic, but their distribution brutally exposes the injustices of global health hierarchies, further entrenching structures of vulnerability and risk. That these forms of intervention are firmly ingrained in global health policy-making is evidenced by the work of the Independent Panel for Pandemic Preparedness & Response. Its report *COVID-19: Make It the Last Pandemic* recommends strengthening leadership, surveillance, financing, and coordination in pandemic response,[11] but does not meaningfully engage with the systemic creation of vulnerability and exposure to health risks.

A second, and related, point is the reinscription of borders into discussions of health security and inequity in a major way. As Rushton notes (as does Youde), within global health circles it is a "well-worn truism that pathogens know no borders" (p. 37). However, as he later frames it, "Whilst pathogens themselves may not recognize borders, in most places the people who are carrying them experience borders as a very real phenomenon indeed" (p. 111). The location of some initial European hot spots in the pandemic (ski resorts in Italy and Austria, for example)

suggests that an ability to traverse borders by virtue of possessing the rights and means to do so must sit at the heart of analyses of disease outbreaks. Importantly, this ability is structured by the same global hierarchies that determine vaccine distribution inequities. The introduction of vaccine passports in some states demonstrates another way in which borders and bordering practices control the stratified movement of bodies. As frequent business travelers and holiday makers rush to travel abroad, it is becoming all the more apparent that the trade-offs between security and other imperatives are not borne by them.

Moreover, we should also look at what forms of border politics are enabled by disease outbreaks. European countries justified migrant pushbacks in the Mediterranean Sea and English Channel and new, more restrictive asylum policies with references to public health (security) prerogatives.[12] At the same time, COVID-19 outbreaks in the dilapidated Napier Barracks in Kent were blamed on the asylum seekers held there rather than the cramped and inhumane conditions in which they were being confined.[13] This demonstrates how health security becomes part of other security areas and logics (if they were not always already so).[14] The success of states such as New Zealand and Australia in limiting COVID-19 case numbers by implementing severe border restrictions will lead to a reevaluation of the role of borders within the International Health Regulations, but the focus for critical scholars of health security must remain on the impact this might have on those who are kept out or confined by borders (in all their multivariate forms). Thus, there are important conversations to be had with the ever expanding critical literature on borders (a conversation Rushton himself begins in a recent article coauthored with Adam Ferhani).[15]

Third, the pandemic has confirmed the role of race (or, more accurately, racism) in these global health hierarchies (and indeed the border politics of health). As Rushton notes in his book, the origins of international cooperation on disease control can be traced back to colonial times and the fear of the risk posed by diseased "others" (which Youde also identifies in his discussion of the SARS outbreak), a fear wrapped up in wider colonial politics of race and domination. Many of these fears persist today and are inscribed into contemporary forms of health governance, not least within the global health security logics and practices aimed at containing outbreaks in specific parts of the world. The way that racism has occurred in this pandemic—from the memes drawing on racist tropes about diets to speculate about the origins of the virus, through the instances of anti-Asian racism and attendant verbal and physical violence, to the racialized

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burden of the pandemic and (lack of) access to healthcare and vaccines within and between countries—suggests that analyses of racism and the racial capitalism that produces these inequities and differences need to be front and center of the critical study of global health politics and global health security going forward. Rushton tells us that we should examine what risks "we" are able to live with, and what trade-offs "we" are willing to make when addressing those risks. He is right, but perhaps a more important question is who constitutes the "we."

Finally, these analyses require a reckoning with the production of knowledge within global health epistemic communities. In particular, epistemic communities made up of a coterie of representatives from philanthropic organizations, international organizations, bi- and multilateral funders, management consultants, and academia that have coalesced around biomedical approaches to public health have been complicit in producing and reproducing situated forms of knowledge that have then been packaged as universal and, as the three books show, valorize the technical interventions so favored by the funders and implementers of global health security mechanisms. Crucially, the "courageous, deeply uncomfortable, and long-term endeavour"[16] of decolonizing global health scholarship would help make central the everyday insecurities Wenham and Rushton point to, and potentially draw climate change, environmental degradation, the intersections between human and nonhuman health, and the wider "structural and pathogenic qualities"[17] of (racial) capitalism into critical global health scholarship in a more meaningful way.[18] The role these processes play in the emergence of new pathogens and in the production of vulnerability to disease outbreaks makes their inclusion essential.

Conclusion

Together, the schisms, inequities, and politics that have emerged from (or been made visible by) the COVID-19 pandemic are "changing the meaning of 'global' and 'health' in rapid and at times unpredictable ways."[19] The question for future studies of global health security is whether—and if so, how—security logics and practices can expand to account for these emerging schisms and become part of a pro-health politics that centers gender, race, class, and other structural determinants of ill health, while also accounting for the downstream effects that health security policies have on specific, often marginalized, populations. Importantly, can health security move beyond short-term "innovative" fixes to take on deeply

systemic issues that would require considerable transfers of resources and power to uproot and address?

I am dubious. As Rushton notes, global health advocates have been very successful at convincing security policy-makers that infectious diseases should be a security concern (and of course will not need to convince them of that again post–COVID-19), but they have been less successful at broadening the agenda to other causes of everyday health insecurity. Given that health security is fundamentally predicated on exclusions, and given that these narrow biomedical and technical solutions are firmly ingrained in global health security policy-making, the more fundamental challenges to the systematic production of vulnerability seem unlikely to arise if the governance of global health continues to operate in a security mode of thinking. Importantly, however, all three books demonstrate how exclusion and health inequities *have* been resisted and opposed—for example, by mothers of children with congenital Zika syndrome in Latin America and people living with HIV/AIDS fighting against stigma or organizing to ensure access to antiretroviral medicines. It is here that we may find lessons to be learned as the pandemic and its stratified aftereffects reverberate on.

NOTES

[1] Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the virus that causes coronavirus disease (commonly referred to as COVID-19).

[2] Joe Biden, "Statement by President Joe Biden on the Investigation into the Origins of COVID-19," White House, May 26, 2021, www.whitehouse.gov/briefing-room/statements-releases/2021/05/26/-statement-by-president-joe-biden-on-the-investigation-into-the-origins-of-covid-19/.

[3] See, for example, the work of the Gender & COVID-19 working group: www.genderandcovid-19.org/about/.

[4] Thomas Cousins, Michelle Pentecost, Alexandra Alvergne, Clare Chandler, Simukai Chigudu, Clare Herrick, Ann Kelly, et al., "The Changing Climates of Global Health," *BMJ Global Health* 6, no. 3 (2021), pp. 1–6.

[5] Stefan Elbe, "Pandemics on the Radar Screen: Health Security, Infectious Disease and the Medicalisation of Insecurity," *Political Studies* 59, no. 4 (December 2011), pp. 848–66.

[6] Anne-Emanuelle Birn, "Philanthrocapitalism, Past and Present: The Rockefeller Foundation, the Gates Foundation, and the Setting(s) of the International/Global Health Agenda," *Hypothesis* 12, no. 1 (November 2014), pp. 1–27.

[7] The Global Health Security Index is a global benchmarking exercise that ranks states on the basis of their national health security capabilities. The U.S. and U.K. ranked first and second in the 2019 rankings.

[8] Lee Jones and Shahar Hameiri, "COVID-19 and the Failure of the Neoliberal Regulatory State," *Review of International Political Economy* (2021), pp. 1–25.

[9] Gideon Lasco, "Medical Populism and the COVID-19 Pandemic," *Global Public Health* 15, no. 10 (October 2, 2020), pp. 1417–29.

[10] Adom Getachew, *Worldmaking after Empire: The Rise and Fall of Self-Determination* (Princeton, N.J.: Princeton University Press, 2019).

[11] Independent Panel for Pandemic Preparedness & Response, *COVID-19: Make It the Last Pandemic* (Geneva: Independent Panel for Pandemic Preparedness & Response Secretariat, May 2021), theindependentpanel.org/mainreport/.

[12] Eric Reidy, "The COVID-19 Excuse? How Migration Policies Are Hardening around the Globe," *New Humanitarian*, April 17, 2020, www.thenewhumanitarian.org/analysis/2020/04/17/coronavirus-

global-migration-policies-exploited; and Joanna Kakissis and Abu Bakr Bashir, "Asylum-Seekers Make Harrowing Journeys in Pandemic, Only to Be Turned Back," NPR, February 13, 2021, www.npr.org/2021/02/13/949182773/the-harrowing-journeys-to-safety-of-asylum-seekers-during-a-pandemic?t=1623168465398.

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Abstract: The COVID-19 pandemic has been shaped by preexisting political, social, and economic relations and governance structures, and will remold these structures going forward. This review essay considers three books on global health politics written by Simon Rushton, Clare Wenham, and Jeremy Youde. Here, I explore what these books collectively and individually can tell us about these preexisting dynamics, the events of the first eighteen months of the COVID-19 pandemic, and possible future directions in the politics of global health. I argue that they provide a firm basis for understanding the inequitable burdens of the pandemic, while juxtaposing these inequities against the narratives of shared vulnerability that sit at the heart of the global health security regime. They also help us make sense of the surveillance, detection, containment, and response mechanisms we have seen during the pandemic; the failures to address the systemic dynamics that drive disease outbreaks; and the national and international politics that have shaped the pandemic response. However, COVID-19 has also vividly and brutally demonstrated how global health hierarchies, racism, border politics, and neoliberal forms of knowledge production have led to a stratified burden of the pandemic. These areas are less apparent in the three books, but ought to be situated front and center in future critical scholarship on global health security.

Keywords: COVID-19, global health security, pandemic response, health inequity, Simon Rushton, Clare Wenham, Jeremy Youde