Ultimately, the question should not be whether a human being is better off in a sweatshop working 100 hours a week or unemployed . . . The question needs to be: can we come up with a better version of global- ization?  

(Heymann & Kidman 2007)

In this chapter we begin to answer the question posed by Heymann and Kidman by examining a number of different discourses in which globalisation and health have been framed. These discourses compete for political influence and hold differing potential for what remains the single most important global health imperative: a dramatic shift in the distribution (and redistribution) of global resources essential to health.

While there are many ways in which the relationship between health and globalisation can be viewed, the immediately discernable and more dominant discourses are as follows:

- Health as security
- Health as development
- Health as global public good
- Health as commodity
- Health as human right

Some, notably health as security, are recent or recently reformulated. The preambular nod to ‘health’ as ‘fundamental to the attainment of peace and security’ in the World Health Organization’s 1946 constitution gathered dust until the destabilising effects of the HIV pandemic and fears over bioterrorism re-wed the two terms in the early 2000s.
Health as a human right emerged immediately after World War II in the text of the Universal Declaration on Human Rights, but languished as a global discourse until the collapse of the Soviet Union left a vacuum in normative alternatives to market capitalism. Health as development has a more continuous, if episodic, lineage, first gaining international notice with the 1978 Alma-Ata Declaration on Primary Health and then rising and falling almost year-to-year as an aid priority of high-income countries. Health as global public good is decidedly new and owes itself to UN agency efforts to harness one economic theory to soften the harsh edges of another. Health as commodity, and the inevitable market failures in its equitable provision, has long jostled with multiple corrective state interventions. Only with the advent of global trade rules has health’s commodification become a global, rather than simply national, concern.

Which elements of any or all of these discourses offer the most emancipating potential for promoting global health equity? Which framings should health promotion incorporate into its practice, philosophy and strategy?

**Health as security**

The most dominant discourse of recent years has been that of national security. At its extreme it finds such expression as the ‘risk of infection by American citizens [and] US military personnel abroad . . . [and] increased political and economic instability in strategically important countries because of failures by their government to control the [HIV] pandemic’ (US National Intelligence Council 2000). Health as national security is consistent with nation-states’ often explicit duties to protect their citizens from foreign risk by guarding their borders, whether the ‘invaders’ are pathogens or people. It has also, post SARS, given long-neglected public health measures more political clout and fiscal resources, at least in many high-income countries. (Public health systems in many low-income countries continue to languish.) But it has also led to a distortion in global health risk and response and elides dangerously with repressive political measures in the ‘war on terror’.

On the first: The securitisation of health, while now ‘a permanent feature of public health governance in the twenty-first century’ (Fidler 2007), disproportionately directs funding to those ills deemed politically to be security risks: HIV, twice addressed by the UN Security Council; and Avian flu as the present exemplar of feared modern pandemics. Such designation is not based upon global risk, since easily preventable maternal