Introduction

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Although public health policy delivery has always been an intensely local process, the "Westphalian" state system had defined health policies in national containers ordered and segmented among others by the World Health Organization (WHO) guidelines, but mostly under the sovereign jurisdiction of nation-states.[1] Public health was defined as *national* health and health policy was *national* health policy under this regime. WHO interventions had to occur within the framework of national sovereignties, whose concern was with both popular health and economic welfare – not necessarily in this order (Fidler 2004; Heymann 2005; interview with David Heymann, 2005). When SARS hit major metropolitan regions in Asia and North America, the need to rethink both global and sub-national health governance was exposed. The process of revising the outdated International Health Regulations (IHR), which was well under way when SARS struck, was momentarily put on hold and ultimately received a boost from the experience gained from that global outbreak in 2003 (interview with WHO infectious disease expert, 2005). The reliance on the hierarchical and hermetic system of nationally based health policy was put to the test as the WHO attempted to carve out a novel activist role in protecting global health beyond national interests, and as sub-national governments, economic, and civil society players moved to react to a localized global health crisis with coordinated action of their own (Abraham 2004; Fidler 2004). At both ends of the redefinition of international health governance – the local and the global – an "institutional

void" (Hajer 2003) existed that could not be filled automatically by traditional, national health governance institutions and their international affiliates:

> [M]ore than before, solutions for pressing problems cannot be found within the boundaries of sovereign polities. As established institutional arrangements often lack the power to deliver the required or requested policy results on their own, they take part in transnational, polycentric networks of governance in which power is dispersed. The weakening of the state here goes hand in hand with the international growth of civil society, the emergence of new citizen-actors and new forms of mobilization. (2003, p. 175)

In this part, we discuss the consequences of these shifts, with particular attention to the level of urban health governance. Under the contemporary conditions of intensified globalization, there is an urgent need for urban governance to be prepared to deal with infectious disease. If today, the local is global and the global is local, then there will be important consequences for the manner in which health governance institutions at different scales are structured, and how the different scales of health governance relate to each other. Such factors will clearly influence the ability to respond to EID. From this perspective, it is important to recognize that global health governance overall may be improved by realizing the opportunities that rest in metropolitan governance.

As major metropolitan centers, global cities possess a wealth of health resources (e.g., healthcare facilities, hospitals, and staff – see Rodwin, Chapter 2), which suggests that compared to other places, global cities would be better prepared to respond to an infectious disease outbreak – or, for that matter, any other type of medical emergency. Despite this mostly accurate generalization, the authors in this part report on significant problems during the SARS outbreak response in three cities which were among the hardest hit by the disease in 2003: Toronto, Hong Kong, and Singapore. Such problems involved limitations in resource mobilization, accessibility, and even availability, and these were critical factors in the public health responses that unfolded in those three cities in the wake of SARS. The contributions in this part also highlight the fact that there were notable similarities and differences in the specific types of problems each city faced, as well as in the nature of the responses that unfolded. For example, both Toronto and Hong Kong shared similar problems associated with inadequate communication linkages and information-sharing capabilities, which thwarted a more expedient response to SARS, at least during the earlier stages of their respective outbreaks. In contrast, although the Singapore response has garnered praise from the World Health Organization in terms of information and resource mobilization, it was criticized on other fronts, most notably in regard to possible civil and privacy rights violations during the outbreak response.

At the core, resource availability and mobilization are political issues, because they deal with resource distribution and investment decisions by those in power. This is no different in the domain of public health. All authors explicitly acknowledge that the political economic context within which global cities function had significant implications for understanding the manner in which the respective government and public responses to SARS took place. The question is how exactly? To address this question we would need, at the very least, to consider the particular political economic history of each of these cities, and all three chapters pay some attention to this dimension in the respective analyses. Second, aside from the historical influences, the current state of the global city will also influence the response. In this light, all three readings implicitly underline the fact that today global cities must first ensure that infrastructure and security features are in place so as to maintain their embeddedness within the global circuits of capital, information, people, and resources. For example, they must provide a suitable communication and information infrastructure, as well as a safe and secure environment for business and everyday life (Friedmann 1986; Castells 2000). For this reason, local governments will often refashion their policies, programs, and development projects with the aim of integrating their metropolitan area in the global space of flows in both material and discursive realms. Such actions, however, may also have consequences for the manner in which a government is able to respond to local health crises. Many specific examples of these are given in the chapters of this part.

Perhaps one way to gain an overall understanding of the specific actions taken and issues faced in each of the cities is to draw upon the work of Olds and Yeung (2004), who discern three types of global cities on the basis of the nature and type of integration each has in the world economy. Such a classification may be useful in understanding the nature of the SARS responses in each city. The first type is the "hyper global city," which refers to cities such as New York or London that are well integrated into the global economy through both the inward and outward flows of capital and resources. In contrast, global cities such as Toronto, that have not yet reached this high level of integration, tend to have a greater reliance on inward flows from the global economy and are referred to as "emerging global cities." These types of cities in essence dominate the regional economy and help articulate this regional economy with the global economy. What is notable about emerging global cities are that they are dependent upon on the endowments of institutional resources from higher levels of government, particularly from the national level. A certain level of national resource support ensures that the emerging global city is able to play a critical role within the country, especially in terms of ensuring that key actors and institutions are engaged with the global flows (Olds and

Yeung 2004, p. 506). The importance of fund transfers from the national to municipal level is revealed most explicitly in the chapter by Roger Keil and S. Harris Ali, in their account of how Toronto's response to SARS was very much hampered by neoliberal-inspired cuts to public health. The consequences of these were seen, for example, in terms of a resultant lack of surge capacity, problems with information handling and communications, and difficulties related to disease surveillance, case management, contact tracing, and quarantine.

In contrast to Toronto, Hong Kong and Singapore are "global city-states" that have a unique governance structure but nevertheless are very well integrated into the global economy. The uniqueness of the governance structure stems from a much greater integration of the national and urban levels of government. As a result, global city-states have the political capacity and legitimacy to mobilize strategic resources to achieve (national) objectives that are otherwise unimaginable in non-city-state global cities. This likely accounted for the ability of Singapore to quickly mount an effective response to SARS. That is, unfettered global city-state capabilities enabled national and urban resources to be quickly mobilized and directed with limited bureaucratic hurdles that were, for example, faced in Toronto. Furthermore, as Peggy Teo, Brenda Yeoh, and Shir Nee Ong note in their chapter, adding to the effectiveness of Singapore's response was that the particular historical and political trajectory of this city-state led to the presence of a citizenry more likely to be trusting, and therefore more compliant with government directives during an emergency situation such as SARS.

While Hong Kong is a city-state similar to Singapore, it is also part of China, and its "One Country, Two Systems" reality posed considerable problems during the SARS crisis. As outlined in the chapter by Mee Kam Ng, many of the problems faced in Hong Kong's response to SARS were due to poor communication, inadequate information sharing, as well as a total lack of coordination involving the various public health agencies. Most of these problems could be traced to a recent historical event; namely, the 1997 British handover of Hong Kong back to China. But as Ng notes, it also had to do with the Asian financial crisis, the ensuing property and stock slump in the city resulting in budget cuts in the health sector and beyond. The economic crisis clearly accounted for reduced resources for the health sector. The lack of coordination between the central government in China and the government in Hong Kong resulted in bureaucratic obstacles in epidemiological data sharing that severely hindered the public health response. Consequently, those political efficiencies characteristic to the city-state that served to benefit Singapore were not existent during the SARS response in Hong Kong. Although Hong Kong was also a global city-state, it was one in political transition, and as such, it was put in circumstances similar to

those faced in an emerging global city such as Toronto – as dramatically illustrated by the fact that Toronto and Hong Kong faced remarkably similar obstacles during SARS.

NOTE

1 "'Westphalian' refers to the governance framework that defined international public health activities from the mid-nineteenth century," based on the political logic of sovereign nation-states that had come into existence after the Thirty Years War (Fidler 2003, pp. 485–6).