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The changed nature of global health risks

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Introduction

Global health issues, and especially global health risks, have risen to increasing prominence on the international political agenda in the last two decades. The harbinger for this change was the emergence of HIV/AIDS in the 1980s, a novel communicable disease which at its height led to the deaths of more than 2 million people a year, and risked the stability of states and the security of regions. Since then, outbreaks of other infectious diseases, such as SARS (2002-3), MERS (2012), Ebola (2014-15) and Zika (2016), recurrent alarms about influenza pandemics such as avian flu (2005) and swine flu (2009), and concerns over antimicrobial resistance (AMR) have all appeared prominently on the international agenda. The United Nations General Assembly has held several high-level meetings on health issues since 2000, including on HIV, non-communicable diseases, the Ebola response, and AMR. The HIV/AIDS pandemic and the Ebola outbreak even triggered resolutions by the United National Security Council, which declared that these outbreaks may constitute risks to stability as well as national and international peace and security. Furthermore, the rise of global health issues on the international political agenda has led to the emergence of numerous new programs and organizations at the global level, within the UN system (such as UNAIDS and the WHO Global Outbreak Alert and Response Network), and outside the UN, notably in the form of public-private partnerships, such as the Global Fund and GAVI.

The rise of global health on the international political agenda was accompanied and, indeed, driven by the rise of a new narrative: health is global. In the era of globalisation, the argument goes, health problems are increasingly global and require global responses. Infectious disease outbreaks in particular were newly identified as being a global risk, given their potentially rapid spread between states and across continents. In 2002-3, the SARS outbreak demonstrated how novel viruses could spread across continents within weeks. Crucially it also led to the World Health Organization taking a proactive leadership role, prompting David Fidler to comment that health had moved into a 'post-Westphalian' phase.[1] Although Fidler's claim was at best premature,[2] the term 'global health' drew new political attention to, and implied the need for new political initiatives concerning, health. Not least, this discursive shift allowed health risks to be constructed as *shared* between and across states. The potential of infectious diseases to spread quickly across the globe meant that, for the first time in more than a generation, high income OECD countries appeared to be vulnerable to outbreaks of infectious disease. Hence, infectious diseases with pandemic potential and also the rise of antimicrobial resistance have been portrayed as threats to national security in several OECD countries. These issues are also increasingly presented as 'global risks', potentially damaging the global economy and thereby global stability and security.

At the same time, the rise of global health has brought with it the rise of a global health *politics*. While the HIV/AIDS pandemic was portrayed as a risk to global stability and security, it also revealed stark differences in how vulnerable different populations are in becoming infected and being able to access treatment. Different interests, perspectives and values have also become apparent with regard to which health issues to prioritise in global health governance, with many high-income countries focussing on infectious diseases with pandemic potential and - more recently - AMR; and many low-income countries being particularly concerned with strengthening local health systems and the many 'neglected' diseases that kill thousands of poor people every day. Furthermore, the rise of global health politics is also linked to the growing acknowledgement that health issues have implications *beyond* health, so that different interests and values now appear in debates on global health issues beyond the physical and mental well-being of individuals and communities. Most significantly perhaps, global health issues have

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[1] David P. Fidler, *SARS, Governance and the Globalization of Disease* (London: Palgrave Macmillan, 2004).

[2] See Adam Kamradt-Scott, *Managing Global Health Security* (London: Palgrave Macmillan, 2015

been presented as threats to national and international security and to macroeconomic growth. In addition, 'global health' problems are intrinsically linked to issues of international development, human rights and global commerce and trade. Global health therefore is not a silo - as multiple studies have shown, global health has become part of the business of organizations and institutions outside the narrowly-defined health field. In January 2000, for example, at its first meeting of the new millennium, the UN Security Council addressed the international security implications of HIV and AIDS; later that year it passed Resolution 1308, principally concerning the risks posed by the disease to peacekeeping missions but also "[s]tressing that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security"[3] . In 2014, the UN Security Council passed Resolution 2177, identifying the West African Ebola outbreak as a "threat to international peace and security". In 2000, the Millennium Development Goals recognized health, and especially high incidence communicable diseases such as HIV and malaria, as risks to sustainable development and human rights; in 2001, the Report of the Commission on Macroeconomics and Health, chaired by Jeffrey D. Sachs, identified poor health as a risk to macroeconomic growth. Methodologies and theories from outside the health sector (including security and economics) are now regularly applied to health. Moreover, as Stefan Elbe has argued,[4] ideas from health have in turn permeated thinking in other sectors: medical and public health communities are important participants in biodefense programs, notably in the US, and WHO is regularly involved in debates on global trade and intellectual property protection.

While the rise of global health politics therefore is intrinsically linked to the rise of global health, there is a notable tension between these two phenomena. Politics sits uneasily with both the emphasis on the global nature of health problems and the tradition of public health as a technical field grounded in positivism and scientific rationality. The notion of 'global health' tends to obscure the fact that some populations are more likely to be affected by health problems than others, that some health issues are more relevant in some countries than in others, and that policy responses tend to benefit some people more than others. Furthermore, the field of global health and global health governance is dominated by policymakers and experts with a background in public health, epidemiology and medicine, and therefore permeated by an ethos

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[3] United Nations Security Council [UNSC] Resolution 1308, 17 July 2000. Available at: http://www.un.org/Docs/scres/2000/sc2000.htm
[4] Stefan Elbe, *Security and Global Health* (Cambridge: Polity, 2010)

of positivism and scientific rationality. In this tradition, rigorous observation, quality data and the application of reason can identify the best response to a given problem, an approach seen across health - from the treatment of disease to the allocation of resources. The idea is that there is an optimal solution to a given problem, which can be arrived at through the use of a robust empirical methodology. Failures to resolve global health problems - such as the HIV/AIDS pandemic, the West African Ebola crisis and Antimicrobial Resistance (AMR) - are therefore ascribed either to poor data, weak reasoning, inadequate resources or the interference in this process by partial forces (often decried as 'political' interference). Change, in this scenario, will be driven by better data, improved processes, greater investment, and better technology.

This paper however takes a different approach. We argue that understanding and driving change in global health requires a shift away from a positivist approach to one which embraces the legitimacy of different interests. To explain this shift we apply insights from two theories: framing and the sociology of risk. Drawing upon established uses by social constructivists, framing has been used in a limited manner in global health, principally as a means of understanding agenda setting and governance.[5] Framing is understood as being when an issue is presented in such a way as to tie it into a broader set of ideas about the world, and through this gain influence and policy purchase. Gitlin, for example, defines frames as 'persistent patterns of cognition, interpretation and presentation, of selection, emphasis and exclusion, by which symbol-handlers routinely organise discourse' (1980, p. 7). They may be deployed and promoted by the range of stakeholders (including transnational advocacy groups, international organisations and epistemic communities) and used by them as a tool of persuasion to generate or legitimise specific pathways of response. They may be deployed to call attention to an issue, influence other actors' perceptions of their own interests, or convince them of the legitimacy/appropriateness of the advocate's preferred policy response. When they are successful in doing so, the chosen frame 'resonates with public understandings, and are adopted as new ways of talking about and understanding issues', and actors will be likely to modify their behaviour accordingly (Finnemore and Sikkink 1998, p. 897).

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[5] For example, Shiffman; Labonte; Colin McInnes and Kelley Lee eds, 'Framing global health governance', *Global Public Health* 7:S2 (2012); and Colin McInnes, Adam Kamradt-Scott, Kelley Lee, Anne Roemer-Mahler, Simon Rushton and Owain Williams, *The Transformation of Global Health Governance* (Basingstoke: Palgrave Macmillan, 2014).

We link frames to risk in two particular ways: first, how framing global health in terms of 'risk' opens up a new, political discourse; and second, how different actors may frame risks from health issues differently, leading to competing understandings of the nature of the problem and the means of resolution. We begin by discussing the policy implications of the 'global risk' frame in global health, notably with regard to infectious disease pandemics, and draw on insights from sociological theories of risk to discuss how this framing can diffuse politics in two ways. First, the global risk frame emphasises the potentially disastrous consequences of these risks, thereby making it difficult to oppose action to prevent such disaster without appearing negligent. Second, the risk frame reinforces the narrative of globality by stressing the universal impact of potential disaster. Yet, the global risk frame is inherently political because it promotes policy responses that benefit some more than others. We then move to analyse how different frames have been used in an actual response to a pandemic, the Ebola outbreak in West Africa in 2014-15. We suggest that a variety of frames exist which construct risk differently, each of which may be privileged by different actors not least because of their sectoral interests and organisational culture. We then discuss how three of the key organisations involved in the global Ebola response, WHO, Medecins Sans Frontieres (MSF) and the UN Security Council, framed the problem in different ways, thereby promoting different pathways of response. We conclude by arguing that, although the concept of 'risk' in health carries a depoliticising tone, in global health it has opened up the requirement for a greater political sensitivity. Politics is inherent in global health, and needs to be accommodated rather than avoided.

Global health risks: unpredictable, unavoidable and potentially catastrophic

This section discusses how health problems, especially outbreaks of infectious diseases and pandemics, have increasingly been framed as 'global risks', and how this in turn has affected responses. The term 'risk' has, of course, a long history in medicine and public health. As a key concept in statistics to calculate the probability of an event happening, the concept of risk is at the heart of modern science, including the medical sciences and public health. Terms such as 'risk factor' and 'mortality risk', which estimate the likelihood of individuals acquiring a disease and dying from a diseases respectively, are commonly used in medical and public health discourse. We suggest, however, that the framing of certain health issues as 'global risks' follows a different logic. Portraying a health issue as a 'global risk' is not a statistical exercise; rather it constructs the issue as a policy problem in a particular manner and promotes a

particular set of policy responses. Moreover, it ties global health into a wider narrative concerning societal vulnerability in the contemporary, globalised world.

In the last decade, we have seen the emergence of a discourse that portrays certain global health issues, notably infectious disease pandemics and AMR, as global health risks. This discourse is manifest in a range of policy documents and reports and several institutions that have recently been created. The Commission on a *Global Health Risk* Framework for the Future [emphasis by the authors] starts from the premise that "Infectious diseases remain one of the biggest risks facing humankind"[6]. The World Bank's *World Development Report* 2014 states that pandemics are one of the key risks facing the world today, and the World Economic Forum's *Global Risk Report 2016* discusses pandemics as one of the global risks 'in focus'. As mentioned above, the term risk has a long tradition in medicine and public health as a technical term for the calculation of probabilities. While this use of the term 'risk' remains predominant among health experts, we observe something different happening in the emerging discourse on global health risks: the term 'risk' here is used to refer to events that are considered *in*calculable. For instance, the Commission on a Global Health Risk Framework for the Future states: "Although there are enormous uncertainties in modeling the risks and potential impact of infectious disease crises, the case is compelling no matter how it is calculated"[7]. Bill Gates, co-Chair of the Bill and Melinda Gates Foundation, which is one of the key players in global health, argues that "[e]ven though we can't compute the odds for threats like bioterrorism or a pandemic, it's important to have the right people worrying about them and taking steps to minimize their likelihood and potential impact"[8]. By highlighting the difficulty or even impossibility of assessing the likelihood of an event occurring, the technical meaning of the term 'risk' as statistical likelihood, as used conventionally in medicine and public health, is turned on its head.

The use of the term risk to refer to events that are considered incalculable and unpredictable is not confined to the field of global health. Rather, a risk-discourse has emerged in a wide range of global debates. The World Economic Forum publishes an annual *Global Risk Report*, now in its 12th edition, which provides an annual list of top 5 global risks; the OECD published a report in 2003 on *Emerging Systemic Risks in the 21st Century*, which proposed a framework for

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[6] The Commission on a Global Health Risk Framework for the Future 2016: The neglected dimension of global security: a framework to counter infectious disease crises. National Academy of Sciences: 1.
[7] Ibd.: 2.
[8] Olga Jonas 2014: Pandemics. Background Paper to the World Development Report 2014: X.

action on risks posed by natural disasters, industrial accidents, infectious diseases, terrorism and food safety; the World Bank's *World Development Report 2014* entitled 'Risk and Opportunity' discusses risk management as a powerful tool for development; and in 2015, the UN General Assembly endorsed the *Sendai Framework for Disaster Risk Reduction*, which constituted a shift in terminology from disaster management to disaster *risk* management, and also includes strong focus on health. Finally, the term 'systemic risk' became common parlance in the context of the financial crisis 2008.

The perception that the world faces a number of risks with potentially disastrous consequences has also been the focus of scholarly debates, driven most prominently by the works of Ulrich Beck and Anthony Giddens[9]. These authors are concerned with new forms of risk that modern societies face, notably those created by industrialisation and the rise of technologies. These risks are man-made and can be distinguished from the natural 'dangers' that have always threatened men, such as earthquakes, floods and disease. Furthermore, Beck not only distinguishes between risk and danger, but also between man-made risks that society and governments have found ways to cope with, such as accidents in factories or traffic, and those large-scale problems that can arise from nuclear power, genetic engineering or climate change, and which call into question the capacity of modern societies to deal with. In addition, Beck highlights the impact of globalisation on the quality of these risks. These new man-made risks have potentially enormous repercussions not only because they are inherently large-scale but also because they are inherently global. The consequences of chemical and nuclear accidents transcend national borders as much as those of genetic engineering in an era where food production is globally interconnected. The link to the current discourse on global health risks is evident and summarised in the much repeated statements that 'germs know no borders' and that in an era of accelerated movement of goods and people 'health is global'.

The perception of infectious disease outbreaks as global risks therefore feeds into a general sense of vulnerability of modern societies to disasters. This sense of vulnerability is linked mainly to the potential *impact* of an event - not its likelihood. The report of the Commission on a Global Health Risk Framework for the Future illustrates this: "There are very few threats that can

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[9] Ulrich Beck 1992: Risk society: toward a new modernity. New York: Sage; Ulrich Beck 2009: World at risk, Cambridge: Policy; Anthony Giddens 2000: Runaway world: how globalisation is reshaping our lives. New York: Routledge.

compare with infectious diseases in terms of their potential to result in catastrophic loss of life]"[10]
. And Bill Gates highlights that "bioterrorism and pandemics are the only threats I can foresee that could kill over a billion people"[11]. The World Economic Forum's *Global Risk Reports* have ranked health issues among the top 5 global risks in terms of impact; they have not made it into the top 5 in terms of likelihood.

In this framing, the potentially catastrophic impact of pandemics is intrinsically linked to globalisation. First, increased travel and trade has made it easier for pathogens to spread across the globe. Second, the potentially catastrophic impact results from an increasingly interconnected world, including increasingly interconnected "systems on which society depends" [12], such as economic and financial systems, energy, communication, transport and trade. In an interconnected world, the argument goes, any disruption to critical systems is likely to have global repercussions. Finally, the framing of pandemics as global risks carries an aura of inevitability: New pathogens with pandemic potential emerge all the time through natural evolution. The systems that can massively accelerate their dissemination across the globe cannot be disrupted, however, because these systems are of vital importance for the functioning of modern society[13]. Hence, it is the combination of natural evolution and a social order based on global infrastructures, that makes infectious disease outbreaks appear as potentially catastrophic, yet unpredictable and unavoidable.

Responding to global health risks through better preparedness

If this is the perception of the problem, what does an appropriate response look like? Interesting insights into this question come from a body of work on US security policy that focuses on the emergence of a new set of organisations and strategies for the protection of transport and energy infrastructures and economic and financial systems[14] . The US government perceives

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[10] The Commission on a Global Health Risk Framework for the Future 2016: The neglected dimension of global security: a framework to counter infectious disease crises. National Academy of Sciences: v.
[11] Jonas 2015: X.
[12] Beck 1992: 30.
[13] Elbe, Stefan, Roemer-Mahler, Anne and Long, Christopher 2014: Securing circulation pharmaceutically: antiviral stockpiling and pandemic preparedness in the European Union. Security Dialogue, 45 (5). pp. 440-457
[14] Andrew Lakoff 2007: Preparing for the next emergency, Public Culture 19(2): 247-271; Andrew Lakoff 2008: The generic biothreat, or, How we became unprepared. Cultural Anthropology 23(3): 299-423. Andrew Lakoff 2013: A dearth in numbers: the actuary and the sentinel in global public health, LIMN 3: 41-45. Andrew Lakoff and Stephen Collier, eds, 2008. Biosecurity interventions: global health and security in question. New York: Columbia.

the threat to these 'vital systems' as emanating from events like terrorist attacks, pandemics and natural disasters. Because these events are deemed unavoidable, conventional security policies that focus on prevention do not work. The US government therefore adopted a strategy focused on mitigating the impact of such events by becoming more prepared for their occurrence. Hence, preparedness emerges as the key rationale for how to respond to incalculable, yet unavoidable and potentially disastrous risk. The basis for acting on risks framed as unpredictable yet unavoidable and potentially catastrophic is not to calculate what is more or less likely to happen, but to be prepared for whatever happens.

The language and rationality of preparedness is evident also in the international debate on global risks, including global health risks. For instance, the Commission on a Global Health Risk Framework for the Future states: "The global community spends relatively little to protect populations from from the risks of pandemics. Compared with other high-profile threats to human and economic security - such as war, terrorism, nuclear disasters and financial crises - we are underinvested and underprepared"[15]. The Global Health Security Agenda, a US-led international initiative of more than 50 countries, argues in a recent report that "[t]he enormous costs of pandemics can be averted with strategic investment in capacity building and preparedness"[16]. The background paper on Pandemics to the World Bank's World Development Report 2014 states: "Active promotion of whole-of-society resilience and pandemic preparedness can benefit countries by reducing not only pandemic impact, but also the costs of other disasters and major crises[17]. Furthermore, the language of preparedness has also made it into the names of newly created institutions, such as the Coalition on Epidemic Preparedness Innovations (CEPI) set up in the aftermath of the Ebola outbreak. In an article in the medical journal The Lancet, CEPI founders underscore the rationale behind the preparedness response: "Although no-one knows what the next outbreak will be we must develop the required arsenal now"[18]. In 2011, WHO member states launched a Pandemic Influenza Preparedness Framework, which lays out rules for the sharing of influenza viruses and access to vaccines developed from these materials. The European Commission launched a Global Research

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[15] The Commission on a Global Health Risk Framework for the Future 2016: The neglected dimension of global security: a framework to counter infectious disease crises. National Academy of Sciences: 1.
[16] GHSA 2016: Advancing the Global Health Security Agenda: Progress and early impact from U.S. investment, p. 1
https://www.ghsagenda.org/docs/default-source/default-document-library/ghsa-legacy-report.pdf?sfvrsn=12
[17] Jonas 2014: 7.
[18] Brende et al 2017: 233.

Collaboration for Infectious Disease Preparedness (GloPID-R) in 2013 as a ready-to-go platform for pharmaceutical research coordination in the event of a public health emergency.

The rationality of preparedness is manifest not only in the language around global health risks, but also in the instruments and tools of policy responses. A key instrument are surveillance systems to to pick up signs of an outbreak early and monitor the spread of diseases. In the last two decades, many countries have strengthened their infectious disease surveillance systems, especially in OECD countries[19]. In 2005, the revision of the International Health Regulations (2005) expanded systematic surveillance at the global level. WHO member states are now required to implement early-warning systems and laboratories that can detect potential threats and report outbreaks to WHO. Many global health initiatives working with the global health risks framework emphasise the importance of the IHR to strengthen pandemic preparedness. Another set of governance mechanisms that is commonly promoted to strengthen pandemic preparedness is the development and stockpiling of medicines and vaccines for infectious diseases with pandemic potential. To that end, WHO has developed a pharmaceutical "R&D Preparedness" strategy, the R&D Blueprint[20]. Starting from the premise that "Infectious disease epidemics pose a clear and ongoing risk to global health, security and economic prospects"[21] the Blueprint is a framework to accelerate the development of drugs and vaccines for infectious diseases with pandemic potential by agreeing on priority pathogens, identifying financing mechanisms, providing coordination and technical guidance. CEPI, an alliance of governments, pharmaceutical companies, philanthropic organisations and academics, was set up to "pursue a proactive ("just-in-case") and accelerated ("just-in-time")"[22] strategy to develop vaccines against infectious diseases with pandemic potential. National governments, especially in Europe and North America have created stockpiles of medicines and vaccines for potential infectious disease pandemics. The EU agreed on a joint-purchasing approach for medicines and vaccines required for such events.

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[19] See, for example, M Stoto 2012: The effectiveness of U.S. public health surveillance systems for situationual awareness during the 2009 H1N1 Pandemic, PLoS One (August): http://dx.doi.org/10.1371/journal.pone.0040984

[20] WHO 2016: An R&D Blueprint for action to prevent epidemics. Plan of action. Geneva: 4.

[21] WHO 2016: Blueprint: 5.

[22] CEPI 2016: New vaccines for a safer world: 1. http://cepi.net/sites/default/files/CEPI_2pager_03_Feb_17.pdf

Finally, the rationality of preparedness as response to global health risks is manifest in the development of procedures, legislation and financing mechanisms that can be activated in an emergency event. Such procedures have been created for how the development and use of relevant medicines and vaccines an be accelerated. As the World Economic Forum's *Global Risk Report 2016* argues: "Preparedness and response measures range from the behavioural… to the need to invest in diagnostic, drug and vaccine R&D and in its enabling environment, especially advancing a regulatory framework[23]. At the national level, legislation is most advanced in the US notably with the creation of the Animal Efficacy Rule and the Emergency Use Authorization. The Animal Efficacy Rule responds to the problem that many diseases that are considered health security threats occur only rarely – or not at all – in nature. Medicines and vaccines against such threats can often not be approved on the basis of human clinical trials. The reason for this is that disease outbreaks may be too short or involve too few people for large-scale clinical testing to be organised, and deliberately exposing humans to pathogens merely for the purpose of pharmaceutical development is considered unethical. Under the Animal Efficacy Rule the US Food and Drug Administration (FDA) can approve pharmaceuticals based on efficacy studies conducted with animal models rather than on human clinical trials. The product's safety, however, has to be demonstrated in human studies. The EUA was established as part of the Project Bioshield Act and the Pandemic and All-Hazards Preparedness Reauthorization Act (2013). It can provide authorisation for the use of pharmaceuticals and medical devices that have not yet been fully tested for safety and efficacy. There is no equivalent to the animal rule in other countries or at the international level, but some countries and international organisations have prepared emergency use authorisation procedures as part of pandemic preparedness strategies. For instance, the European Medicines Agency has initiated procedures for accelerating the availability of vaccines during an influenza pandemic, including a 'mock-up procedure' whereby a vaccine can be authorised on the basis of the virus strain that might cause a pandemic – before the pandemic has actually occurred.. In the wake of the Ebola outbreak, WHO created Emergency Use Assessment and Listing procedures that were used for Ebola diagnostics and are currently being used also for the first Ebola vaccine. In addition financing facilities have been created to strengthen global pandemic preparedness. In 2015, WHO member states set up a Contingency Fund for Emergencies to

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[23] WEF 2016: 7.

fund initial response activities, and a year later, the World Bank launched the Pandemic Emergency Financing Facility to "create the first-ever insurance market for pandemic risk"[24].

Global health risks: a moral imperative for global action?

The framing of pandemics as a global risk shapes the perception of the problem as unpredictable yet unavoidable and potentially catastrophic, and sets the path to the policy response of pandemic preparedness. Moreover, this frame generates a tone that seems to make it particularly suitable for global governance and global collective action[25]. A key insight from sociological theories of risk is that modern societies not only create new risks (by creating new technologies), but that they also want to control them. As Giddens writes: "Risk is the mobilizing dynamic of a society bent on change, that wants to determine its own future rather than leaving it to religion, tradition, or the vagaries of nature"[26]. Niklas Luhmann in his sociological theory of risk finds that there is a common perception that "the future depends on decisions made in the present"[27]. From this perspective, the future risk of disasters depends on decisions that someone has made - or not made. If this is the case, "one can demand that such dangers be obviated"[28]. Hence, with the perception that risks depend, at least partly, on human decisions comes the expectation that decisions are made that minimise future risks. Inherent in the modern perception of risk, therefore, is a call to action.

Yet, how to combine this call to action with a portrayal of risks as unpredictable? If we perceive risks as unpredictable we remove the rational calculation of relative likelihood and impact as the basis for decision-making. Then how do we decide about which risks to prioritise, which risks to act on and where to allocate finite resources? In the public and political debate on global health risks, the key rationale for decision-making and action is the potentially disastrous impact of a pandemic.[29] The Commission on a Global Health Risk Framework for the Future suggests that

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[24] World Bank 2016: World Bank Group launches groundbreaking financing facility to protect poorest countries against pandemics, Sendai, 21 May. Available at:
http://www.worldbank.org/en/news/press-release/2016/05/21/world-bank-group-launches-groundbreaking-financing-facility-to-protect-poorest-countries-against-pandemics

[25] See also anthropological studies on risk as a manifestation of political tensions, e.g. Douglas; Nelkin?

[26] Giddens 2000: 42.

[27] Niklas Luhmann 1993: Risk: a sociological theory. Translated by Rhodes Barrett. Berling and New York: De Gruyter: X.

[28] Ibid.

[29] This rhetoric feeds into the sense of urgency and emergency that has been created through the framing of certain health issues as security threats. Several scholars have illustrated how the securitisation of health issues has created a certain "political modality" for dealing with health problems, an "emergency modality of

an annual commitment of $4.5 billion could significantly strengthen global pandemic preparedness. It then goes on to ask: "How does $4.5 billion per year stack up against the potential risks? The 1918 influenza pandemic killed approximately 50 million people (CDC, 2014) and arguably as high as 100 million in 1918–1920 (Johnson and Mueller, 2002)" and "during the 21st century global pandemics could cost in excess of $6 trillion" (2015: 17; 18). CEPI, with its mission to develop vaccines against future pandemics, argues that "[i]nfectious disease epidemics … match wars and natural disasters in their capacity to endanger lives, disrupt societies and damage economies...Many of the epidemic diseases that we know pose the greatest threat to society could be prevented with vaccines. But very few vaccines against these threats have been developed to create proven medical products"[30]. And the Global Health Security Agenda points out that: "Experts estimated that the 2003 SARS outbreak cost the global economy between $30 billion and $40 billion in just 6 months. The next severe influenza pandemic, for example, could cost the world economy up to $6 trillion. The enormous costs of pandemics can be averted with strategic investment in capacity building and preparedness".[31]

By emphasising the potentially catastrophic impact of global health risks, this framing makes it difficult to oppose measures that could help mitigate or even prevent the catastrophe. Faced with potentially enormous losses not only in human lives but also in economic terms, "[i]t is no longer possible to say, without exposing oneself to criticism, that according to the calculations, the risk is negligible"[32]. In other words, faced with the potential enormity of the catastrophe, it is difficult to argue that the resources should be spent on other things. Hence, the sense of fear and urgency created by this framing lifts the issue beyond the level of political conflict about different interests and perspectives. This dynamic resembles the effects that framing an issue

intervention" (Lakoff and Collier 2008: ?) and a "World on Alert" (Weir and Mykhalovskiy XXXX) (see also Craig Calhoun). In particular, the rhetoric of urgency and emergency seems to promote governance responses that are short-term and focus on technological interventions, such as surveillance systems and pharmaceuticals, which are perceived as politically neutral and therefore supposedly more easily justified in international politics than social and economic interventions (Roemer-Mahler and Elbe 2016; Collier and Lakoff 2008; Calhoun XXXX).

[30] CEPI n.d. Mission. Available at: http://cepi.net/mission

[31] GHSA 2016: Advancing the Global Health Security Agenda: Progress and early impact from U.S. investment, p. 1
https://www.ghsagenda.org/docs/default-source/default-document-library/ghsa-legacy-report.pdf?sfvrsn=12

[32] Chateauraynaud, Francis and Didier Torny. 2005. Mobiliser autour d'un risque. Des lanceurs aux porteurs alerte in Risques et crises alimentaires, C Lahellec (ed.), Lavoisier, pp. 329-339. (p.4)

as a security threat has, and scholars of global health politics have used securitisation theory to tease out these effects when health issues such as HIV/AIDS and Ebola were portrayed as threats to national and international security[33]. Furthermore, it has been argued that it is precisely the move of lifting security debates out of the realm of normal politics that makes securitisation such an attractive strategy for actors who seek to mobilise resources and attention for an issue[34].

The risk-frame has, however, a significant advantage compared to the security-frame: The notion of security tends to be divisive as most people associate security with national interest. The term risk carries an aura of science, objectivity and neutrality and is therefore less obviously politically charged than the notion of security. The risk-frame is therefore more inclusive than the security-frame. This inclusive character is strengthened further by language that underscores the global nature of the impact: millions of lives lost globally, damages to the global gross domestic product (GDP), and the rapidity with which "an airborne influenza virus could spread to all major global capitals within 60 days"[35]. The inclusive character of framing health issues as global risks is of particular relevance in the global political arena where the range of interests and perspectives - including on health - is wide, where cooperation is voluntary, and where persuasion can be a powerful tool to promote cooperation[36].

The risk-frame may seem particularly suitable for global governance and global collective action because it combines a moral imperative to act with a tone of neutrality and inclusiveness. Yet, it merely shuts out politics rather than remove it. In the aftermath of the Ebola outbreak, several reviews and lessons-learned reports were published[37], all of which highlighted the need to strengthen local health systems in low- and middle-income countries. This would certainly benefit those people the most who are most likely to be mainly affected by a pandemic. Not only are pandemics most likely to spread first and foremost in poor countries, but stronger health systems would also help local populations in the absence of a pandemic by preventing

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[33] references
[34] reference
[35] UN High-level Panel on the Global Response to Health Crises 2016: Protecting humanity from future health crises. Advance unedited copy. 25 January. Available at http://www.un.org/News/dh/infocus/HLP/2016-02-05_Final_Report_Global_Response_to_Health_Crises.pdf
[36] A Betts 2009: Protection by Persuasion. Cornell.
[37] WHO 2015; Moon et al., 2015; UN Secretary General 2015; UN High-level Panel 2016.

thousands of deaths every day from already existing health threats. The focus of the preparedness agenda lies, however, with the establishment of logistical, financial and technological mechanisms requirement for early detection and containment. While this could certainly reduce the global impact of infectious diseases, it would do little to reduce the impact of infectious diseases in poor countries (MSF 2015). Despite the tone of neutrality and inclusiveness, framing pandemics as global risks privileges the interests of some over those of others.

Framing risks in global health

This section discusses a different form of framing: how global health has been framed as different types of risk. Framing has been used by a small number of studies to explain why some global health issues achieve greater prominence than others.[38] These studies point out that levels of mortality and morbidity do not always offer a satisfactory explanation for which health issues appear on international agendas and which do not. The appearance of the Zika virus in South America in 2015-16, for example, received widespread attention and was declared a Public Health Emergency of international Concern by the WHO (only the fourth health emergency to reach this highest level of alert), despite no one having died from the disease; while the 750,000 infants who die *each year* of diarrhoeal disease barely warrants a mention on international agenda. Instead these studies suggest that what matters is how health issues are presented, or 'framed' to resonate with powerful actors' interests. Thus Owain D. Williams argues that economic framings for patent protection tapped into sectoral interests which limited the ability of pharmaceutical companies to produce cheap and affordable generic medicines needed to save lives. Reubi goes further, suggesting that successfully framing tobacco control as a human right allowed activists to then 'tap into the powerful, judicial monitoring and enforceabiity mechanisms that make up international human rights'[39].

In the literature on global health, framing has therefore been principally used to explore how advocates persuade powerful actors to take positions and use their influence on a particular health issue (agenda setting). But framing may also be used to explain or legitimise the actions of these powerful actors. Thus the World Bank plays a major role in health policy *because* it can frame health as an issue for developing economies. Here, however, we use frames in a new

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[38] Notably Shiffman 2009, Labonté and Gagnon 2010 , McInnes and Lee 2012.
[39] Reubi (2012), S176.

manner: to suggest that a health issue cannot be successfully constructed as a risk without framing it as a risk *to something or to someone*. Risks are therefore framed to resonate with particular communities who possess power in an attempt to generate action. Frames in global health are used both by advocates and actors, to persuade and to legitimate actions. Its utility as an analytical tool is in highlighting the material effects that changes in language may have in both limiting the range for 'appropriate' policy responses and in laying out a pathway into the future through institutionalisation. It is also useful for us in highlighting that health is a political space in that: framings are driven at least partly by strategic interests; that alternative - and sometimes competing - framings of health issues (can) exist; and that framings create winners and losers.

We suggest that four frames relating to risk can be derived from the more general literature on framing for global health:

- The biomedical frame is perhaps the most straightforward and longstanding, and is used to suggest that an issue is a risk to human health. In its narrowest sense, it focuses on the risk to the functioning of the human body from exposure to pathogens and toxins, but may also be scaled up to consider the risk to the physical and mental health of communities. Thus a highly pathogenic zoonotic virus such as H5N1 (avian influenza) has been successfully framed as a biomedical risk because of its high mortality rate (currently in excess of 50% of humans infected by poultry), but also because of the potential of a pandemic if the virus mutates to allow human-to-human transmission.
- The rights frame is based not simply on the idea of a risk to 'the enjoyment of the highest attainable standard of health', articulated in the constitution of the WHO and subsequently developed in international law (including the Universal Declaration on Human Rights in 1948), but on how ill-health may lead to discrimination. This has been particularly prominent in campaigns concerning HIV/AIDS and in tobacco control. AIDS activists from the 1980s on have fought against discriminatory practices affecting both individual people living with HIV and AIDS (PLWHA), and communities which are perceived as being at high risk from HIV infection (notably the gay community, but also immigrants from countries with a high incidence of the disease). In contrast, while 'big tobacco' has argued that restrictions on tobacco use infringes the right of individuals to choose, advocates of tobacco control counter that smoking (including passive smoking) affects the right to health enshrined in the WHO constitution.

- The economics frame suggests that a health issue may be a risk to global economic growth or to development in low income economies. Arguments such as lost productivity due to worker absenteeism, reduced investment in areas where disease is endemic, formal restrictions or a general unwillingness to travel affecting both businesspeople and tourists, and a lack of mobility in people moving to/from regions have all been deployed to suggest how economies may be affected by health issues and especially communicable diseases. During the first decade of the twenty-first century, for example, fears were commonly expressed that HIV represented an economic risk to fragile African states, potentially threatening their viability; while early assessments of the SARS outbreak in 2002-03 identified the economic costs in terms of tens of billions of dollars, feeding into ideas that newly emerging communicable diseases threatened global economic growth and were a risk not only to LICs but to high income states as well.

- Finally health may be framed as a security risk, not least because of its effects on (inter)national stability. HIV for example has been presented as a risk to 'the glue that holds societies together' because of its effects on professional classes such as teachers, civil servants and the police; viruses such as smallpox have been identified as possible weapons for use by terrorists; epidemics threaten the social contract, where governments provide protection for their citizens; and new diseases, or diseases new to a region, may provoke widespread fear in society (as briefly occurred in 2015 when Thomas Edward Duncan was diagnosed with Ebola in the US).

Framing Ebola as a global risk

As an example of how these different frames are used, we explore three organizations central to the 2014-15 outbreak of Ebola in West Africa: the WHO, the international humanitarian NGO Médecins Sans Frontières/Doctors without Borders (MSF) and the UN Security Council. Each of these organisations presented the risk from the outbreak in different ways, allowing them to construct different pathways for response. Predictably, the WHO framed the outbreak in biomedical terms. In her Report to the Special Session of the [WHO] Executive Board on Ebola in January 2015, for example, Director General Margaret Chan spoke of the outbreak in almost solely health terms. She emphasised its size and complexity compared to previous outbreaks, the weakness of the public health infrastructure which allowed it to develop, the establishment of new laboratories to provide diagnoses, and the skill and bravery of health personnel in treating those infected. The risk presented was clearly to the lives and well-being of individuals

in West Africa.[40] This framing established a pathway for response based on established public health and biomedical methodologies of surveillance, prevention of infection, controlling the spread of the disease and treatment of those affected. The WHO emphasised its role in assisting nearby states to prevent the spread of the disease; the need for improved health system functions to prevent new outbreaks of ebola from developing into crises; and its role in fast tracking the development of improved diagnostics and vaccines.[41] It was also sceptical over the introduction of travel restrictions, *not* because of the potential economic impact (a common concern), but because of its potential to limit the number of aid workers being sent to West Africa. Nevertheless, the WHO did also deploy additional frames. In the opening paragraph of its Report to the January 2015 Special Session of the Executive Board on Ebola, the WHO Secretariat wrote that the outbreak 'represents a threat to global health security',[42] while for the same meeting Margaret Chan wrote that 'what began as a health crisis quickly escalated into a humanitarian, social, economic and security crisis'.[43] The use of additional framings was also evident in Chan's September 2014 briefing to the UN Security Council. In this she deployed not only the security frame, talking of the risk of state failure, but she also deployed the economic frame, reiterating the World Bank's warning of a 'potentially catastrophic blow' to economies in an already weak region.[44] The economic framing is also seen in other WHO documents, which talk of the manner in which Ebola 'devastated the health systems *and* economies [emphasis added]' in West Africa,[45] and the manner in which health emergencies such as the Ebola outbreak 'can have long-term consequences that undermine decades of social development'.[46]

In widening the framing of the Ebola outbreak beyond the biomedical, the WHO was legitimising the involvement of other actors rather than resisting. Whether this was a conscious strategy to gain wider support and assistance, or a reflection of the manner in which the crisis had developed is unclear. But it does stand in stark contrast to the framing presented by MSF, the other high-profile health actor involved. MSF consistently presented the Ebola crisis in biomedical terms, focusing on the nature and spread of the disease, and on the suffering of

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[40] Margaret Chan, 'Report by the Director General'. See also WHO, 'Ebola virus disease' and 'WHO response';; BBC, 'WHO: Ebola "an international emergency".
[41] See for example WHO, 'Current context and challenges', 'Fast tracking' and 'Ensuring WHO's capacity'
[42] WHO, 'Current context', paragraph 1.
[43] Margaret Chan, Report by the Director General.
[44] UN, 'Spread of Ebola'
[45] WHO, 'Building resilient health systems', paragraph 1.
[46] WHO, 'Ensuring WHO's capacity', paragraph 1.

patients. Although the use of the biomedical frame is hardly surprising, the heavy - almost total - focus on this frame is perhaps more so, given the potential utility of the rights and economic (especially economic development) frames for health provision. Given MSF's historic wariness over working with militaries however, the avoidance of the security frame is perhaps more predictable.

A typical example of MSFs biomedical framing is the short, high profile article posted on its website in June 2014. In this MSF makes the plea for additional resources. Dr Bart Janssens (MSF Head of Operations) is prominently quoted, stating 'The epidemic is out of control… there is a real risk of it spreading to other areas'. The focus is on the spread of the disease, the high numbers of cases, that MSF have 'reached our limits', and the need for additional medical and public health resources to bring it under control.[47] Two months later, in reaction to the WHO declaring the outbreak a PHEIC, Janssens commented:

> Declaring Ebola an international public health emergency shows how seriously WHO is taking the current outbreak but statements won't save lives. Now we need this statement to translate into immediate action on the ground. For weeks, MSF has been repeating that a massive medical, epidemiological and public health response is desperately needed to saves lives and reverse the course of the epidemic. Lives are being lost because the response is too slow. Countries possessing necessary capacities must immediately dispatch available infectious disease experts and disaster relief assets to the region. It is clear the epidemic will not be contained without a massive deployment on the ground from these states. In concrete terms, all of the following need to be radically scaled up: medical care, training of health staff, infection control, contact tracing, epidemiological surveillance, alert and referral systems, community mobilisation and education.[48]

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[47] MSF, 'Ebola in West Africa'. See also for example MSF, 'Pushed to the limit', 'Guinea: Ebola epidemic', 'Ebola: MSF response', and 'Ebola: after five months, where is the response?'.
[48] Quoted in MSF, 'Ebola: official MSF response to the WHO declaring Ebola an international public health emergency'.

MSFs consistent use of a biomedical framing led to a clear pathway of response: 'a massive deployment of medical and disaster relief specialists from states'.[49] When MSF's International President, Dr Joanne Liu, provided a special briefing for the UN, she similarly used the biomedical frame:

> Six months into the worst Ebola epidemic in history, the world is losing the battle to contain it. Leaders are failing to come to grips with this transnational threat. In West Africa, cases and deaths continue to surge. Riots are breaking out. Isolation centers are overwhelmed. Health workers on the front lines are becoming infected and are dying in shocking numbers. Others have fled in fear, leaving people without care for even the most common illnesses. Entire health systems have crumbled. Ebola treatment centers are reduced to places where people go to die alone, where little more than palliative care is offered. It is impossible to keep up with the sheer number of infected people pouring into facilities. In Sierra Leone, infectious bodies are rotting in the streets. Rather than building new Ebola care centers in Liberia, we are forced to build crematoria.[50]

This led to her identifying and discussing a particular pathway of response based on prevention, containment and treatment. Most notably, she departed from MSF's traditional aversion to working with military's to ask for military aid. However, this was *within* the biomedical frame and its identified pathway of response, rather than an attempt to securitise the outbreak:

> Many of the Member states represented here today have invested heavily in biological threat response. You have a political and humanitarian responsibility to immediately utilize these capabilities in Ebola-affected countries. To curb the epidemic, it is imperative that States immediately deploy civilian and military assets with expertise in biohazard containment. I call upon you to dispatch your disaster response teams, backed by the full weight of your logistical capabilities.[51]

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[49] MSF, 'International response'. See also MSF, 'Guinea: Ebola epidemic'
[50] Liu, 'UN special briefing'
[51] Liu, 'UN special briefing'

Unlike the WHO and MSF, whose organisational focus was on health, the UN Security Council had only occasionally intervened on health issues. Its most notable health interventions prior to the Ebola outbreak concerned HIV, including UNSC Resolution 1308 (which concerned the impact of HIV on peacekeeping).[52] In September 2014 however, in under a week, it passed two Resolutions concerning the Ebola outbreak, both following discussions in the Council. The first, Resolution 2176 of 15 September, expressed the Council's 'grave concern' over the outbreak and extended the UN peacekeeping mission in Liberia (UNMIL, authorised under Chapter VII of the UN Charter) until 31 December 2014. Significantly the Council determined the outbreak to be 'that the situation in Liberia continues to constitute a threat to international peace and stability in the region', effectively securitising the outbreak.[53] The second, longer Resolution followed an extended (but consensual) discussion in the Council on 18 September. This discussion included briefings from amongst others Margaret Chan, David Nabarro (Senior UN System Coordinator for Ebola) and Jackson KP Niamah from MSF. The Council reiterated its position that the 'unprecedented extent of the Ebola outbreak in Africa constituted a threat to international peace and security', a security framing which was consistently used during the Council's discussion and in the subsequent Resolution 2177.[54] In particular the risk of state failure was alluded to when several Council members noted the fragile and vulnerable condition of affected countries, a point reiterated in Resolution 2177 which recognised

> that the peacebuilding and development gains of the most affected
> countries concerned could be reversed in light of the Ebola outbreak and
> underlin[ed] that the outbreak is undermining stability of the most affected
> countries concerned and, unless contained, may lead to further instances
> of civil unrest, social tensions and a deterioration of the political and
> security climate.[55]

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[52] United Nations Security Council Resolution 1308, 17 July 2000. Available at
http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/1308(2000)
[53] UNSC Resolution 2176, 15 September 2014. Available at
http://www.un.org/en/sc/documents/resolutions/2014.shtml
[54] UNSC Resolution 2177, 18 September 2014. Available at
http://www.un.org/en/sc/documents/resolutions/2014.shtml; Minutes of the United Nations Security Council 7268th Meeting, S/PV.7268, 18 September 2014, available at
http://research.un.org/en/docs/sc/quick/meetings/2014. For a summary of the discussion see UN Meetings Coverage: Security Council, 'With Spread of Ebola Outpacing Response, Security Council Adopts Resolution 2177 (2014) Urging Immediate Action, End to Isolation of Affected States' available at
http://www.un.org/press/en/2014/sc11566.doc.htm

[55] UNSC Resolution 2177.

Although the security framing dominated both the discussion in the Council and its two Resolutions, legitimising the deployment of military forces to assist in the region, other framings were also used. These allowed the Council to develop a pathway of response which emphasised collaboration between not only elements of the UN system, but those states able to provide aid. Resolution 2177 for example 'stress[es] the need for coordinated efforts of all relevant United Nations System entities to address the Ebola outbreak'.[56], while Secretary General Ban Ki-Moon's opening comments in the Council debate drew on multiple frames to portray the outbreak as a 'complex emergency' requiring coordinated response.[57] The economic frame was used by a number of those participating in the debate,[58] with Resolution 2177 also noting the risk to economies, including the risk posed by travel restrictions;[59] the rights frame was deployed, with the Council noting in particular the impact on women and the humanitarian dimensions of the outbreak;[60] while multiple contributions (including those from all P5 Representatives) referred to the outbreak as a health crisis (though often as 'more than' a health crisis).[61] Interestingly, Resolution 2177 linked both health and security by referring to the Global Health Security Agenda, allowing it to include public health measures in its pathway of response.[62]

Conclusion

The rise of global health on the international political agenda has been accompanied with rise of global health *politics.* Yet, there is an uneasy relationship between the two because public health has traditionally been considered a largely technical, scientific field that operates largely on the basis of positivist rationalities. Moreover, in the global arena, where cooperation and collective action is difficult to enforce, political conflict can be seen as particularly problematic for the pursuit of public goods such as improved health. We illustrate the uneasy relationship between global health and politics through the lens of framing analysis.

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[56] UNSC Resolution 2177, p.3.
[57] Minutes of UNSC 7268th meeting, p.2.
[58] See for example the contributions made by Representatives from Australia and Chad, available in the Minutes of UNSC 7268th Meeting, pp. 16 and 19.
[59] UNSC Resolution 2177, pp.1-2.
[60] For example, Resolution 2177, pp.1 and 2.
[61] Minutes of UNSC 7268th meeting.
[62] UNSC Resolution 2177, p.2.

In the first part of the paper, we show how the framing of infectious disease pandemics as a global risk creates a certain perception of the policy problem at hand: how to respond to a future event that is potentially catastrophic, yet unpredictable and unavoidable? Furthermore, we show how this framing also has material consequences in that promotes a policy response of various preparedness initiatives, programs and institutions. We argue that the global risk frame is inherently political in that its material consequences benefit populations in wealthy countries more than those in poor countries and therefore privilege the interests of the former of those of the latter. At the same time, however, the frame is particularly conducive to diffusing political conflict. First, it combines a sense of urgency - derived from its focus on potential catastrophe - with the suggestion that measures can be taken to mitigate or even prevent disaster. In this situation, is difficult to oppose those measures without seeming negligent. Second, the global risk frame can help diffuse politics because of its neutral, almost scientific tone. It also promotes a sense of inclusiveness by articulating the potentially catastrophic impact of pandemics in global terms - as global loss of lives, damage to the global economy, and the global spread of disease. In other words, be creating a moral imperative to act and a sense of inclusiveness the global risk frame can help diffuse political argument about where the benefits and costs of preparedness policies lie.

In the second part of the paper, we illustrate the difficult relationship between global health and politics by looking at how different organisations involved in the international response to a recent infectious disease outbreak, Ebola, framed the problem in different ways and, consequently, advocated different pathways of response. This opens up the possibility of competition and contestation, where there is no scientifically valid optimal response but rather a clash of interests and values each of which are legitimate from perspective of the particular frame used. The significance of what we are arguing therefore is that global health has opened up the requirement for a greater political sensitivity. Politics is inherent in global health, and needs to be accommodated rather than avoided.