POLICY|brief

Coordinating Global Health Responses

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Introduction

The end of the Cold War gave the (Western) world an apparent reprieve from weapons of mass destruction. Then came HIV and AIDS. Since then, a host of human insecurities and pandemic threats have converged to upend that semblance of order.

The 'grand decade of global health' (2000-2010) posited a litany of responses. These were meant to (re)establish order. They were overwhelmingly characterized by vertical (top-down) solutions to individual health threats: HIV, tuberculosis, and malaria being the three diseases which received the most attention. Being infectious diseases, this focus left non-communicable diseases (NCDs), maternal health, mental health, and even (re)emerging (infectious) diseases largely in the lurch. It also neglected horizontal responses based on local networks and knowledge: the successful response of some communities to the 2014-2015 Ebola outbreak in West Africa showcases alternative solutions.[1] Yet with the grand decade over, the a priori importance once attached to health has disappeared from the international agenda.

Indeed, health has only regained a fraction of its policy prioritization through the ascendance onto the international agenda of potential epidemic/pandemic threats such as Ebola and Zika. Here, however, the risk of non-intervention almost pales in comparison with the risk of intervention: "Epidemics appear not only as a threat, but as a challenge, a chance for the interventionist state that wants to prove its ability to act against infectious disease."[2] Compounding the direct challenges posed by epidemics and pandemics themselves are the indirect complications such as "panic, social unrest and economic consequences"[3] which up the ante for response – with unknown consequences:[4] A number of regions of Brazil "proactively declared a public health emergency with regard to Zika in November 2015."[5] If and when the expanded political, and military, powers granted under the emergency are not revoked, these could lead to serious infringement of biological and civil liberties.

The current context is one defined by varying degrees of disorder. This is the state of affairs in the realms of geopolitics to market (dis)regulation, of climate (dis)agreement to (il)legal migration status. Each of these has a bearing on global as well as local health. In fact, health is of particular importance as its causes and consequences, alongside its associated vulnerabilities and threats, crosses borders.

As such, mounting a coordinated effort to respond to global health issues is an imperative. The question is, how to do it?

Evidence and Analysis

The most critical challenge to coordinating global health responses is that there is no global health coordination.[6]

At the global level the World Health Organization (WHO) serves as an institutional figurehead. It collects and collates information on health risks and vulnerabilities. It also issues guidelines towards which states can orient their health policies. The WHO does not, nor does any other organizational body, issue, direct, and enforce global health policy.

There are two glaring problems with this arrangement:

1. The WHO has no authority with which to implement or intervene[7] to enable or enforce its guidelines.

2. WHO-directed global health coordination is a vertical construct which assumes global guidelines can or should be suitable for state-level or local political, economic, and social conditions. Any strength of the WHO's recommendations rests on the acceptance and integration of a norm – for example the norm of reporting an infectious disease outbreak within a prescribed period of time: 24 hours. If the norm is not accepted and integrated, it does not become a norm. While various mechanisms have been employed to attempt to bridge the gap between local and global health perceptions and policies, none has proven to have sustainable traction. An additional third problem is with the norm propagation itself: 73 new 'harmonization initiatives'[8] have been initiative in an attempt to secure agreement on global health coordination: an oxymoron.

This is the case with regard to the WHO's curtailed powers, and pertains to health coordination at the regional level, e.g. within the European Union (EU) as well. On the global level, the EU participates in the Global Health Security Agenda, which while raising relevant concerns has no action mechanism. On the regional level, the EU Commission articulates 'principles' and offers guidance to Member States on health policies, but it does not and cannot issue – and thus coordinate – binding legal policies. The emergent gaps of this approach include, in the post-2007 financial crisis era, Spain's revoking much health care access for new migrants, and the systemic discrepancy between commitments to health and health spending and actual disbursements.[9] Fundamentally, global health coordination is *State* health coordination.

Acknowledging that States are the entities which retain the right and responsibility for implementation of health policies, the challenge is to formulate and coordinate health responses in support.

In order to do this, five critical policy issues must be taken into account:

First, local outbreaks can and do rapidly spread to become epidemics and even pandemics. Given increasingly mobile populations, this trend is set to increase. Knowledge and information collected at the global level has the potential to both inform local preparedness and to mobilize in turn global and local resources in a joint response. The response itself has the highest chance of proving successful when it includes local, national, international and global entry – and exit – points.

Second, responding to a health risk or threat is a fundamentally political act. "The fundamental lesson, unsurprising to anyone familiar with the history of social engineering and foreign aid in Africa, is that AIDS effects are driven ultimately by institutional and political interests."[10] National as well as international political leaders must be on board.[11]

Third, responses to health crises – risks or threats – exhibit a disconnect between State, non-state and global institutional responsibilities. The result is a diffusion of definitional, prioritization, decision-making and implementation powers. The result is more confusion than coordination.

Fourth, each disease outbreak is different, and its required response is as well.

Each disease outbreak is potentially different, with varied epidemiology, infection, morbidity, and mortality rates and requiring diverse control measures, means that each outbreak obliges governments to be flexible in how they respond.[12]

The **fifth** and final critical insight is that disease outbreak, including epidemic and pandemic anticipation and response, depends on and in turn creates health security. Health security is a local, national, regional, international, and global challenge.

Global health security depends on many factors—robust disease surveillance systems, reliable health information, prevention, diagnostic, and treatment services, financing, and strong political commitment. But without skilled health professionals, who should be valued and protected everywhere, to act as the first line of defence of individual health security, other efforts will be in vain.[13]

It means that at every level individual health is a constitutive part of global health security. On all levels, such health security is not merely a 'nice to have', but a 'must have', in an increasingly interconnected world.[14] Connecting these levels is diplomacy; notably a diplomacy that takes into account local conditions and culture and renders these relevant globally. The EL-CSID project explores the role in particular of cultural, science and innovation diplomacy – also to innovate in heath security.

Policy Implications and Recommendations

Successful policy depends upon its resonance, applicability and implementation at the individual, local, State, international and global levels.

1. At the global level, the current restrictions of State authority demand a policy response which focuses on defining and defending global health. The Framework Convention on Global Health (FCGH) is a step in this direction.[15, 16] If adopted, the FCGH's status as a treaty would enhance – but not guarantee – its enforcement.

2. Critically, the enforcement guarantee, or the ultimate global health coordination, remains with States. Here three new policy ideas are proposed to facilitate such coordination:

First, that States be recognized as bearing the onus of identifying and prioritizing necessary health interventions. This has three components.

1. The establishment of the University of Pretoria, South Africa's Zoonoses Research Unit (2016), for example, anticipates the further (re)emergence of this class of diseases, to which HIV, Ebola and Zika all belong. The research resulting from this should be shared (inter)nationally for the benefit of global preparations for (r)emergent zoonoses.

2. Concomitant to this is the necessary rearrangement of responsibilities between States and non-state actors (NSA) to preserve such State primacy, or, alternatively, to (d)evolve accountable responsibility: For instance, State A gives State B or NSA X the authority to delivery health care against disease Y. In the first instance of State primacy, all actors involved in disease Y defer to the State's authority, and the State retains responsibility and accountability for health responses. In the second instance of (d)evolutions, those States or NSAs to whom authority is (d)evolved assume responsibility – and accountability vis-à-vis the deferring State for the health of its citizens.

3. For example, this might work with regard to a Memorandum of Understanding (MoU) between a (weak) State A and a (stronger) State B in terms of (military) logistical support in the event of a (zoonotic) epidemic. With a MoU in place prior to an outbreak, State A would pre-emptively grant authority to State B to assist. If State B failed to assist, or infringed upon the MoU, State A could hold it to account on behalf of the health of its (un)served citizenry.

Second, that individual human rights and health systems' responsibilities be brought into better international balance. That brain gain for State B does not automatically become brain drain for State A. On the one hand, programmes across the EU already exist to fund medical trainees from States A in States B which foresee their return, which are not always successful.[17] On the other hand, national policies within EU Member States (B) are particularly attractive to professionals from States A where their certifications are recognized.[18] An alternative to trainee programmes would be to have States B compensate States A for professionals who contribute to their brain gain, while enabling States B to continue to educate and train and retain further crops of such professionals.

Such a scheme would have three benefits:

1. It would retain the individual right to migration;
2. It would reduce development aid by directly contributing to the health systems of States A with clear lines of accountability; and
3. It might in the long-term counteract the net effects of brain drain in States A.

Third, that States, individually and in regional (EU) and international for a (UN, WHO) reorder the legal underpinnings of health rights pertaining to citizens versus migrants. This is necessary for two reasons:

1. Human beings interact with one another regardless of such a differentiation, and so, too, do microbes. The distinction is obsolete.
2. By distinguishing between citizens' rights as associated with State responsibility, whilst excluding migrants, the legal lines of accountability are preserved: But the borders of health insecurity remain untouched. Expanding the health rights of migrants would shore up State responsibility while protecting heath security for all.

Research Parameters

The EL-CSID project has the ambition to codify and articulate the relevance of cultural, science and innovation diplomacy for EU external relations as part of a systematic and strategic approach. It aims to identify how the Union and its member states might collectively and individually develop a good institutional and strategic policy environment for extra-regional cultural and science diplomacy.

The over-arching objectives of this project are threefold:

1. To detail and analyse the manner in which the EU operates in the domains of cultural and science diplomacy in the current era; comparing its bilateral and multilateral cultural and science ties with other states, regions, and public and private international organisations.
2. To examine the degree to which cultural, science and innovation diplomacy can enhance the interests of the EU in the contemporary world order and specifically, to identify:

   a) How cultural and science diplomacy can contribute to Europe's standing as an international actor;

   b) Opportunities offered by enhanced coordination and collaboration amongst the EU, its members and their extra-European partners;

   c) Constraints, both existing and evolving, posed by economic and socio-political factors affecting the operating environments of both science and cultural diplomacy.
3. To identify a series of mechanisms/platforms to raise awareness among relevant stakeholders of the importance of science and culture as vehicles for enhancing the EU's external relations. The research will generate both scholarly work and policy-oriented output, which will be disseminated through an extensive and targeted dissemination programme.

   Together, these objectives should not only contribute to a strengthening of EU policy towards the use of science, culture and innovation in its wider diplomacy, but also to a deepening of scholarly understanding of

diplomacy as an abiding, if changing, institution.

To these ends, EL-CSID will marshal an empirical and analytical narrative that will offer practical support to the further development and enhancement of the EU's science, cultural and innovation diplomacy. It will study the current and future role of science, innovation and cultural diplomacy as a feature of its foreign relations through a programme of historical stocktaking and multidisciplinary and cross-national comparative research.

Footnotes

[1] Villagers in a number of the affected countries identified transmission chains and implemented isolation of the sick to interrupt the spread of disease.

[2] Author's translation. Original: "Epidemien erschienen nun nicht nur als Bedrohung, sondern ebenso als Herausforderung, ja als Chance für den Interventionsstaat, der seine Handlungsfähigkeit in der Seuchenbekämpfung unter Beweis stellte," in Thießen, Malte (2015). 'Infizierte Gesellschaften: Sozial- und Kulturgeschichte von Seuchen,' in Aus Politik und Zeitgeschichte (ApuZ), 65. Jahrgang, 20-21/2015, S. 16.

[3] Author's translation. Original: "Panik, soziale Unruhen und wirtschaftiche Folgen" in Ehlkes, Lutz und Jürgen May (2015). 'Seuchen – gestern, heute, morgen.' in Aus Politik und Zeitgeschichte (ApuZ), 65. Jahrgang, 20-21/2015, p. 9.

[4] ibid.

[5] Gostin, Lawrence O. and Daniel Lucey (2016). "The Emerging Zika Pandemic: Enhancing Preparedness," JAMA (Online), (27 January).

[6] Conversation with Dr. Walter Biederbick, Robert-Koch-Institute Berlin, 20 September 2016.

[7] Interview with Dr. Rüdiger Krech, original: 'Durchgriffrecht'

[8] Holzscheiter, Anna, Thurid Bahr and Laura Pantzerhielm (2016). 'Emerging Governance Architectures in Global Health: Do Metagovernance Norms Explain Inter-Organisational Convergence?' Politics and Governance, Vol. 4, No. 3. DOI: http://dx.doi.org/10.17645/pag.v4i3.566

[9] For an overview of EU participative action on global health see, http://ec.europa.eu/health/eu_world/global_health/index_en.htm.

[10] De Waal, Alex (2006). AIDS and Power: Why there is no political crisis – yet. (Cape Town: Zed Books): p. 123.

[11] See reference to Indonesia's invoking of 'viral sovereignty' with regard to H5N1 in 2007.

[12] Davies, Sara E., Adam Kamradt-Scott, and Simon Rushton. (2015). Disease Diplomacy. International Norms and Global Health Security. (Baltimore: Johns Hopkins University Press): 122

[13] 'No health workforce, no global health security,' (2016), The Lancet, Vol. 387, No. 10033, (21 May), p. 2063.

[14] See also Moon, Suerie et al., (2015). "Will Ebola change the game? Ten essential reforms before the next pandemic," The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola Health Policy, The Lancet, (November 22). Available at: http://dx.doi.org/10.1016/S0140-6736(15)00946-0, Global Health Committee as part of the UN Security Council should be created "to expedite high-level leadership and systematically elevate political attention to health issues, recognizing health as essential to human security."

[15] See http://www.globalhealthtreaty.org/

[16] In his report for the June 2016 UN High-Level Meeting on Ending AIDS, Secretary General Ban Ki-moon stated, 'I further encourage the international community to consider and recognize the value of a comprehensive framework convention on global health.' See, Report, 1 April 2016, para. 74.

[17] With the exception of those who remain to, for example, marry, and gain permanent legal residency or citizenship.

[18] This is notably the case with regard to medical professions trained in East Africa whose credentials are automatically recognized by the UK's National Health System (NHS). This applies to the Brief as long as the UK is effectively part of the EU.

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