

Global Governance and the Limits of Health Security

The Ebola outbreak in West Africa has exposed the limits of the current approach to the global governance of infectious diseases, which mixes public health and security interests. International efforts to strengthen 'health security' quickly faltered when confronted with weak national health systems. Costly attempts by Western governments to strengthen global health security by developing new medical countermeasures, though important, did not yield a single, effective, widely available treatment or vaccine before the outbreak occurred. The World Health Organization (WHO), which had made strengthening global health security a strategic objective, was unable to marshal a rapid international response to the epidemic due to its institutional structure and recent cutbacks in its outbreak and emergency response department. In the end, governments could only try to get 'ahead' of the disease via a heavily militarised response that came too late for the thousands who have already died, that remains of uncertain sustainability, and that raises profound challenges for already stretched armed forces. The time has come to move from a focus on health security and international crisis response, to a system of global governance capable of addressing infectious disease outbreaks in an orderly, organised and sustainable manner.

Investments in global health security prove powerless against Ebola

For much of the past decade, the global governance of infectious diseases has been largely framed in the language of security. Responding to a series of infectious disease outbreaks – from HIV/AIDS, SARS and H5N1 through to H1N1, MERS and H7N9 – policymakers, particularly in the United States and western Europe, sought to protect their populations and economies through unprecedented investments in strengthening 'global health security'. WHO thus defined global health security as 'the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries' (WHO 2007: ix). The Ebola outbreak in West Africa is a pressing example of precisely such an emergency.

Prominent elements of this 'securitisation' of health emergencies include declaring diseases such as HIV/AIDS threats to international peace and security by the United Nations Security Council; establishing a new Global Health Security Initiative (GHSI); developing new international surveillance systems for detecting infectious disease outbreaks; updating the International Health Regulations (IHR); and devising a new pandemic influenza preparedness framework to coordinate the sharing of virus material and access to vaccines. As recently as February 2014, the United States launched a Global Health Security Agenda (GHSa) with the explicit goal to 'promote health security as an international security priority' by building surveillance, laboratory and emergency operations capacity in its currently 29 member countries (US Dept of Health and Human Services n.d).

The Ebola outbreak has been a test for many of these new mechanisms built on linking health and security concerns. Yet rather than confirming their robustness, the Ebola outbreak exposed a number of gaps and vulnerabilities, especially as the international community seemed powerless initially to stop the rapid spread of Ebola in West Africa. For many months, the response of the international community lacked proper coordination and leadership, directly contributing to the extent of the current crisis. Existing international mechanisms could not compensate for the challenging local conditions – characterised by weak national health systems and state capacities precluding effective outbreak control.

Confronting pressures at the World Health Organization

As the UN agency mandated to direct international health policy, WHO was facing a cascade of pressures even before the Ebola outbreak occurred; but the epidemic has further exposed some of the underlying institutional and financial challenges it faces. Despite a broad mandate to take on issues ranging from infectious diseases to universal health coverage and non-communicable diseases, WHO has limited budget control to fulfil this mandate. Not only have contributions by member states increased very modestly in the past decade but 80 per cent of the organisation's budget is dependent on voluntary contributions that are earmarked for specific projects determined by donor interests (Clift 2014). Limited budget control makes it difficult for WHO to implement core programmes, such as the IHR, which require member countries to report disease outbreaks that might constitute an international public health emergency and implement control measures. While outbreak reporting has improved since the revision of the IHR in 2005, the extent to which WHO can help low- and middle-income countries to strengthen national health systems to better manage disease outbreaks remains limited.

The effects of WHO's constrained control over its budget were aggravated further by severe funding cuts in the wake of the global financial crisis. The cuts were implemented at a time when political attention had shifted from infectious to non-communicable diseases, and therefore hit WHO's infectious disease work particularly hard: the outbreak and crisis budget was cut in half, and its epidemic and pandemic response department dissolved (WHO 2013; New York Times 2014). After the Ebola epidemic spiralled out of control, WHO was criticised for not responding earlier and providing global health leadership. Yet this also requires the political support of WHO's member states including through the sustained provision of resources and less focus on budget control by individual donors.

Medical countermeasures: Where are the Ebola medicines and vaccines?

Government efforts to strengthen health security also focused on developing new pharmaceutical defences against infectious diseases – like medicines and vaccines (Elbe *et al.* 2014). The US government, in particular, has released significant funding for the development and procurement of so-called 'medical countermeasures', including against Ebola. The European Commission also approved a Joint Procurement Agreement in April 2014, to enable all European Union (EU) countries to procure pandemic vaccines and other medical countermeasures as a group. Yet governments depend heavily on the cooperation of pharmaceutical companies in this area, because pharmaceutical development and manufacture is still mostly in the hands of private companies.

The core challenge encountered by US and European governments is that pharmaceutical companies generally do not view medical countermeasures as a commercially attractive area. Despite a range of government incentives,¹ big pharmaceutical companies in particular have shown limited interest; and governments have instead had to work mostly with smaller firms, for which biodefense money is one of the few available sources of funding. Yet smaller companies usually do not have the capabilities and expertise to take drug and vaccine candidates from the laboratory to the market – through the proverbial 'valley of death' in pharmaceutical development.

The medicines and vaccines currently under investigation against Ebola exemplify this situation. Initially developed mostly by small companies with significant biodefense funding from the US government, none of the medicines and vaccines was taken into late-stage development. While clinical trials in humans were not feasible in the absence of a large Ebola outbreak, the alternative pathway for regulatory approval on the basis of animal studies was not undertaken either.² Furthermore, government funding for the development of medical countermeasures too has waned in recent years in light of the economic recession and changing political priorities more than a decade after the terrorist attacks.

By the time the current Ebola epidemic occurred not a single new, safe and proven effective treatment or vaccine was widely available. Only after an international crisis was announced were some candidate drugs and vaccines rushed into clinical trials by international consortia consisting of public and philanthropic organisations, non-governmental organisations (NGOs) and pharmaceutical companies. Even if some of them eventually prove successful, those efforts will come too late for the thousands who have already died. Here too, the Ebola crisis has exposed the limitations of the current approach to the global governance of infectious diseases.

The militarisation of the international Ebola response

With existing governance mechanisms proving unable to contain the outbreak, and with no treatment available 'off the shelf', governments felt they had little choice but to catch up with the epidemic through recourse to a heavily militarised approach. After several months of inaction, governments finally leaped from complacency to emergency mode, as the Ebola outbreak was designated a threat to international peace and security by the UN Security Council in September 2014 and US President Barack Obama declared Ebola a threat to national security. By this point, even NGOs such as Médecins Sans Frontières (MSF) and Oxfam, often critical of military intervention, could see no other

way forward than calling for the deployment of military medical capability – especially given the urgency, the challenging local environment and the logistical complexity involved. Several governments, including those in the United States, China and Europe, heeded the call and dispatched personnel and equipment to the affected region.

Invoking the language and policy instruments of security is a double-edged sword. It has undoubtedly helped to rapidly mobilise funding and resources that were desperately needed. Furthermore, the temporary curtailment of individual liberty through measures such as quarantines may be required in infectious disease outbreaks. Yet securitising infectious disease governance also bears the risk of facilitating the disproportionate use of force and privileging short-termism. Guinea, Liberia and Sierra Leone all declared states of emergency, including curfews and executive orders that allowed for arrests without court orders. The United Kingdom, the United States and other countries issued airport screening and quarantines, while vital international flights to the region were suspended. Dramatic media coverage fuelled popular fears far beyond West Africa. Moreover, the militarised response has raised difficult challenges for already stretched armed forces, while at the same time jarring with much longer and often painful legacies of outside military intervention in the region. As with previous infectious disease outbreaks, the sustainability and long-term benefits of measures taken in an emergency response remain uncertain. Although the language of security evokes perceptions of urgency and existential threat – powerful in mobilising resources in the short term – experience has shown that they are difficult to maintain in the long run (Elbe 2006: 119–44).

Policy implications: From emergency response to global governance

As Ebola is added to the proliferating list of new infectious disease outbreaks unfolding in the twenty-first century, how can the global governance of infectious diseases be placed on a more orderly, organised and sustainable footing? The Ebola crisis shows that at least three building blocks are crucial for such a system to emerge:

- **Closing the gap by strengthening national health systems:** When it comes to the threat of lethal infectious diseases, the world is only as secure as its weakest link. Health systems in low- and middle-income countries therefore need to be strengthened. As long as the global governance of infectious diseases remains largely focused on the security interests of the United States and some European countries, and at the same time misaligned with local conditions in the countries where outbreaks are most likely to occur, it will be difficult to properly protect populations across the world against infectious diseases.
- **Strengthening global outbreak response:** To address issues of slow response and short-termism, governments need to invest in a sustainable rapid response programme with standing responsibility and capacity to respond to new infectious disease outbreaks. This should include a network of health-care workers, doctors, mobile hospitals and logistics experts from different countries. Earlier programmes pioneered by WHO, but since cut back, need to be rebuilt; or new forms of institutionalisation will need to be explored.
- **Bridging the ‘valley of death’ for new medicines and vaccines:** Greater international investments, notably from governments, are needed to bring promising new medicines and vaccines from the laboratory to regulatory approval. Current efforts to establish a global fund for pharmaceutical research and development should be accelerated, and governments should explore an internationally agreed approach to approval standards, manufacturing and stockpiling. The current work of international consortia for the clinical trials and the manufacture of Ebola therapeutics and vaccines needs to be evaluated carefully with regard to lessons that can be learned about transnational collaboration on pharmaceutical development.

If the Ebola outbreak in West Africa can be a catalyst for moving from a focus on health security and international crisis response to a system of global governance capable of addressing outbreaks in a more orderly, organised and sustainable manner, then that at least would be one good thing to come out of the current crisis.

¹ Following the 9/11 terrorist attacks and the anthrax mailings, in 2003 the US government provided US\$1.5bn to NIAID (National Institute of Allergy and Infectious Diseases) to conduct and fund research related to biodefense and emerging infectious diseases, and one year later US\$5.6bn to purchase medicines and vaccines (US National Institutes of Health 2011).

² The US Food and Drug Administration can approve medicines and vaccines on the basis of animal studies rather than clinical trials in humans when human efficacy trials are not feasible or ethical, and when the medicine or vaccine can reduce or prevent a serious or life-threatening condition caused by exposure to lethal or permanently disabling toxic agents. This so-called ‘animal rule’ was authorised by the US Congress in 2002 following the 9/11 terrorist attacks.

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This Practice Paper In Brief was written by Stefan Elbe and Anne Roemer-Mahler (Centre for Global Health Policy, University of Sussex). It was produced as part of the IDS Strengthening Evidence-based Policy programme, funded by UK Aid from the UK Department for International Development. The opinions expressed are those of the authors and do not necessarily reflect the views of IDS or the UK government's official policies.

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AG Level 2 Output ID: 558