

European Research Council



## **From AIDS to swine flu: the politicization of global health**

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*This research has been made possible through funding from the European Research Council under the European Community's Seventh Framework Programme - Ideas Grant 230489 GHG. All views expressed remain those of the author.*

Why has health become an international political issue? Why has it started to appear in books and journals on International Relations? And why are researchers in Public Health interested in foreign and security policy? Health is normally seen as a domestic policy concern. It is dominated by a series of familiar and often interlinked questions including the appropriate level of state resources to be spent on health care, what level of capacity is required, how to structure health services, the balance between private health care and public provision, how to determine which treatments and drugs are appropriate, and of the qualifications necessary to practice health care. In other words, it is about numbers of doctors, nurses and other health professionals, who pays for them, how they are organised, managed and trained, and what tools they can use to improve individual and community health. All this appears to be a long way from International Relations, with its historic focus on questions of war and peace, national security and 'power politics' (Wight, 1979). It is the difference between the high politics of peace and security and the low politics of efforts to increase standards of living and improve quality of life.

This paper explicitly engages with the emergence of health issues in the discipline of International Relations. Its purpose is not however to trace the evolution of this development by providing a historiography or intellectual history of this move. Rather it is to ask questions of a more critical nature concerning what issues have become part of this new agenda and whose interests are served by this. Its position therefore is not one of rationalism – that the emergence of health issues is a response by the academic and policy community to exogenous developments 'in the real world'. Instead it adopts a more reflectivist position, seeing this development as a construction which serves some interests over others. Robert Cox famously commented, 'Theory is always *for* someone and *for* some purpose' (Cox, 1981: 128). In this vein, the paper asks how the emergence of health onto the agenda of International Relations serves some interests over others and is for some purpose.

### *Creating a New Agenda*

International Relations has traditionally been concerned with what it views as the 'big questions' of war and peace, security and the national interest. In so doing it removed itself from the day to day questions of survival as experienced by millions on the planet struggling with poverty and ill health and focused instead on the

exceptional events affecting the state in its relations with other states. Gradually however more critical voices established a foothold linking individual experiences to global forces, and the 'low politics' of quality of life to the 'high politics' of the national interest. Arising from this move were two key ideas which developed a degree of purchase in the policy as well as academic world. The first of these was that of human security - that security did not simply affect the state but was a concern for individuals as well, and that the security of the state and the security of individuals were not necessarily one and the same. The second was the idea that the policy and academic agenda had been too narrowly focused, especially with regard to security, and that a significant broadening was required. New risks such as the environment and climate change, migration and transnational crime began to be articulated as legitimate security concerns for International Relations, alongside the more established concern with military threats and the balance of power. At around the same time as this, an awareness of the manner in which globalization was affecting world politics began to be emphasized. The speed and intensity of interactions appeared to have increased and were continuing to increase, creating a change in the pattern of world politics. States appeared to be increasingly subject to broader trends and developments over which they had sometimes only slight control. Within this context the move to incorporate health into International Relations appears relatively straightforward: health affects the security of individuals but is dependent upon increasingly global developments such as the increased mobility of health professionals, international trade regulations affecting the availability of drugs, and increased human mobility leading to the spread of disease. Equally, the broadening of the agenda created a space which allowed health issues such as bio-terrorism and disease to be considered security risks. Thus over the past decade health issues have increasingly featured as part of the academic agenda of International Relations (for example, Davies, 2008; Elbe, 2009 and 2010) and in the policy world (see McInnes and Lee, 2006).

This change began in the policy community in the 1990s but developed more significantly in the early years of the following decade. Similarly, although there were a small number of academic works in the 1990s which attempted a link between public health and the sort of concerns which might resonate with International Relations (most notably perhaps Garrett 1994), it was in the following decade that a growing number of International Relations scholars began to address health issues as a new part of the discipline's agenda. The dominant narrative underpinning this

emerging academic and policy agenda can be summarized in three linked moves: that health issues such as bio-terrorism and new diseases posed new risks; that the problems were global not local or national; and that this required a political response engaging the foreign and security policy community rather than a technical response limited to public health professionals. This narrative is important because it constructs a particular view of what is happening and establishes acceptable pathways for response. This not to say that this narrative was the only manner in which International Relations engaged with health issues, but it did quickly establish a dominant position. Nor is it to claim that this was the only major narrative concerning global health apparent at this time. The World Health Organization's Commission on Macroeconomics and Health, chaired by the Harvard economist Jeffrey Sachs (2001), exemplified a narrative which emphasized the economic value of good health. Crudely put, this narrative suggested that when people were healthy, they were the sort of productive consumers which encouraged economic growth; and that when they were ill, the reverse was the case and people became a drain on the economy. Thus health promotion was in the economic interests of a state. What the Sachs Report highlighted however was that these were no longer national concerns but global – that poor health in one area of the world impacted elsewhere because of the manner in which trade and economies had become globalised. Another narrative focused upon bio-medical initiatives: that diseases can be treated through understanding the nature of viruses and developing better drugs to combat them, but that the globalised nature of the pharmaceutical industry and the speed with which diseases could travel because of improvements in human mobility meant that this was now a global issue not national. This narrative for example informed the approach of the Bill and Melinda Gates Foundation whose giving power exceeded that of the development aid of almost all states.

What is being claimed in this paper however is that the manner in which health issues were incorporated into the agendas of International Relations and foreign and security policy reflected in large part a particular narrative emphasizing new risks especially from infectious disease, the global nature of the problem, and the need for a political rather than technical response. But in so doing this narrative maintained a link with more traditional International Relations concerns in prioritizing a particular form of global health: one which emphasized exceptional events and which had traction with a national security agenda (for example, Davis 2008, Elbe 2010, Prescott 2003). Thus interest focused on disease outbreaks such as SARS,

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pandemic influenza and HIV and on the potential for bio-terrorist attack, rather than on endemic conditions (such as malaria) or non-communicable diseases (such as those associated with tobacco use).

The dominant narrative also suggests that International Relations' interest in health arose from exogenous developments (the emergence of new risks in a globalised environment, which required a new form of political response). A more reflectivist position however would suggest that narratives construct the world in a particular way to emphasize certain features over others. These can then develop into what people consider a 'normal' or 'common sensical' way of seeing the world, despite being nothing more than one particular construction of the social world. More critically it may be argued that narratives serve some one or some purpose. Therefore rather than a reasoned response to novel developments, this narrative reflects (explicitly or implicitly) a range of interests by privileging certain aspects of global health over others. In this respect the concern which has emerged over linking health to foreign policy – that it might allow one set of policy interests to dominate the other (typically that health policy will be subservient to foreign policy or security needs) - is misplaced. Rather what the dominant narrative does is privilege a series of concerns which are *shared* by *some* health *and* foreign policy communities. This is explored in the three following sections, each of which focuses on one of the elements of this dominant narrative: the new risks from infectious disease; the globalised nature of health; and the need for a political response.

### *Infectious Disease and the New Outbreak Narrative*

Infectious diseases account for approximately one quarter of all deaths annually, and a comparatively small number of diseases a high percentage of this. As a consequence it is hardly surprising that infectious disease has been a, possibly *the* major preoccupation of global health policy. However diseases such as HIV/AIDS, SARS and swine flu have become headline issues beyond the health community, engaging not only the World Health Organisation but other international institutions such as the World Bank, the G8 and the UN. What is apparent in this expanded interest in infectious disease is a sense of both emergency and that something has changed. To understand this the paper expands Priscilla Wald's (2008) idea of an

'outbreak narrative' into a five stage narrative (see box 1). This is the story which is commonly used to explain what has changed and why infectious diseases are now a source of global concern.

### BOX 1: THE NEW OUTBREAK NARRATIVE

#### (i) The Conquering of Infectious Disease

Infectious disease is probably as old as humanity itself and for much of our history has been one of the major threats to individual existence. Pandemics such as the Black Death and 1919 Spanish Flu may have been exceptional both in their scale and the numbers affected, but infectious disease appeared to be endemic to the human condition. In the period following the Second World War however advances in public health and in drugs, especially antibiotics, appeared to change this leading the US Surgeon General in the 1960s to – probably apocryphally – declare infectious disease to be conquered. The highpoint of this was the successful eradication of smallpox in 1979 following more than a decade of decline, and for several generations the fear of infectious disease prematurely ending lives receded (at least in high income states).

#### (ii) Emerging and re-emerging infectious diseases (ERIDS)

This optimism began to change in the 1990s, although harbingers date back to the emergence of the human immuno-deficiency virus (HIV) which first came to prominence in the early 1980s. New diseases began to emerge with unprecedented frequency, by the turn of the millennium averaging one a year. These exploded into public consciousness first with the 2002-3 SARS outbreak, followed by fears over avian flu and then the 2009 outbreak of swine flu. Moreover new, drug resistant forms of diseases believed to be under control began to appear, most notably multi-drug-resistant tuberculosis (MDR-TB) and extensive drug-resistant tuberculosis (EDR-TB). Finally, diseases previously confined to one part of the world began to spread, most notably from Africa to the developed world. These included Ebola and West Nile Virus, both of which appeared for the first time in the US in the 1990s. These three developments were all explicitly linked together through the use of the term ERIDS, creating the impression of a significant new risk from infectious disease.

#### (iii) The Social Ecology of Infectious Disease

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This new and unwelcome development was explained by reference to globally changing patterns of human behaviour. Increased human mobility allowed diseases to be spread quickly into areas previously unaffected. Most dramatic was the advent of so-called 'superspreaders' – individuals infected with a disease who, through their high mobility, could pass the disease on to widely dispersed communities. Increases in urbanisation and population density led to increased contact rates, enabling diseases to spread and rapidly maintain a hold on communities. And perhaps finally many of these diseases were zoonotic – that is, originating in the animal kingdom but spreading to humanity – suggesting that the changing relationship with the animal world offered some explanation for the emergence of new diseases. Thus the 2009 H1N1 flu pandemic originated with pigs ('swine flu'); the highly pathogenic influenza A sub-type H5N1 originates in birds, and is associated with the close proximity to chickens in an urban environment; and HIV is generally considered to have originated in primates.

#### (iv) The Increased Risk

Key to this narrative is the argument that these new and re-emerging diseases pose an increased risk to individuals, society and economies. The risk to people is in alarmingly high morbidity and mortality rates. This has already been realized with HIV/AIDS in sub-Saharan Africa. But the potential can also be seen in fears over pandemic influenza. The risk to society is seen clearest in the case of HIV/AIDS. Fears of high prevalence amongst the professional and middle classes, especially in some weak and fragile states in sub-Saharan Africa, led organisations ranging from the UN Security Council to think tanks such as the International Crisis Group to worry over the impact on state stability. Concerns were not limited to HIV/AIDS and sub-Saharan Africa however. The potential for pandemic influenza to disrupt the functioning of industrial and post-industrial states has been highlighted by the World Bank (for example, Burns, van der Mensbrugghe and Timmer: 2008). Finally these diseases pose risks to economies through disrupting trade and preventing people from going to work (either because they are ill, fear becoming ill, are prevented by quarantine measures from attending work, or cannot get to work because of disruption to transport infrastructure). The economic costs of the SARS outbreak has been estimated as several tens of billions of dollars, despite the fact that fewer than 10,000 cases were reported and fewer than 1,000 people died of the disease. This indicates the potential for not only disease but *fear* of disease to disrupt economies.

Indeed it is widely believed that the British and American governments placed pressure on the World Health Organisation not to declare swine flu a pandemic because of fears over the economic impact at a time when the global economy was facing recession through the banking crisis.

#### (v) Response

Priscilla Wald identifies a particular 'outbreak narrative' as constructing public health's understanding of how to respond to disease. This involves an established methodology consisting of: disease surveillance leading to outbreak alerts; the development of vaccines and an understanding of the disease's epidemiology; and finally the control of disease through drugs and public health measures (Wald). The new narrative which this paper identifies goes further than this however, advocating the need for increased international co-operation and improved global health governance measures, especially over surveillance and disease control. In other words, what has happened is that in this narrative the emergence of new diseases coupled to increased risks has led to the requirement for more than a technocratic response involving better public health measures. Rather what is needed is better health governance at a global level.

The significance of this narrative is not that it tells a story which explains what has happened, but the work it does in shaping our understanding both of what has happened and of what is significant. In other words, it is not a neutral account of an exogenous reality but a particular construction which privileges certain interests and issues over others. Specifically this new outbreak narrative does four things. First, it privileges acute infections and outbreak events (such as SARS and swine flu) over chronic conditions. This is not simply because the media find such events newsworthy – as Melissa Leach rightly comments 'chronic is the flipside of exciting' (Leach, 2010). Rather if the focus is on chronic conditions, then attention shifts: away from the risk of new diseases spreading to the West and towards those regions, especially Africa, where diseases such as malaria are endemic; and away from the control of infectious disease by drugs and towards so-called 'lifestyle' issues such as obesity and tobacco control. Second, it privileges the global over the local. Outbreaks are constructed as global events requiring a co-ordinated response which will be similar across borders. But local differences exist: social ecologies vary; different

health determinants exist from one community to another; the social consequences of disease may vary; and the acceptability or consequences of public health measures may be different from one society to another. The 'global' narrative imposes a degree of homogeneity with certain values and assumptions privileged over others. For example the 'ABC' campaign to prevent the spread of HIV ('abstain, be faithful, use a condom'), reflected more about Western and especially US views on morality than the situation in some parts of Africa where women may be unable to negotiate safe sex, or where transactional sex may be a necessary survival strategy. Indeed attempts to portray the disease as the same across societies forced UNAIDS to react by arguing 'know your epidemic' – that HIV was better understood as a series of epidemics with different causes and consequences across different societies rather than a single pandemic. A second example of how globalised narratives lead to inappropriate local responses concerns the 2009 swine flu pandemic when global concern over pigs led to widespread culling to cut off the source of the disease. When this was done in Egypt however, it affected the livelihoods of the Christian minority disproportionately since the majority Muslim community considered the animals unclean and had little to do with them. Additionally, pigs were an important mechanism for garbage disposal in Egypt, leading to a negative public health outcome as garbage increased.

Third, the narrative focuses on the downstream treatment of disease and prevention of its further spread rather than the upstream social and economic causes. It is concerned with responses to outbreaks through the development of drugs and implementation of public health measures, rather than identifying and changing underlying patterns of behaviour. Thus the emergence of swine flu led to a focus on the availability of the drug tamiflu and the need to quarantine individuals and groups, rather than on methods of intensive pig breeding which probably caused the outbreak. Finally the narrative develops an 'inside/outside' dichotomy where infectious disease is a threat emanating from 'outside'. Thus the narrative emphasizes the origin of these diseases as coming from Asia (SARS and avian influenza) or Mexico (swine flu), but that the risk is to Western states. There is more than a hint here of colonial assumptions over backward customs and insanitary lifestyles (see Leach, 2010) - though given that Mexico (the origin of swine flu) is part of the G20 and China (the origin of SARS and a major concern for avian influenza) is part of the G8, this is a poor reflection of twenty-first century realities. What this element of the narrative also does however is to place blame on the outside,

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legitimising in Western minds a privileging of our interests because we are threatened through no fault of our own.

In conclusion then this new outbreak narrative constructs a particular view of the world by offering an explanation of what is happening, but in so doing privileges certain interests. It is a narrative of the powerful. It privileges the West through an emphasis on new infectious diseases which have the ability to spread here rather than diseases which are endemic in poorer countries, especially in Africa, and which each year kill significantly more people than died of swine flu or contracted SARS. It privileges established public health methodologies through its response. And it is consistent with the interests of Western multinationals: large pharmaceutical companies benefit through their ability to develop new drugs to treat new diseases; food and tobacco companies avoid problems through a focus on acute infections rather than chronic conditions.

#### *'Health is Global'*

That health has an international dimension is well established – in the nineteenth century for example, the fear of disease being spread through increased international trade led to the first series of international health agreements, the International Sanitary Conventions. But by the end of the twentieth century the sense that this had changed was revealed by a shift in terminology from 'international' to 'global' health. Indeed the UK's Department of Health produced a policy statement in 2008 entitled *Health is Global* addressing this very phenomenon, arguing that a national perspective on health policy was inadequate and that health was now subject to global forces (Department of Health, 2008).

As Kelley Lee (2003) has argued, the shift to global health is a by-product of globalization and reflects intensified interactions across three boundaries: spatial; temporal and cognitive. What has emerged is a dominant consensus that health is no longer a predominately national concern with some international elements, but has strong and increasing global dimensions. This qualitative shift in the nature of not only health risks but the provision of health care (including both products and services) has reinforced calls by some for the development of better global health governance, given the limits placed on national governance frameworks by globalization (see Rushton and Williams, forthcoming). David Fidler has gone even

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further in arguing that the WHO's role in the SARS epidemic demonstrated its emergence as a body capable of overriding the wishes of sovereign states and that this heralded a post-Westphalian era in health governance (Fidler, 2007). The empirical evidence not only for Fidler's claims but for the wider global health argument are more equivocal however. Leach for example identifies the importance of local practices and difference in health care (Leach 2010), while Frank Smith persuasively argued at last year's ISA that responses to the 2009 swine flu pandemic were largely informed by national interests rather than global health governance. In other words health remains local as well as global, and the pursuit of national interests suggests the continued potency of sovereign states rather than a decisive movement towards a post-Westphalian system. But what is clear is that, despite these qualifications, globalization and 'global health' form an important element in the dominant narrative identified above and in so doing serve some interests over others. It privileges certain interests, practices and forms of knowledge over others. Crucially, the global health narrative promotes not only a homogenous view of what health is and how it can be promoted, but one based on particular medical practices and responses. Global health promotes the idea of a shared problem and, implicitly, the requirement for a common response. In other words, global health means accepting Western biomedical and public health practices, Western-style drugs, and Western views over the provision of health care (including a mixture of public and private provision and a free market in the mobility of health professionals).

### *The Politicisation of Global Health*

The final element of this dominant narrative is perhaps the most obviously controversial. Traditionally political interference has been resisted by the argument that health care should be based on need rather than politically determined priorities. Indeed, the Geneva Conventions even require parties in war to provide medical care to wounded prisoners and that occupying powers provide health care. In other words, health care is prioritized over political enmity. Health professionals are required to be neutral as to who they treat and partial only to the need of patients.<sup>1</sup> Of course this does not mean that politics has no part in health. The allocation of resources – how much of a government's budget to spend on health and where, as well as the

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<sup>1</sup> The exception being in that of military medics in conflict situations whose first loyalty is to their own forces.

balance between public and private provision – are questions with a strong political dimension. Moreover the decision to base provision on need rather than other criteria reflects a series of assumptions about the way in which the world should operate which also have a political dimension: if politics is about who gets what, then the normative basis underpinning decisions can be considered political. What is therefore resisted is the more direct political interference in health care. This is reflected in the two main approaches to health policy following the Second World War, which may be summarized as the ‘scientific’ and ‘rights’ based approaches.

The scientific approach broadly views health as a technical problem where the gathering of evidence can lead to identification of lessons and development of ‘best’ solutions. This approach covers the full spectrum from the working of the human body to the manner in which disease spreads through communities. It is based in positivism and rationalism – that there is an external world which is subject to rational analysis and the identification of lessons based on the gathering of evidence. Crucially for the purposes of this paper, politics is considered to be not only unnecessary but a hindrance. At best, politics muddies the water in preventing objective assessment and at worst it can lead to disastrous policies. A recent example of this was the manner in which South African President Thabo Mbeki dismissed the connection between HIV and AIDS, arguing that this was a ploy to force his country into buying expensive anti-retrovirals to treat those infected with the disease. His health minister, Manto Tshabalala-Msimang, promoted cheaper alternatives such as beetroot and garlic, based on ideas rooted in traditional medicine. A large part of this policy can be understood politically: as a post-colonial discourse of an African nation wishing to resist continued Western domination, on this occasion through Western bio-medical practices. The result was condemned by the scientific medical community, and that it almost certainly led to unnecessary suffering and loss of life from HIV/AIDS in South Africa was seen as further reinforcing the arguments against political interference.

The rights based approach is similar in that political interference is considered potentially damaging. In this approach health is seen as being *beyond* politics and based instead upon natural justice. In so doing of course, some may argue that this is in itself a political construction in privileging certain rights. Indeed to promote rights may in itself be seen as a political move. For the most part however, the rights based approach is seen rather differently, as being in some sense superior to and

trumping more narrowly based politics. The approach is seen in a range of international documents over the past sixty years: from the preamble to the WHO Constitution with its explicit declaration of health as a human right, through the Alma Ata Declaration on the right to primary health care, to the thinking underpinning the Millennium Development Goals. In all of these health is portrayed as a superordinate goal and political interference can only undermine the rights of individuals to a basic level of health care. It is an approach associated with international development, of poverty relief and improving the human condition, rather than one linked to power politics and the pursuit of interests.

Recently however two new approaches have emerged which place politics much more firmly in the arena of global health. The first emphasises health as a global social good. The origins of this approach lie in something of a reaction to the neo-liberal paradigm which dominated health economics at the end of the twentieth century. The neo-liberal paradigm stressed the efficiency of the market in delivering health care and viewed patients as consumers exercising rational choice to maximize benefits. Its influence was seen in the policies not only of major Western states, but in key international institutions such as the IMF and World Bank. This approach was resistant to political interference as reducing the efficiency of the market. At the turn of the millennium however this approach was challenged by the WHO's Commission on Macroeconomics and Health, chaired by the Harvard economist Jeffrey Sachs (2001). In what proved to be a highly influential report, Sachs argued that the disease burden on the poor threatened global wealth and security. Investment was needed in global health to ensure continued global economic development and prevent the development of security issues which might have regional or global implications. Unlike neo-liberals who argued against interference in markets, Sachs appeared to be arguing for such interference motivated essentially by political concerns over security and development.

The second more political approach to emerge at the turn of the millennium was the linkage between health and foreign and security policy. These two realms have traditionally been seen as pulling in opposite directions, health policy having a strong normative bias and rooted in the individual and community while foreign and security policy is the realm of realpolitik and state centred interests. But, as discussed above, for more than a decade links have been made between the two, in both the policy and academic worlds. Moreover these links have been bi-directional in that both

communities have seen benefit in making the link. This has led to concepts such as 'global health security' and 'global health diplomacy' and to a variety of explicit policies linking the two. Examples of the latter include: the use of health investments by the US military in Afghanistan and Iraq as part of a 'hearts and minds' campaign; the use of foreign policy tools to negotiate a 'treaty' on tobacco control, the Framework Convention on Tobacco Control; the involvement of public health in planning against bio-terrorist attacks in the US; and the UN Security Council's passing of Resolution 1308, expressing concern over HIV/AIDS and peacekeeping missions as well as its linkage of conflict to the spread of HIV. To some extent this interest can be seen as part of the broadening of the security agenda after the end of the Cold War, and to some extent it may be seen as a response to a 'clear and present danger', especially from disease and from bio-terrorism in the wake of 9/11. However neither of these are supported empirically: the number of bio-terrorist attacks has actually reduced since 9/11 while infectious disease has yet to lead to national security crises or state collapse. An alternative argument is that the link was deliberately constructed by a number of opinion formers in the health community as a means of garnering greater attention to a series of emergent public health crises. However it is not clear that this has always been successful as a motivating force in increasing aid for health issues. Although Elbe (2009) appears persuaded that the securitisation of HIV/AIDS has had on balance a positive impact, McInnes and Rushton (2009) question the extent to which many of the major international policies on HIV/AIDS were a product of securitisation. What this paper would suggest however is that something slightly different has occurred linked to the construction of a narrative which privileges some interests over others.

### *Conclusion: Narratives and Interests*

At the beginning of this century there was a degree of optimism that a more 'political' engagement – either with foreign and security policy or with macro-economic policy - could create new pathways for response. Included in this was a belief that elite opinion could be mobilized for action by appealing beyond humanitarianism and international development. And part of this was a more open acknowledgement that (global) health was more than a technical/scientific exercise, but rather that the distribution of resources, including health resources, had consequences on global health. Putting these together constitutes what may be seen as a politicising move

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for global health. And central to this move was the development of a new narrative focusing of the emergence of new diseases, the global nature of health, and the political dimensions in which health did and could operate. Understandably this politicising move has created discussion and debate. Much of this has focused on who controls the agenda behind this move and where resources have gone as a consequence of the move (for example, Elbe, 2009; Ingram, 2010). At its heart this debate was about whether the linkage between global health and foreign and security policy was complementary, or whether one would be subsumed into the other's agenda (usually health into foreign and security policy). This paper however attempts to suggest something else. It develops an argument that this narrative constructs social reality to privilege some interests over others. The narrative frames discussion in a particular way which leads to an authorized account of the world of global health. This account privileges Western approaches, state interests and pharmaceutical interventions. Of course this does not mean that other interests and approaches are absent – clearly this is not the case; but what is important is that the manner in which this narrative is framed emphasises, endorses or prioritises (often implicitly) certain interests and approaches over others. Thus the key question is not whether there is a struggle between health and foreign and security policy for control of the agenda, but over whose interests are served by this narrative construction. And to my mind the answer is less one of competition between established policy communities, but one of where power lies.

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