POLICY FORUM

How Should Global Health Security Priorities Be Set in the Global North and West?

Abraar Karan MD, MPH, DTM&H

Abstract

Epidemics threaten all countries, yet epidemic responses are not implemented in all countries. One reason why is that transnational disease containment efforts (to keep diseases from spreading across borders) differ in important ways from efforts to protect those in countries where an epidemic is active. This article explores these 2 approaches to global health security and suggests reasons to reconsider prioritizing the former first.

Who Is Threatened Matters More

Advances in transportation and increasing numbers of people travelling internationally mean a disease outbreak in Western or Central Africa can reach Europe or the Americas quickly. The potential for rapid spread of a pathogenic threat as deadly as Ebola suggests the importance of asking how we set global health security priorities and what their implications are. For instance, death rates from Ebola during 2014 and 2015 were about 19% in the United States and Europe and 28% to 75% in West and Central Africa.[1,2] These figures suggest that global health security has been less about a pathogen's virulence than who is threatened by it. Although pandemics don't regard transnational borders, responses to pandemics certainly do, and these responses will be interrogated and investigated here.

Let's first consider responses to the ongoing Ebola epidemic, which started in 2018 in the Democratic Republic of the Congo (DRC). It is unclear whether this epidemic would have made headlines and garnered international attention if the West African epidemic a few years earlier had not penetrated the borders of Europe or America. Accordingly, one might wonder whether and to what extent prioritizing containment of Ebola in the DRC is a function of how we (those of us in the global North and global West) perceive the risk of Ebola becoming a transcontinental pandemic.

One might suppose that how threatened "we" feel corresponds in some ways to how robust our clinical—and generous our financial—responses are to Ebola epidemics abroad. Two facts should figure prominently in our investigation of this set of issues. First, there have been 10 Ebola outbreaks in the DRC since 1976,[2] none of which garnered nearly as much global media coverage as Ebola incidents in Europe and North America. Most past Ebola outbreaks have been in the DRC but transpired without major spread beyond

its borders, occurred among small populations, lacked high transmissibility (since they were not concentrated in major cities), and tended to end as infected community members died.[2] In short, these Ebola outbreaks had low risk of spreading outside the DRC. Second, war in the DRC—along with malnutrition and the spread of infectious disease—killed about 45 000 people per month and more than 5 million people total between 1998 and 2007,[3] but received little global media attention.[4] If security efforts are centered on how many lives are lost, why did war, malnutrition, and disease in the DRC not generate as much global concern as Ebola? How should this source of puzzlement inform our thinking about what we owe the global community and regions navigating outbreaks?

Conceiving Health Security Priorities

Reconsidering what we owe the global community and affected regions means reconceiving what we think of as global health security priorities. Pandemics expert David Heymann and colleagues distinguish between 2 such priorities: individual health security (that of individual people regardless of where they live) and collective health security (that of nation-states defined by their borders). They argue that though they traditionally have been seen as separate, these 2 priorities are inextricably intertwined[5] because without individual health security there is functionally no collective health security. When we deploy a vaccine as a containment effort, for example, if we cannot guarantee access to the vaccine for each person, we risk spread of the disease, which can put an entire nation or region at risk of a pandemic or an epidemic of that disease. Smoking is another example of how the two are linked: if individual smokers are not treated and their behaviors modified, others will continue to suffer negative health effects of secondhand smoke exposure. This relationship holds for any behavior that causes both primary harms and widespread negative consequences and illustrates a pragmatic reason for focusing first on individual, rather than collective, health security.

Prioritizing collective health security enables *us* (the global North and global West) to justify prioritizing our own (collective) health interests. In doing so, we neglect the health interests of people in poor regions of the world—to their systematic detriment and exploitation—often for pragmatic (eg, financial, safety) and political reasons. In the specific example of Ebola, the pragmatic and political reasons are clear: sending US troops or public health workers to the DRC is costly and dangerous; focusing on keeping Ebola out of the United States, even if that means that Ebola stays in the DRC, is politically beneficial for the current administration. However, from a public health standpoint, these reasons are overstated and run the risk of distracting us from what is needed most: treating Congolese victims of the disease. Ebola has a lower R-naught (ie, average number of people that one infected person will likely infect) than most other common infectious diseases that we in the global North and global West regularly encounter, such as the common flu. Given North America's low population density compared to that of sub-Saharan Africa, the chance of a major and uncontrolled Ebola outbreak in the United States is low.

In past situations in which collective health security has been prioritized, pragmatism has proved dangerous: it has translated into wealthy countries

standing idly by as people in poorer global regions die. While one might argue that, from a collective health security standpoint, these lives are not the responsibility of wealthy countries, this argument is morally reprehensible. An ethics lens is needed to complement such pragmatism and can help us here, as there is a clear ethical imperative to protect the health of individuals, regardless of where they live.

Ethical Commitment to Health for All

Thus far, we have mainly referred to collective health security as the health of nation-states and individual health security as the health of individuals regardless of any larger so-called collective of which they are a part. An ethical argument for why the health of a child in the DRC suffering from Ebola is the responsibility of all clinicians worldwide is that it is unethical to differentiate what people deserve based on geographic or political boundaries, ability to pay, or whether those affected are *us* or *them*. In US emergency rooms, clinicians are not allowed to differentiate among patients suffering health emergencies[5]; the ethical principle of beneficence demands that no patient be denied emergency care.

Pandemic response is, globally speaking, emergency care. Upholding the principle of global beneficence during pandemics broadens our understanding of collective health security. This does not mean that every clinician should fly to the DRC tomorrow, but it does mean that clinicians who are part of global health programs and organizations (eg, academic, governmental, private) should regard an Ebola epidemic in ethical terms, not just in pragmatic terms, and as a call to which we are obligated to respond wherever it occurs, given our abundant resources and relative global wealth and power.

Strategies for Ethical Global Health Security

Several strategies that regard all lives as equally important regardless of nation-state boundaries can promote global beneficence and inclusive health security. These strategies cannot be comprehensively explored in this paper. Nonetheless, individual physicians can promote global beneficence and inclusive health security by making donations of medical supplies and medications; providing telehealth to help aid management of disease remotely; raising funds to help financially support health systems capacity; and facilitating on-the-ground management by working with humanitarian agencies, including Doctors Without Borders, the World Health Organization, or the Red Cross, to name a few.

Longer term and at a systems level, these strategies demand the building and continued support of strong primary health care infrastructure with local leadership. Pandemics have traditionally been seen as unpredictable, acute events but, to better prepare for them, responders must not fall into the trap of a vertical response and instead horizontally address the health system that is treating them. With primary health care systems founded on trust among clinicians and community members, outbreaks would likely be stopped quickly and regionally. Transmission chains could be more easily followed; ring vaccination would be less susceptible to failure; cases could be detected earlier; and patients would be more amenable to treatment. Primary health care models in wealthy countries might help inform, at a very basic level, what

primary health care could look like in impoverished regions, although its instantiation would be very different. As useful as infrastructure support is, even more important—particularly in acute settings—is provision of financial support for pandemic response. In emergency situations, financial resources and access to care are linked: wealthy nations can help ensure adequate response measures by contributing equipment, medications, vaccines, and laboratory services.

A third strategy should focus on bolstering health care quality, although this can be difficult to achieve in the acute emergency setting. Studying past pandemics could help generate data on outcomes and on the efficacy of various public health strategies. Unfortunately, without such data, we are shooting in the dark, hoping experimental therapies will work and not cause harm. Furthermore, improving the quality of response depends on pandemic experts (eg, clinicians, epidemiologists, attorneys, and anthropologists) collaborating with local leaders. Accordingly, wealthy nations must not only support but also encourage needed experts to participate in international response, providing them with the security, funds, and organizational capacity to be of service at short notice.

If the global community and its actors are responsible for the failure of individual health security, they should pursue a fourth implementation strategy that focuses on accountability measures for high-income countries. Such measures might include financial penalties or future financial commitments in the form of a progressive global tax to contribute to infrastructure and capacity building in poorer regions.

Although wealthy countries may have considered the containment of the 2014-2016 West African Ebola epidemic to be a global health security "success" because very few cases escaped the continent, it was in reality a failure. More than 11 000 Africans died.[2] Today, the same tendency to prioritize collective over individual security remains in the DRC. While the WHO's efforts have contained Ebola within the DRC and now Uganda,[2] the death toll is the second largest of any Ebola epidemic—more than 2000 lives.[6] This death toll expresses a failure of individual health security and, as such, a failure of collective health security. Global beneficence demands that protection of human life should supersede protection of nations, borders, international relations, and politics. The global health community's failure to prioritize beneficence and individual health security is ethically unacceptable.

References

1. Uyeki TM, Mehta AK, Davey RT Jr, et al; Working Group of the US-European Clinical Network on Clinical Management of Ebola Virus Disease Patients in the US and Europe. Clinical management of Ebola virus disease in the United States and Europe. *N Engl J Med*. 2016;374(7):636-646.
2. World Health Organization. Ebola virus disease. https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease. Published May 30, 2019. Accessed July 11, 2019.
3. McGreal C. Congo conflict causes 45,000 deaths a month: study. *Guardian*. January 22, 2008.

https://www.theguardian.com/world/2008/jan/22/congo.chrismcgreal. Accessed July 11, 2019.
4. Moszynski P. 5.4 million people have died in Democratic Republic of Congo since 1998 because of conflict, report says. *BMJ*. 2008;336(7638):235.
5. Emergency Medical Treatment and Labor Act (EMTALA), 42 USC §1395dd (1986).
6. DR Congo Ebola deaths top 2000. *BBC News*. August 30, 2019. https://www.bbc.com/news/world-africa-49521739. Accessed October 22, 2019.

Abraar Karan MD, MPH, DTM&H is an internal medicine resident in the Doris and Howard Hiatt Residency in Global Health Equity and Internal Medicine at Brigham and Women's Hospital in Boston, Massachusetts.