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The European Union's role as a global health actor

Óscar Fernández Fernández

PhD dissertation

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Supervisor:
Dr. Robert Kissack

Universitat Autònoma de Barcelona

Department of Public Law and Legal History Studies

PhD programme in Politics, Policies and International Relations

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I dedicate this PhD dissertation, first and foremost, to her.

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List of acronyms

ACT-A	Access to COVID-19 Tools Accelerator
AMR	Antimicrobial Resistance
ASEAN	Association of Southeast Asian Nations
BSE	Bovine Spongiform Encephalopathy
CD	Conflict Dictionary (LIWC)
CEPI	Coalition for Epidemic Preparedness Innovations
CFSP	Common Foreign and Security Policy (EU)
CSDP	Common Security and Defence Policy (EU)
DAH	Development Assistance for Health
DG DEV	Directorate-General for Development (European Commission)
DG INTPA	Directorate-General for International Partnerships (European Commission)
DG SANCO	Directorate-General for Health and Consumers (European Commission)
DG SANTE	Directorate-General for Health and Food Safety (European Commission)
EC	European Community
ECDC	European Centre for Disease Prevention and Control
EEAS	European External Action Service
EEC	European Economic Community
ENGAGE	Envisioning a New Governance Architecture for a Global Europe (Horizon project)
ESS	European Security Strategy
EU	European Union
FAO	Food and Agriculture Organization
FIGO	Formal Intergovernmental Organisation
G7/G8/G20	Group of Seven/Eight/Twenty major economies
GHS	Global Health Strategy (EU)
HD	Health Dictionary (LIWC)
HIC	Hybrid Institutional Complex
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
ILO	International Labour Organization
IO	International Organisation
IP	Intellectual Property
IR	International Relations
LIO	Liberal International Order
LIWC	Linguistic Inquiry and Word Count software
NGO	Non-Governmental Organization
PASO	Pan-American Sanitary Organization
PPP	Public-Private Partnership
REIO	Regional Economic Integration Organisation
SLD	Security Language Dictionary (Baele & Sterck, 2015)
SOTEU	State of the European Union (address by the president of the European Commission)
SRHR	Sexual and Reproductive Health and Rights
TD	Threat Dictionary (Choi et al., 2022)
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
UHC	Universal Health Coverage
UN	United Nations
UNSC	United Nations Security Council
US	United States
WHO	World Health Organization
WTO	World Trade Organization

Abstract

English

After COVID-19 shocked the entire world, the significance of global health in international affairs became crystal clear, if it was not already apparent from previous epidemics and pandemics. Likewise, the role of the European Union (EU) in the area of health, both internally and beyond its borders, has received increasing scrutiny. However, the academic literature is yet to explore in a thorough, systematic way whether the EU constitutes a global health actor. In fact, there is no consensus on what being a global health actor actually means. Academic perceptions on the matter are not trivial, since overly narrow ontological approaches to health and external action risk obscuring the EU's actual impact, while leading to a suboptimal division of labour across its political-institutional system. This PhD dissertation fills a research gap by asking the next overarching questions: (1) to what extent and why have prevailing perceptions on the EU as a global health actor changed as a result of the COVID-19 pandemic, and (2) how has the EU's global health policy become integrated into and shaped an evolving EU external action? These questions inspire each of my three PhD publications, which address them from slightly different prisms. The first publication is a journal article that focuses on the notion of EU *actorness*, critically examines its modest application in the field of global health, and outlines a research agenda that seeks to adapt it to the post-COVID-19 era. The second publication is a book chapter that delves into the EU's engagement with the ever-growing complexity of global health governance, analysing whether EU institutions, Member States and other stakeholders have fostered or resisted this development. Finally, the third publication is another journal article that looks at the EU's maturation as a global health actor in conjunction with the concept of *securitisation*, raising the possibility that COVID-19 represented a critical juncture in the EU's adoption of "health security" language. As a whole, the dissertation features a mixed-methods approach that combines quantitative and qualitative techniques, with different forms of content analysis taking centre stage. Despite a recognition of COVID-19 as a catalyst of numerous changes, such as in the EU's institutional framework, I detect some important – and often problematic – elements of continuity in scholarly assumptions about the EU, in the fragmentation of the global health architecture, and in the relationship between health policy and other vectors of EU external action. This PhD thesis concludes that the EU is a highly relevant global health actor and warns against the dangers of not identifying it as such. Through this research, I not only seek to contribute to the emerging literature on the EU's health policy, but also to present global health as a suitable space to investigate the EU's evolution as an international actor.

Español

Después de que el COVID-19 golpease al mundo entero, la importancia de la salud global en los asuntos internacionales se volvió más que evidente, si es que no lo era ya a raíz de epidemias y pandemias anteriores. Asimismo, el papel de la Unión Europea (UE) en el ámbito de la salud, tanto a nivel interno como más allá de sus fronteras, ha suscitado un interés cada vez mayor. Sin embargo, la literatura académica aún no ha explorado de manera exhaustiva y sistemática si la UE constituye un actor de salud global. De hecho, no existe consenso sobre lo que ser un actor de salud global significa realmente. Las percepciones académicas sobre dicha cuestión no son triviales, dado que enfoques ontológicos demasiado estrechos sobre la salud y la acción exterior corren el riesgo de ocultar el impacto real de la UE, así como de conducir a una división del trabajo subóptima en su sistema político-institucional. Esta tesis doctoral llena un vacío de investigación al plantear las siguientes preguntas generales: (1) ¿en qué medida y por qué han cambiado las percepciones predominantes sobre la UE como actor de salud global a consecuencia de la pandemia de COVID-19?; y (2) ¿cómo se ha integrado y cómo ha influido la política de salud global de la UE en una acción exterior europea en evolución? Estas preguntas inspiran cada una de mis tres publicaciones de doctorado, que las abordan desde prismas ligeramente distintos. La primera publicación es un artículo de revista que se centra en la noción de *actorness* de la UE, examinando críticamente su modesta aplicación en el campo de la salud global y esbozando una agenda de investigación que busca adaptarla a la era pos-COVID-19. La segunda publicación es un capítulo de libro que profundiza en la aportación de la UE a la creciente complejidad de la gobernanza de la salud global, analizando si las instituciones de la UE, los Estados miembros y otros actores interesados han fomentado o rechazado este desarrollo. Finalmente, la tercera publicación es otro artículo de revista que examina la madurez de la UE como actor de salud global en relación con el concepto de *securitización*, planteando la posibilidad de que el COVID-19 haya representado un punto de inflexión en la adopción de una retórica de "seguridad sanitaria" por parte de la Unión. En conjunto, la tesis presenta un enfoque de métodos mixtos que combina técnicas cuantitativas y cualitativas, y en el que destacan diferentes variantes de análisis de contenido. Pese a reconocer que el COVID-19 catalizó numerosos cambios, como por ejemplo en el marco institucional de la UE, detecto algunos elementos importantes —y a menudo problemáticos— de continuidad en los supuestos académicos sobre la UE, en la fragmentación de la arquitectura de salud global y en la relación entre la política de salud y otros vectores de acción exterior de la UE. Esta tesis doctoral concluye que la UE es un actor de salud global altamente relevante y advierte sobre los peligros de no identificarla como tal. Mediante esta investigación, no solo busco contribuir a la literatura emergente sobre la política de salud de la UE, sino también presentar la salud global como un espacio adecuado para investigar la evolución de la UE como actor internacional.

Català

Després que la COVID-19 colpegés el món sencer, la importància de la salut global en els afers internacionals es va fer més que evident, si és que no ho era ja arran d'epidèmies i pandèmies anteriors. Així mateix, el paper de la Unió Europea (UE) en l'àmbit de la salut, tant a nivell intern com més enllà de les seves fronteres, ha suscitat un interès cada cop més gran. No obstant, la literatura acadèmica encara no ha explorat de manera exhaustiva i sistemàtica si la UE constitueix un actor de salut global. De fet, no existeix consens sobre el que ser un actor de salut global significa realment. Les percepcions acadèmiques sobre aquesta qüestió no són trivials, ja que enfocaments ontològics massa estrets sobre la salut i l'acció exterior corren el risc d'ocultar l'impacte real de la UE, així com de conduir a una divisió del treball subòptima en el seu sistema polític-institucional. Aquesta tesi doctoral omple un buit de recerca al plantejar les següents preguntes generals: (1) en quina mesura i per què han canviat les percepcions predominants sobre la UE com a actor de salut global a conseqüència de la pandèmia de COVID-19?; i (2) com s'ha integrat i com ha influït la política de salut global de la UE en una acció exterior europea en evolució? Aquestes preguntes inspiren cadascuna de les meves tres publicacions de doctorat, que les aborden des de prismes lleugerament diferents. La primera publicació és un article de revista que se centra en la noció d'*actorness* de la UE, examinant críticament la seva modesta aplicació en el camp de la salut global i esbossant una agenda de recerca que busca adaptar-la a l'era post-COVID-19. La segona publicació és un capítol de llibre que aprofundeix en l'aportació de la UE a la creixent complexitat de la governança de la salut global, analitzant si les institucions de la UE, els Estats membres i altres actors interessats han fomentat o rebutjat aquest desenvolupament. Finalment, la tercera publicació és un altre article de revista que examina la maduresa de la UE com a actor de salut global en relació amb el concepte de *securititzaci*ó, plantejant la possibilitat que la COVID-19 hagi representat un punt d'inflexió en l'adopció d'una retòrica de "seguretat sanitària" per part de la Unió. En conjunt, la tesi presenta un enfocament de mètodes mixtes que combina tècniques quantitatives i qualitatives, i en el qual destaquen diferents variants d'anàlisi de contingut. Malgrat reconèixer que la COVID-19 va catalitzar nombrosos canvis, com ara en el marc institucional de la UE, detecto alguns elements importants —i sovint problemàtics— de continuïtat en els supòsits acadèmics sobre la UE, en la fragmentació de l'arquitectura de salut global i en la relació entre la política de salut i altres vectors d'acció exterior de la UE. Aquesta tesi doctoral conclou que la UE és un actor de salut global altament rellevant i adverteix sobre els perills de no identificar-la com a tal. Mitjançant aquesta investigació, no només busco contribuir a la literatura emergent sobre la política de salut de la UE, sinó també presentar la salut global com un espai adequat per tal d'investigar l'evolució de la UE com a actor internacional.

1 Introduction

1.1 The European Union's role as a global health actor: relevant debates and milestones

With or without the COVID-19 pandemic, the purpose of this thesis would be highly relevant. After all, it is not too daring to declare the following as a universal and timeless truth: health *matters*. However, it does not matter to everyone equally, nor uniformly. In relatively healthy regions, like the European Union (EU), it often takes a wake-up call for politicians and the wider public to pay genuine – albeit often also fleeting – attention to global health.[1] Although my research interest in health policy long precedes COVID-19, the pandemic's influence on my decision to undertake this project, as well as on its eventual content, is therefore inescapably evident. The research process began in October 2021, at a time when the COVID-19 crisis was still ongoing but starting to subside in the EU, and extended over the next three years. Throughout this time, the political agenda in the EU and its Member States experienced rapid and remarkable shifts: global health went from representing *the* top concern of policymakers and citizens alike (unprecedentedly so) to being displaced by other issues, such as rising prices and international security crises – chief among them, Russia's full-scale invasion of Ukraine and the Israel-Palestine conflict.[2]

There are several ways to interpret this shift, from the perspective of the EU's role in global health. The rosier view is that the EU earned its right to move on because it managed to reduce the incidence of COVID-19 within its borders in record time, thanks to an unprecedented, large-scale vaccination campaign. A bleaker take is that, even if most (if not all) international issues of public concern have direct or indirect health consequences, the salience of global health in the EU – much like in other regions and countries – is too dependent on the immediate impact of epidemics and

[1] Three caveats must be made here. Firstly, significant health-related inequalities within and between EU countries continue to persist. Secondly, transnational global health crises do not necessarily result from contagious diseases, as the ongoing opioid crisis demonstrates, as well as threat multipliers like climate change and antimicrobial resistance (AMR). Thirdly, communicable diseases do not always originate beyond the EU or the West either. One does not need to look back at colonial times to identify examples of transmissible diseases emanating from Western countries. A relatively recent example is the Bovine Spongiform Encephalopathy (BSE) or "mad cow disease", which first emerged in the United Kingdom.

[2] In June-July 2021, 28% of EU citizens polled mentioned health as one of the two top concerns for their country (European Commission, 2021, QA3a). In April-May 2024, only 14% of EU citizens polled did so (European Commission, 2024a, QA3).

pandemics. This reflects and reinforces the familiar "cycle of panic and neglect" that compromises adequate preparedness and response to global health crises, be they of epidemic nature or not (International Working Group on Financing Preparedness, 2017, p. 77). Similar patterns apply to scholarship on the EU's external action, whose attention to global health has been and continues to be sporadic. While academia is often late to join policy-relevant debates, however, it is often also late to abandon them. In other words, when attention to global health dwindles within the EU's policy community, that does "not mean that the issue is completely off the European agenda. It merely lies quiet in the community [as it] is being developed further by stakeholders and in academia" (Aluttis, 2016, p. 18). This research endeavour is a testament to that, as well as a call to prevent "pandemic fatigue" – which has become widespread among the public – from taking hold in academia too.

The jury is still out on the long-term health effects of COVID-19, and the same goes for its socio-political implications, both within countries and at the international level. While this PhD thesis seeks to shed some light on the latter, the dust is yet to settle, which means that the answers I provide here should be regarded as early takes on what is becoming a rather prolific field of study. Based on its effects on public perceptions and on the global health governance landscape *so far*, the coronavirus pandemic can be characterised as both a typical and a unique event. It has been largely overcome, allowing a return to "business as usual" (for better or worse), but also left some indelible marks in terms of institutional structures, resource allocation, and public and academic interest. This holds true when zooming in on the EU, although this entity has not experienced such a pronounced reversal to "business as usual" in its policy and institutional dynamics, some of which have quietly yet markedly changed.

This is what can be tentatively inferred from recent scholarship, which has explored this issue from different, complementary angles. Drawing on historical institutionalism, Wolff and Ladi (2020) wondered shortly after the onset of the pandemic whether it would remembered as a "critical juncture" for the EU.[3] The authors identified some early "signs of adaptability to a 'permanent' emergency mode" (p. 1026), although they admitted that it was too soon to tell. From a neofunctionalist perspective,[4] Brooks et al. (2023) claimed a few years later that, relative to other entities' reaction to COVID-19, "the EU stands out for the scale of the change in something as fundamental as its role, and for the consistently integrating direction it has taken" (p. 736).

[3] Other scholars have also explored COVID-19 as a "critical juncture" (see, for example, Dupont et al., 2020; Koch et al., 2024).

[4] In its early days, neofunctionalism did not conceive regional integration as a crisis-driven phenomenon, but subsequent reformulations of the theory have explored spill-over effects in conjunction with the role of crises (Schmitter, 1969, 1970; see also Brooks et al., 2023; Schimmelfennig, 2024).

These accounts align with the oft-quoted assertion by Jean Monnet (1976) that "Europe will be forged in crisis, and will be the sum of the solutions adopted for those crises" (p. 417). Of course, this does not imply that crises are desirable, nor that they always propel the EU to "fail forward": indeed, extensive research shows that this outcome is not guaranteed (see, for example, Schramm, 2024). However, amidst ominous warnings that each crisis might spell its demise, the EU has not only proven remarkably resilient but has also frequently embodied the concept of "antifragility" (Taleb, 2012).[5]

Beyond institutional developments, COVID-19 can be seen as a catalyst for significant cognitive shifts within the EU. Firstly, the pandemic highlighted the shortcomings of global value chains, prompting a re-evaluation of interdependence as a source of vulnerability rather than strength. This shift, also fuelled by geoeconomic and geopolitical tensions such as trade disputes with the US, economic competition with China, and Russia's war of aggression against Ukraine, has reinforced the EU's turn towards "strategic autonomy" and "de-risking" (see Herranz-Surrallés et al., 2024, and the rest of the Special Issue). Cognitive shifts also potentially involve the consolidation of health as a full-fledged area of EU external action, in conjunction with an updated understanding of global health. Before COVID-19, the academic consensus was that the EU still interpreted global health as largely indistinguishable from "international health" – a term with strong solidaristic connotations closely connected to development policy (Aluttis, 2016, p. 16; Steurs et al., 2018, pp. 437–439). As Bergner (2023) suggests, the pandemic represented a turning point in this regard, driving the EU to adopt a more inward-looking, security-oriented and disease-specific mindset. This is consistent with other actors' approach to global health (Steurs et al., 2018, p. 437) and reflects the EU's concern that we may be facing "a new age of pandemics", as expressed in its new Global Health Strategy (European Commission, 2022a, p. 14).[6] This recognition has spurred concrete policy initiatives, but it remains unclear whether it has led to an improvement of EU readiness commensurate with the gravity and imminence of these pandemic-related threats. Moreover, it is important to recognise the trade-offs of a sharp focus on epidemic and pandemic prevention. While this disposition might help the EU to solidify its standing as a global health actor, it can also inspire narrow and restrictive measures that sit uneasily with a normative aspiration to "reassert its responsibility and deepen its leadership" in global health (European Commission, 2022a, p. 4; see also Bergner, 2023, p. 9). Dilemmas of this sort speak directly to broader debates about what kind of actor the EU *is* and *wants to be* in the

[5] "Antifragility is beyond resilience and robustness. The resilient resists shocks and stays the same; the antifragile gets better" (Taleb, 2012, p. 3). For an application of this concept to the history of the EU, see Solana (2021).

[6] This expression was borrowed from Peter Piot, special adviser to European Commission President Ursula von der Leyen on global health security (see Roberts, 2021).

international arena – assuming that it is an actor at all, which EU scholars have not always agreed on.

This is precisely the topic I will next address, as a necessary entry point for the scrutiny of some crucial issues that the literature has left under-researched, including the prevailing perceptions on the EU as a global health actor, the role of global health within the EU's external action, and the EU's engagement with the complex governance of global health.

The EU as an international actor

In 1982, Bull famously claimed that "'Europe' is not an actor in international affairs, and does not seem likely to become one" (p. 51). This statement did not come from a staunch realist, but from a central figure in the English School of International Relations (IR). Despite the English School's focus on the shared norms and institutions that make international anarchy manageable,[7] many of its core tenets are compatible with realism, which was the dominant IR school during the Cold War. Realist scholars maintain that states are the primary actors, and certainly the only ones worthy of consideration, on the international stage. This stance was hardly ever challenged back in those days, as states indeed appeared to reign supreme. To be sure, International Organisations (IOs) and non-state actors were already proliferating, inspiring eloquent calls to move beyond the "state-centric paradigm" in IR (Nye & Keohane, 1972). But there was ample consensus that few of those new entities operated beyond the confines of the bipolar structure defined by the rivalry between the United States (US) and the Soviet Union, and that those that did possessed limited influence. The fall of the Berlin Wall offered glimpses of a new era, but international conflicts still raged and entities other than states were ill-equipped to play a meaningful role in them. In 1991, when commenting on the response to the Gulf War, Belgium's then-Foreign Minister Mark Eyskens notoriously described Europe as "an economic giant, a political dwarf, and a military worm" (see Whitney, 1991). At that time, the European Economic Community (EEC) – the EU's predecessor – lacked a common approach to foreign and security policy, aside from the relatively weak European Political Co-operation framework that had been in place since 1970. The failure to prevent the Yugoslav Wars of the early 1990s was the final spur leading to the establishment of the Common Foreign and Security Policy (CFSP) as one of the pillars of the EU, which was born as such with the entry into force of the Treaty of Maastricht in 1993.

[7] The English School can be seen as "a forerunner of contemporary constructivist IR theory" (Wendt, 1999, p. 31). Similarly, Ruggie (1998) argued that "the so-called English School anticipated constructivist concerns, but one of its major aims was to resist the influence of American social scientific modes of analysis and less to firm up its own theoretical basis" (p. 862, see also Adler, 2002, p. 100).

Progress in overcoming European states' reluctance to accept coordination – let alone supranationalism – in the area of foreign affairs has been slow and modest. However, academic interest in the external dimension of the European integration project emerged years and even decades prior to the establishment of CFSP, and not all scholars shared Bull's view that Europe constituted a *non-actor*. In fact, the concept of "actorness", closely associated with scholarly research on the EU, long precedes its formal creation in 1993. This notion can be traced back to Cosgrove and Twitchett (1970), who argued that both the EEC and the United Nations (UN) – and not just sovereign states – could be considered international actors in their own right, despite their significant limitations. A great deal of subsequent scholarship on (EU) "actorness" acknowledges instead the foundations laid by Sjöstedt (1977), who did not actually employ that term but formulated a widely reproduced definition of "actor capability" as "the capacity to behave actively and deliberately in relation to other actors in the international system" (p. 16). Sjöstedt focused specifically on the EEC and emphasised autonomy (a function of distinctiveness and internal cohesion) as a prerequisite for its "actor capability". In 1990, Allen and Smith implicitly objected to Sjöstedt's behavioural perspective, by claiming that there were intangible elements that gave the EEC "presence" without requiring deliberate action, such as "ideas, notions, expectations and imaginations" (Allen & Smith, 1990, p. 22).

A few years later, Hill (1993) delivered a sober reality check in the form of another prominent concept in EU studies: the "capability-expectations gap". His analysis of Europe's international role shared much of Bull's (1982) scepticism, which he labelled as "coolly prescient" (Hill, 1993, p. 306), although Hill's take was more nuanced, conceding that "few would follow [Bull] so far" (p. 309). In Hill's view, the progress made by the European Community (EC)[8] in terms of its actorness and presence on the world stage deserved recognition, but he still did not consider it a full international actor. Moreover, he identified a "dangerous tension" produced by a tendency to expect of it what it simply could not deliver (Hill, 1993, p. 321). Hill paid particular attention to security and defence, coming to the stark conclusion that "there are certain things that the EC simply cannot or will not do" (Hill, 1993, p. 326). That being said, Hill admitted that "with intelligence and time the capability-expectations gap might be closed, and the concept rendered redundant", adding that "it is a static concept which cannot do full justice to the complexities of the Community's evolving impact on world politics" (Hill, 1993, p. 322). Despite this and subsequent caveats introduced by its original proponent (see Hill, 2007) and further examined

[8] Following the entry into force of the Treaty of Maastricht (1993), the EEC was renamed as the EC. It became part of one of the three key pillars of the newly constituted EU. With the Treaty of Lisbon (2009), the pillar structure was abandoned, and the EU acquired a single legal personality.

throughout this thesis, the "capability-expectations gap" would go on to become one of the most influential concepts in the study of the EU's external action, remaining largely – and somewhat puzzlingly – uncontested (Larsen, 2020).

In 1998, Jupille and Caporaso developed their own analytical framework for assessing actorness (to which they also refer as "actorhood" and "actor capacity") in an attempt to make it generalisable beyond the EU. This not only reflected a recognition of the EU's "evolving impact on world politics" – as Hill (1993, p. 322) put it – but also of the changing nature of world politics *per se*. In the late 1990s, issues beyond hard security and defence had been promoted to the top of the multilateral agenda, including environmental policy, which was the focus of their case study. Jupille and Caporaso's (1998) "actorness" framework focused on four key criteria, both of an external and internal nature: "authority" (legal competence), "recognition" (by other actors), "autonomy" (distinctiveness) and "cohesion" (in terms of values, tactics, procedures and outputs). Soon thereafter, Bretherton and Vogler (1999, 2006, 2013) proposed and gradually refined yet another understanding of actorness, which they reverted to applying to the EU as a *sui generis* entity – at least in its earlier formulations. Their markedly constructivist framework rests upon the pillars of "presence" (following Allen & Smith, 1990), "opportunity" (the material and ideational international environment), and "actor capability" or "actorness". Inspired by Sjöstedt (1977), this final category alludes to those internal factors that allow the EU to "exploit opportunity . . . and capitalize on its formidable presence" (Bretherton & Vogler, 2006, p. 212). The approaches proposed by Jupille and Caporaso, on the one hand, and Bretherton and Vogler, on the other, have been broadly reproduced in the literature on EU actorness. Not surprisingly, they also underpin those studies that focus on global health, as this dissertation will show (see Publication 1).

Research on the EU's actorness has coexisted, engaged and sometimes competed with the various "Power Europe" narratives, which tend to devote more attention to what the EU *is* than to what it *does*, although the two dimensions clearly intersect (Wendt, 1992, p. 24). This research strand was inaugurated by Duchêne's (1972, 1973) "Civilian Power Europe", which is the concept that Bull challenged in his 1982 article, wondering whether it might be a "contradiction in terms". The notion of "Civilian Power Europe" has been widely echoed by EU scholars and policymakers alike, with the latter embracing it much more uncritically (Larsen, 2020; Orbie, 2006). The "Power Europe" agenda also drew on Galtung's (1973) characterisation of the EEC as a "superpower in the making" – a scenario he warned against from his structuralist stance (see Bretherton & Vogler, 1999, p. 184; Orbie, 2006, p. 124). Much more recently, it progressed through alternative conceptualisations such as "Normative Power Europe (Manners, 2002) and "Market Power

Europe" (Damro, 2012), among many others (see Michaels & Kissack, 2021, p. 6; Orbie, 2008a, p. 2; Smith, 2010, pp. 339–343). In a way, Bradford's (2020) "Brussels Effect" and her depiction of the EU as a "global regulatory power" (p. 7) also derives from this rich scholarly tradition.

Another research strand, which can be thought of as an offshoot of "actorness" and has been rather prolific in the past decade, is the one placing EU "effectiveness" under the spotlight. Effectiveness can simply equate to broad influence in the international system (Smith, 2010, p. 335). However, it is usually framed more narrowly as "goal attainment" or "problem-solving" (Niemann & Bretherton, 2013, p. 267), therefore presupposing volition and serving as a more comparative-oriented successor to actorness. A few years ago, Rhinard and Sjöstedt (2019) took issue with this narrow approach, calling instead for delving into how the EU actually *impacts* and – importantly – *is shaped by* the international context (following Ginsberg, 2001; Smith, 2010). To do so, they introduced the intervening variable of "actor performance", which refers to "the kinds and quality of transactions originating from the EU system carrying a potential to shape addressees in the external environment" (Rhinard & Sjöstedt, 2019, p. 15) and is applicable to other entities too (p. 5). While the notion seeks to revitalise Sjöstedt's (1977) behavioural approach and in principle assumes a degree of intentionality, the authors treat it with nuance, claiming that soft power is relevant and "intention should not be narrowly defined . . . since performance need not be linked to an influence strategy" (Rhinard & Sjöstedt, 2019, p. 15). The concept of "performance" had already been used in the study of the EU's external action (see Jørgensen et al., 2011, and the rest of the Special Issue), albeit with a slightly different connotation.[9] To some extent, the revamped conceptual framework proposed by Rhinard and Sjöstedt's (2019) tackles the common critique that scholars of the EU's foreign policy are prone to engage in "navel-gazing" (Keuleers et al., 2016; see also Drieskens, 2017, p. 1542; Rhinard & Sjöstedt, 2019, p. 10).[10] Borrowing the terminology of Keuleers et al. (2016), it may be argued that Rhinard and Sjöstedt (2019) combine an "inward-oriented approach" (i.e. internal processes and decision-making structures) with both an "inside-out" (i.e. policy outputs) and an "outside-in" perspective (i.e. policy outcomes and how those feed back into the EU).

A surge in "outside-in" analyses, advocated by the "decentring agenda" (Keukeleire & Lecocq, 2018) and taken further by decolonial scholars (Orbie et al., 2023), is certainly a welcome development. It invites a problematisation of the EU's external action by taking into account the

[9] Jørgensen et al. (2011) define "performance" as a function of "effectiveness, relevance, efficiency, and financial/resource viability" (p. 601).
[10] For a response to Keuleers et al. (2016), including some necessary caveats, see Dijkstra and Vanhoonacker (2017).

viewpoints and interests of other actors, as well as broadly shared normative goals such as the provision of global public goods. That said, it must be underlined that investigating the impact of the EU's normative externalisation from an "inside-out", unidirectional lens (see Bradford, 2020; Schmitter, 1969, 1970) is not equivalent to claiming that the EU is a force for good, although the rhetoric emanating from Brussels-based institutions frequently conflates these two dimensions of normativity (Aggestam, 2008). According to Cebeci (2012, 2019), academia has legitimised this sort of rhetoric: in her view, notions such as "Civilian Power Europe" (Duchêne, 1972, 1973) and "Normative Power Europe" (Manners, 2002) have been barely disguised attempts to construct an "ideal power Europe" meta-narrative. However, Manners himself considers it problematic to "compound discourses of 'force for good' with 'normative power'" (Manners, 2011, p. 243), a point echoed by Damro (2012, p. 698). Just like an actor can play both a hero and an anti-hero, definitions of actorness need not have ethical undertones, and the same applies to concepts like presence, effectiveness, performance and power, *inter alia*. Recently, Bradford (2020) put it this way: "whether the Brussels Effect should be viewed positively or negatively is . . . secondary to the less disputed conclusion that the Brussels Effect simply exists and matters in today's global political economy" (p. 263).[11] Throughout this dissertation, I similarly prioritise sober analysis not because I see ethical judgment as "secondary" in terms of importance, but merely out of a concern for proper sequencing. Without the suitable analytical tools to assess the EU's role in the world, and their suitable empirical application, ethical judgment is simply impossible or, at the very least, misguided.

Recent works, such as Rhinard and Sjöstedt's (2019) and a Special Issue coordinated by Maurer et al. (2024) on the EU's "maturation" as a foreign and security actor (see Publication 3 in this PhD thesis), build upon almost half a century's worth of debates around (EU) actorness. Nevertheless, whether they will succeed in clearing up the current "conceptual fog" (Drieskens, 2017, p. 1537), or whether they will add to it, remains to be seen. The different notions and analytical yardsticks referenced in this sub-section ultimately suggest a "lack of academic consensus on what constitutes an international actor" and "complicate comparisons over time, across policies and settings, and, resultantly, knowledge-building" (Drieskens, 2017, p. 1537). Smith already identified this challenge over a decade ago, observing that, while research on the EU's role in the world is increasing, "there is too little accumulation of knowledge (not enough attention is being paid to the large questions we face and to the answers that have already been suggested in the literature) and there is still a great need for more substantial empirical analysis, which has historical depth" (Smith, 2010, p. 329). Of course, dissent can be positive, and in any

[11] Bradford does not refrain from discussing the negative implications of the "Brussels Effect", even if her normative assessment of the EU's regulatory power is generally positive (Bradford, 2020, pp. 235–263).

case it is largely unavoidable, as it reflects profound ontological discrepancies between schools of thought in IR – i.e. some are more state-centric, others more pluralist; some focus only on "high politics", others emphasise "low politics" too;[12] some are more materialistic, others more ideational and/or legalistic. Efforts have been made to bridge these gaps: for example, ideational and materialistic approaches such as Normative Power Europe and Market Power Europe, respectively, are not mutually exclusive but can be seen as compatible (Drieskens et al., 2024). These valuable contributions aside, scholarship on the EU's role in the world is still overly fractured, due to a lack of integrated approaches, combined with the widespread practice of subscribing to a given understanding of actorness (or a similar notion) without justifying the choice or conducting a rigorous operationalisation (Drieskens, 2017, p. 1537; Drieskens et al., 2024). Since Smith's warning in 2010, the volume of empirical studies of the EU's international role has increased significantly, in line with a growing recognition of the multiple global governance areas where the EU has an impact, beyond CFSP and explicit treaty-based domains of EU external action. But the price to be paid has been a proliferation of *ad hoc*, unsystematic operationalisations that tend to disregard general validity. Accumulation of knowledge, therefore, has been partial at best, as illustrated by one of these novel spheres of EU external action: global health.

Global health as an area of EU external action

As this PhD thesis will show, the trends described above have trickled down into the literature on the EU's actorness in global health, which is still in its infancy. Granted, the EU has been referred to as a "global health actor" (Emmerling et al., 2016), but this characterisation has been inconsistent and sometimes ambiguous (see, for example, Guigner, 2012, p. 108). More to the point, the concept of "actorness" has served as a "heuristic device" (Drieskens, 2017, p. 1537) guiding a few scholarly analyses of the EU's activity in the health sector (see Anghel & Jones, 2023; Vandendriessche et al., 2023). A more systematic application of the concept surfaced very recently, with a ground-breaking study of the European Parliament's "actorness" in global health (Rollet, 2024). Nevertheless, comprehensive assessments of the EU's global health actorness, combining a criteria-based systematic analysis with a broad scope, are scarce and outdated (see Battams et al., 2014; Guigner, 2012; Rollet & Chang, 2013).[13]

[12] Although some scholars have argued that this dichotomy has become virtually irrelevant in international politics (see Hill, 2003, p. 4; Kissack, 2010, p. 485; Youde, 2016, p. 157).
[13] Other studies have dealt with EU "performance" (van Schaik, 2009, 2011) and "effectiveness" in global health (Battams & van Schaik, 2016).

This finding, discussed in detail in the first publication of the current dissertation, should not come as a surprise. IR scholars have been slow to recognise global health as an area of study, and the same holds true for scholars of the EU's external action. As recently as 2018, Schunz et al. pointed out that health and other "internal policies in which the EU has gradually developed – and is still developing – external action" (p. 4) had been traditionally neglected by the foreign policy literature (see also p. 5). Schunz et al. praised the modest but significant academic progress that had been made concerning the fields of energy, environment, and freedom, security and justice – but not so in the case of global health (Schunz et al., 2018, pp. 5, 8). These scholars edited an influential volume that goes a long way in dissecting and comparing many of the EU's emerging "sectoral diplomacies", with an important takeaway being that EU actorness can arise even in areas where Brussels institutions possess limited legal competence (Schunz et al., 2018, p. 240). While this theoretical insight has profound implications for EU actorness in (global) health, and health issues do come up at various points throughout the edited volume, none of the chapters is exclusively dedicated to this topic. The editors acknowledge this shortcoming through an explicit call to develop a research agenda on the matter (Damro et al., 2018, p. 255).

In most other widely-cited, far-reaching explorations of the EU's external role(s), health is similarly treated in a tangential way (see, for example, Bindi, 2010; Orbie, 2008b; Smith, 2014; Telò, 2009). A partial exception, as identified by Schunz et al. (2018, p. 5), is Keukeleire and Delreux's (2014) book on the EU's foreign policy, which contains a brief section on "health and demography" within a chapter on "the external dimension of internal policies". Health and demography are addressed jointly under a resounding headline: "challenges without a real external policy" (Keukeleire & Delreux, 2014, p. 237).[14] The authors place the spotlight on the links between health policy, on the one hand, and foreign and security policy, on the other, arguing that these connections are more recognised by the health community than by the foreign policy community (Keukeleire & Delreux, 2014, p. 239). Consequently, the global health agendas of the EU and its Member States are often subsumed to their respective security agendas (see also McInnes & Lee, 2006, p. 22). Policy goals thus disregard a "human security" approach (Keukeleire & Delreux, 2014, p. 239; see also Davies, 2010, pp. 1170–1171), reflecting a national security25/09/2024 11:38:00 one instead. This creates a distortion in favour of issues affecting European countries (see also Rushton, 2019), which explains the tendency of the EU's global health policy to deviate from the so-called "global burden of disease" when setting policy

[14] In the first edition of the book (Keukeleire & McNaughtan, 2008, pp. 249–253), health and demography are also presented jointly, although the authors do not refer to them explicitly as "challenges without a real external policy".

priorities.[15] As I address in Publication 3 of this PhD thesis, the securitisation of global health became more prominent in the aftermath of COVID-19, attracting more attention and resources to global health. But the drawbacks of a "health security" perspective – which add to those already noted by the Copenhagen School scholars who first developed the concept of "securitisation" in reference to other policy areas (Buzan et al., 1998) – became even more evident after the pandemic, including the promotion of an overly Euro-centric approach to global health. This was stressed in the third edition of Keukeleire and Delreux's book (2022), which this time devoted an exclusive section, albeit still a brief one, to health (pp. 269-271).

Keukeleire and Delreux are right to point out that the EU only has supporting competence vis-à-vis health,[16] which sets this policy area apart from some others where outward effects are increasingly observed (see also Vandendriessche et al., 2023). At the time when they argued that the EU had no real external policy in the health sector (Keukeleire & Delreux, 2014, p. 237), the mood within the EU's health community was decidedly bleak. A widely held view was that the Treaty of Lisbon "did not empower the EU as a global health actor" (van Schaik & Battams, 2014, p. 47), not even when it comes to dealing with the World Health Organization (WHO) in a more coordinated manner (see also van Schaik, 2011). In addition, the first (unofficial) global health strategy of the EU – a Commission Communication on "the EU role in global health" (European Commission, 2010) that was "welcomed" by the Council (Council of the European Union, 2010, p. 1) – had fallen well short of its objectives. Much like other elements of the EU's burgeoning global health policy, this Commission Communication derived from a concatenation of health crises (Kickbusch & Franz, 2020, p. 9), the latest of which had been the H1N1 "swine flu" pandemic, where EU responses had been worryingly disjointed (Greer et al., 2022, p. 95). The EU "failed forward", but momentum soon fizzled out in a climate of budgetary austerity and global health vanished from the limelight once again (Aluttis, 2016; Battams et al., 2014; Emmerling, 2016; Emmerling & Rys, 2016). The 2010 Communication's push to promote "coherence between relevant EU policies related to global health" (European Commission, 2010, p. 7) – in other words, "Health in All Policies" (Council of the European Union, 2010, p. 1) – was singled out as yielding particularly disappointing results (see Battams et al., 2014; Guigner, 2012; Rollet & Chang, 2013). The mainstreaming of human health protection across all Union policies and activities is a treaty-enshrined goal,[17] but it remains largely confined to lofty rhetoric (Ruiz Cairó, 2021, pp. 377–378), as the EU's economic-oriented institutional context "is not particularly favourable for

[15] The Global Burden of Disease study "is the largest and most comprehensive effort to quantify health loss across places and over time, so health systems can be improved and disparities eliminated" (IHME, n.d.).
[16] The only exception are "common safety concerns in public health matters", where the EU possesses shared competence (Article 4, paragraph 2(k), Treaty on the Functioning of the European Union (TFEU)).
[17] Article 9, TFEU, and Article 168, paragraph 1, TFEU.

implementing [Health in All Policies] in a normatively meaningful way" (Godziewski, 2022, p. 124).

Following the terminology of Schunz et al. (2018, pp. 19–21), a "sectoral diplomacy" in the area of health has been slow to come by and is arguably yet to fully materialise. That does not mean, however, that the EU's health policy has no real external effects – in fact, those effects have existed for decades. A case in point is the EU's significant contribution to the first and, to this day, only treaty adopted under WHO auspices: the 2003 Framework Convention on Tobacco Control, to which the EU became a party even though it is only an informal observer at the WHO. The EU acted as a "real rule-shaper", with the final content of the Convention being "close to pre-existing EU tobacco-control legislation" (Ruiz Cairó, 2021, pp. 225–226; see also Chamorro, 2016; Guigner, 2009). Based on Schunz et al.'s (2018, pp. 19–21) typologies of external action, this amounts to a clear, intentional "externalisation of EU internal policy". In addition, "unintended external effects" of EU health policy (another of Schunz et al.'s typologies, more aligned with the notion of EU "presence") can be perceived, for instance, in the field of consumer health and safety. This is very much the focus of the European Food Safety Authority, which was founded in 2002, as well as of the European Commission Directorate-General for Health and Consumers (DG SANCO), which was created in 1999 and later evolved into the Directorate-General for Health and Food Safety (DG SANTE). In her landmark book on "the Brussels Effect", Bradford (2020, pp. 171–206) dedicates an entire chapter to the ways in which health-related EU regulations have been adopted by foreign actors, in terms of business practices and even legislative reforms, without active EU promotion. Furthermore, while there is no strong integration of internal health objectives into external policies (the final form of external engagement foreseen by Schunz et al.), health provisions have found their way into bilateral EU cooperation agreements (Rollet & Chang, 2013, pp. 319–320). On occasion, EU health-related norms (such as the so-called "precautionary principle") have also permeated well-established areas of external action areas, like trade policy.[18]

Importantly, it may very well be argued that being considered a global health actor should not imply having "a primary intent to improve health" (cf. Hoffman & Cole, 2018, p. 4), as this would overlook the global health impact of other external policies, be it positive or negative. Instead,

[18] For instance, the EU decided not to comply with a 1999 ruling by the World Trade Organization (WTO) Appellate Body establishing the illegality of its ban on imports of hormone-treated beef. The EU imposed this ban by virtue of its "precautionary principle" (Bradford, 2020, pp. 175–176; Pollack, 2003, p. 126), developed in part as a result of the 1990s BSE "mad cow" crisis (Vogel, 2012). This principle, emanating from environmental law, is also at the heart of other examples of stringent EU legislation with a health dimension, such as REACH (the regulation on Registration, Evaluation, Authorisation and Restriction of Chemicals) and regulations on genetically modified organisms.

this PhD thesis heeds Schunz et al.'s (2018, p. 8) call, echoed by other scholars (see Kickbusch & de Ruijter, 2021, p. 1), not to treat domains of EU external action in isolation from each other. As we will see in the following sub-section, this is particularly important in global health, whose governance is characterised by a series of overlapping "political spaces" transcending institutions with an explicit health mandate (Kickbusch & Szabo, 2014). In keeping with this rationale, I argue that, to various degrees, there is a health component in all of the different layers of EU external action[19] (see **Chart 1** below):

1. The Common Security and Defence Policy (CSDP), including its deployments abroad.
2. CFSP, including the promotion of human rights and democracy, conflict resolution and prevention, as well as sanctions and restrictive measures.
3. Other classical, treaty-enshrined areas of external action (trade, development, and humanitarian aid).[20]
4. Internal policy areas that have given rise to, or can potentially give rise to, sectoral diplomacies (e.g. climate change, energy, competition, research, migration, digital affairs and health).

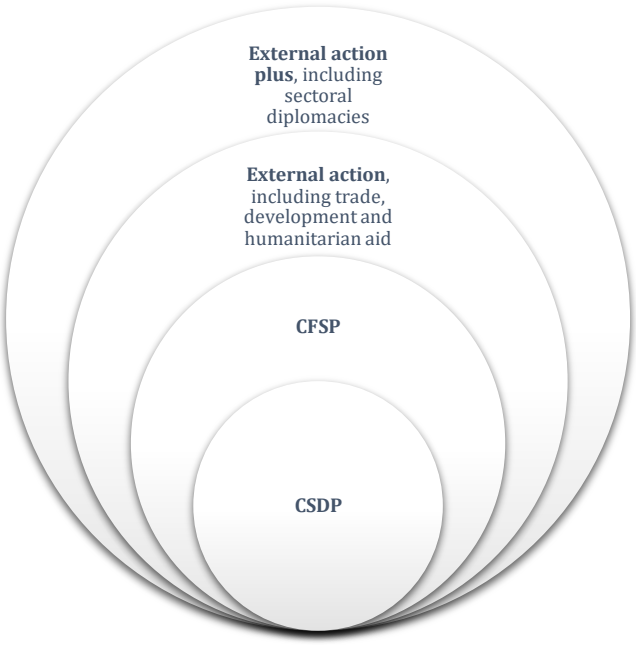

Chart 1. *The different layers of EU external action. Own adaptation from the ENGAGE project overview, available at https://www.engage-eu.eu/project-overview*

[19] This follows the multifaceted conceptualisation of EU external action devised by the Horizon 2020 project "ENGAGE" ("Envisioning a New Governance Architecture for a Global Europe"), which closely matches the one presented by Keukeleire and Delreux (2022).
[20] Part Five ("the Union's external action"), Titles II ("common commercial policy") and III ("cooperation with third countries and humanitarian aid"), TFEU (see Szép & Wessel, 2022).

As observed by Keukeleire and Delreux (2022, p. 270), the links between health and other policy areas such as climate change are being increasingly recognised. In this sense, COVID-19 represented a watershed moment: the widely accepted zoonotic origins of the pandemic (Gostin & Gronvall, 2023) underscored the relevance of the human-animal-environmental interface, encapsulated by the "One Health" approach to delivering health security.[21] The EU's own health security agenda has consistently underscored the importance of this concept. In the 2010 Commission Communication on "the EU role in global health", One Health was already mentioned (European Commission, 2010, p. 8), when the concept was still in its early days.[22] In addition, the EU has pursued some more concrete initiatives regarding the promotion of One Health, such as the Commission's "One Health action plan against Antimicrobial Resistance (AMR)", which tackled the abuse of antimicrobials in human and veterinary medicine and the resulting decline in their effectiveness (European Commission, 2017). After COVID-19, the EU spearheaded a new agreement on pandemic prevention, preparedness and response, which might become the second convention adopted under Article 19 of the WHO Constitution, after the Framework Convention on Tobacco Control (Ruiz Cairó, 2022, pp. 5–6).[23] According to the various drafts that have circulated of this potential agreement, whose adoption was foreseen for May 2024 but has been postponed, One Health features prominently within it. This reflects the EU's increased proactivity and leadership within the WHO,[24] in line with a broader effort to sustain this battered multilateral organisation in the context of COVID-19 (Schuette & Dijkstra, 2023) and a newfound assertiveness in global health matters (Bergner, 2023). Said approach marks a clear departure with the EU's prior engagement with the WHO: during the decade leading up to the COVID-19

[21] A wide range of anthropogenic factors have become important drivers of zoonoses – in fact, more and more so. These include mass urbanization and land conversion, which give rise to novel forms of contact at the human-livestock-wildlife interface. In addition, climate change has been found to alter the geographical ranges of host species, such as bats and rodents, and increase the size and incidence of vector species, such as mosquitoes and ticks (Carlson et al., 2022; Kelland, n.d.). For the first time ever, the UN Climate Change Conference included in 2023 a "Health Day", which sought to showcase health arguments for climate action. A declaration on "climate and health" was adopted, through which 151 countries (as of July 2024) have committed to "facilitat[e] collaboration on human, animal, environment and climate health challenges, such as by implementing a One Health approach" (*COP28 UAE Declaration On Climate And Health*, 2023, p. 2).

[22] The concept was first coined in 2004 by the Wildlife Conservation Society, as "One World, One Health" (Wildlife Conservation Society, n.d.). Soon thereafter, it was jointly borrowed, renamed and redefined by the WHO, the Food and Agriculture Organization (FAO) and the World Organization for Animal Health (WOAH) (Chien, 2013; Guilbaud, 2023, pp. 66–67).

[23] In parallel, negotiations were set in motion concerning the revisions of the International Health Regulations (IHR), which were led by the US. These amendments were approved by the World Health Assembly in June 2024. The EU is not a party to the IHR, adopted under Article 21 of the WHO Constitution, because regulations only apply to states. By contrast, it could become a party to a pandemic convention adopted under Article 19.

[24] EU influence has not remained uncontested. For example, provisions concerning One Health have been a delicate subject throughout the pandemic agreement negotiations, with their exact operationalisation remaining murky. Some Global South countries and civil society organizations have expressed their reluctance about making binding commitments in this department, due to fears over potential trade restrictions, excessive data sharing obligations and resource allocation.

pandemic, the EU's coordination struggles – dating back to the post-Lisbon period – had only been partially overcome and the EU's voice within the organisation still sounded muffled (van Schaik et al., 2020).

Another major post-COVID development was the EU's adoption of its first official global health strategy (European Commission, 2022a), which replaced the 2010 Commission Communication. It took the most impactful health crisis of our lifetimes for the EU to finally answer the repeated calls to define an actual global health strategy (see, for instance, Speakman et al., 2017). This much-awaited document declared global health "an essential pillar of EU external policy" and was conceived as "the external dimension of the European Health Union" (European Commission, 2022a, p. 4) – an umbrella term referring to a series of institutional and policy initiatives undertaken after the onset of the pandemic in the fields of health security, access to medical countermeasures, health systems strengthening and global health cooperation (European Commission, 2024b). In its 2022 Global Health Strategy, the EU reaffirmed its commitment to the One Health perspective, which should allow its health policy to further leverage synergies with its more consolidated agricultural, climate and environmental policies. The strategy also lauded the "Team Europe" approach, established as a result of the pandemic in an attempt to harness the combined strengths of EU and Member State action. Noteworthy "Team Europe" policy outputs include the EU's co-sponsorship and funding of the Access to COVID-19 Tools Accelerator (ACT-A) and its vaccine pillar, COVAX (European Commission, 2022a, p. 5), as well as a number of regional projects (European Commission, 2022a, p. 31). While this approach is not entirely new, "Team Europe generated a level of traction that had never been achieved by earlier more technical and process-oriented efforts to promote coordinated action between the EU and the member states" (Koch et al., 2024, p. 421).

Despite these positive developments, I concur with Keukeleire and Delreux's (2022) post-COVID-19 assessment that the external dimension of EU health policy remains "weakly developed" (p. 269) compared to other internal policy areas with outward effects. One reason for this is that the legal basis for the EU's global health action is flimsy, with the treaty provision to "foster cooperation with third countries and the competent international organisations in the sphere of public health"[25] lacking specificity. Tellingly, public health is not mentioned among the objectives of the EU's external action, as established in the Treaties (Ruiz Cairó, 2021, pp. 377–379).[26] But the EU's health policy is a paramount example that treaty-imposed constraints can be circumvented: since the Treaty of Maastricht laid the modest foundations for this policy, legal

[25] Article 168, paragraph 3, TFEU.
[26] Article 21, Treaty on European Union (TEU).

advances have been limited, but spill-overs from other areas have propelled it forward in practice.[27] Furthermore, if we turn to policy realms like competition and gender equality, we can notice that lack of explicit inclusion among external action objectives has not prevented the development of relatively advanced forms of external engagement (Damro et al., 2018, p. 246). I therefore argue that the fundamental reason health issues have struggled to impact the EU's larger foreign policy agenda is a deficit of political will. This explains the fact that it was "largely absent" from the EU's otherwise very comprehensive Global Strategy (Speakman et al., 2017, p. e393; see European External Action Service, 2016) as well as from the much more defence-oriented, but post-pandemic Strategic Compass (European External Action Service, 2022).

All in all, there is no question that COVID-19 raised the external action profile of health issues, often through their securitisation. In doing so, it furthered the EU's development of a health-focused "sectoral diplomacy", which is "the most challenging form of external engagement and testifies to a certain *maturity* of the EU as an external actor" (Schunz et al., 2018, p. 9 emphasis added; see Maurer et al., 2024). However, the EU's more consolidated global health agenda has also elicited contestation, especially from the Global South, where objections emerged about the EU's vaccine hoarding and its resistance to waive Intellectual Property (IP) rights for medical countermeasures at the WTO. The pandemic also added to the complexity of global health governance, a subject where the EU lacks a clear position (as shown in Publication 2 of this PhD thesis): its expressed support for the WHO's central role (European Commission, 2022a, pp. 7, 28) coexists and sometimes conflicts with a desire to explore alternative forms of governance, where states leave more space for the participation of other entities (Battams et al., 2014; Battams & van Schaik, 2016; van Schaik & Battams, 2014). Since the EU's contemporary role in global health cannot be understood without accounting for the remarkable evolution of its governance architecture, which is indeed moving closer to the latter model, this is the subject to which I now turn.

Global health governance: a complex picture

To speak of a "global health order" would be a gross overstatement. For decades, the governance of global health has rather been characterised by "chaotic pluralism" (see Belle et al., 2018) or "unstructured plurality" (Fidler, 2007, pp. 3-4). Fragmentation came about in a multiplicity of

[27] Article 168, TFEU, on "public health" has been referred to as a "gate with no fence", given that EU Member States' efforts to keep it closed have not prevented *de facto* integration based on other legal provisions (such as Article 114, TFEU, on the functioning of the internal market). As a result of COVID-19, the "gate" itself suddenly swung wide open (Greer et al., 2022, pp. 31–32).

ways, manifesting itself in virtually all dimensions of the global health ecosystem – from financing to norm-setting, all the way to impact evaluation. This has obstructed the constitutional mandate of the WHO "to act as the directing and coordinating authority on international health work" (World Health Organization, 1946; see also Clinton & Sridhar, 2017, p. 4; Leon, 2015, p. 83). Some catalysts of fragmentation concern the WHO's own finances and governance framework. The first one has to do with a growing dependence on voluntary contributions relative to assessed contributions by its Member States, with the latter funding source representing a mere 13% of the overall WHO budget by 2023 (World Health Organization, 2023). This severely compromises the organisation's financial sustainability and decision-making autonomy. Whereas assessed contributions feed into the WHO's general budget and can be used with full discretion, voluntary contributions tend to be earmarked and favour vertical approaches targeting specific diseases. Said strategy deviates from the WHO's traditional focus on strengthening health systems and fostering Universal Health Coverage (UHC), inspired by the Declaration of Alma-Ata (World Health Organization, 1978). A second driver of fragmentation relates to the WHO's decentralised governance structure, which relies on regional offices to an extent that is entirely unique among UN agencies. To be sure, the fragmented character of the WHO is not new, as it can be traced back to the post-foundational intent to integrate the Pan-American Sanitary Organization (PASO)[28] while preserving its independence – a model that was then reproduced by the five other, newly created regional offices (Hanrieder, 2015, pp. 58-62). That said, the autonomy of the WHO's regional offices has even increased over time, becoming a recurrent point of contention (Hanrieder, 2015, pp. 6-8; van der Rijt & Pang, 2013, p. 4).

The fragmentation of the global health architecture has also emanated from other corners of the UN system. Perhaps most importantly, it has been spurred by an IO whose primary mandate does not directly concern health: the World Bank. Since the 1980s and especially the 1990s, the World Bank's health portfolio has grown considerably (Ruger, 2005), even coming to rival – and at times overtake – the WHO as a channel of Development Assistance for Health (DAH) (IHME, 2023). The booming health agenda of the UN Development Programme (UNDP) is another case in point (Leon, 2015), as are the extended roles of the UN Children's Fund (UNICEF) and the FAO (Lerer & Matzopoulos, 2001). Fragmentation within the UN system has also involved the appearance of new multilateral entities whose remit of action touches upon global health, such as the Joint UN Programme on HIV/AIDS (UNAIDS), founded in 1994, and UN Women, established in 2010. Occasionally, the UN Security Council (UNSC) has joined the global health chorus too. The unanimous adoption in 2000 of UNSC Resolution 1308, on "HIV/AIDS and international

[28] In 1958, the PASO was renamed as the Pan American Health Organization (PAHO).

peacekeeping operations", paved the way towards a few other health-related Resolutions (Basu & Nunes, 2020). While there is a degree of functional differentiation in all of these UN-related efforts on global health, turf wars have been common.

Beyond the UN system, the global health architecture has experienced widespread power diffusion away from states and traditional IOs (e.g. the WHO). Chief beneficiaries of this power shift have included non-state actors, hybrid or multistakeholder entities – also known as Public-Private Partnerships (PPPs) – and, to a lesser extent, informal IOs. By far, the most important non-state actor with a specific health purpose is the Bill and Melinda Gates Foundation, which was founded in 2000 and has remarkably become the second-largest financer of the WHO (World Health Organization, 2023). As for PPPs, two of the most prominent ones are the Gavi Vaccine Alliance (also launched in 2000) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (created in 2002), both of which have received considerable support from the Gates Foundation. The BRICS group, the G7/G8, and the G20 – all of which represent informal fora – have also gradually developed an interest in global health and adopted a series of communiqués dealing with health matters (McBride et al., 2019).

Yet another source of fragmentation in global health has come in the form of initiatives undertaken by individual governments as complements or substitutes for multilateral action. The US President's Emergency Plan For AIDS Relief (PEPFAR), set up in 2003, is a primary example. There have also been some noteworthy developments at regional level. The EU's adoption of a larger and more coordinated role in health matters has given rise to synergies but also tensions with the WHO Regional Office for Europe (WHO/Europe), where EU countries represent a slim majority (van Schaik et al., 2020; van Schaik & Battams, 2014). The Association of Southeast Asian Nations (ASEAN) has also become more involved in public health, which has posed a different challenge to the WHO: given that ASEAN Member States are split into two WHO regional offices, inter-institutional coordination has been difficult to achieve (Lamy & Hong, 2012, p. 241). Finally, tensions between the Global North and the Global South, together with the ongoing power transition from West to East and ensuing great-power competition, have had some important repercussions. For instance, they have impeded progress on the Doha Development Round of the WTO and led to a surge in bilateral free trade agreements, some of which contain unfavourable provisions for developing countries in terms of IP protection for medicines (Correa, 2006).

These dynamics paint a clear picture of how fragmentation in other areas of global governance can affect global health. For years, scholars and policymakers have raised awareness about commercial, environmental, social, political and other determinants of health (Kickbusch & de

Ruijter, 2021). Following this comprehensive "whole-of-society" understanding of global health, and considering also the specialisation and fragmentation trends that I have delineated, I argue that the global health architecture of the 21st century is best described in terms of "regime complexity" or "hybrid institutional complexity". The notion of "regime complex" was coined by Raustiala and Victor (2004), who defined it as "an array of partially overlapping and nonhierarchical[29] institutions governing a particular issue-area" (p. 279). Regime complexity theory thus seeks to make sense of "the growing concentration and interconnection of institutions in the international system" (Raustiala & Victor, 2004, p. 296), and has been applied to fields as diverse as climate change, finance, trade, security and human rights. For its part, the concept of "hybrid institutional complex" (Abbott & Faude, 2022) captures the current global trend towards more heterogeneity and informality in global governance, with the area of health being presented as a prime example (pp. 267, 272, 284). While hybrid institutional complexes were conceived as different from regime complexes, I treat the two categories as complementary, with the former being a particular manifestation of the latter.[30] Most of the already vast literature on regime complexity has focused on the internal workings and policy outputs of these decentralised, dense and often diverse governance arrangements, but there has been some incipient academic interest in analysing how they are navigated by specific actors, like the EU (see Delreux & Earsom, 2023, and the rest of the Special Issue).

In global health, regime complexity is a relatively underexplored framework of analysis. However, it has been employed by a few authors. One of the first instances of this came in 2010, when Fidler described "the regime complex governing health [as arguably] one of the most complicated in world affairs" (Fidler, 2010, p. 9). In his taxonomy of global health players, Fidler went as far as to include private enterprises with a clearly deleterious health impact (tobacco companies), thus advancing a highly expansive, non-normative understanding of global health governance (Fidler, 2010, p. 10). In 2015, Leon built upon these and other contributions to publish what is to date the most extensive and detailed analysis of the global health regime complex, which he vividly depicted as a "chorus without a conductor" (Leon, 2015, p. 18). Other studies applying the concept of "regime complex" to global health have focused on more specific issue-areas – or what Fidler (2010) would call "regime clusters" – such as food security (Naiki, 2009) and AMR (Weldon et al., 2022). The academic spotlight has also illuminated the health-related externalities of environmental governance from a "regime complexity" lens. An important study by Morin and

[29] This does not refer to each institution's internal structure, but conveys the notion that no institution clearly sits over the others (i.e. regime complexes are polycentric).
[30] "While we treat them separately for purposes of comparison . . . one can view even pure regime complexes as low-diversity HICs [hybrid institutional complexes]" (Abbott & Faude, 2022, p. 268). By the same token, hybrid institutional complexes can be viewed as high-diversity regime complexes.

Blouin (2019) revealed that "the global environmental regime includes more than 300 treaties with health-related provisions" (p. 7) and urged health policymakers to "not only consider the instruments available to them within the realm of global health institutions" (p. 1). This call came just before COVID-19 struck, with the discussion about its origins directing further attention to the environmental determinants of health and reinvigorating the One Health approach, as emphasised in the previous sub-section.

Much of the existing scholarship on regime complexity has sought to determine what the lack of a unifying "conductor" entails. Some studies conclude that it is mostly detrimental, as it can lead to an ever-growing cacophony of voices and an inefficient use of resources (see Alter & Meunier, 2009, and the rest of the symposyum). Others believe that harmonisation can occur more organically and that fragmentation can be creative, enhancing adaptability and flexibility (Acharya, 2016; Keohane & Victor, 2011; Telò, 2020). Similar debates have taken place among global health scholars. Negative views of fragmentation have been widespread, with some analysts blaming it for impinging effective resource allocation, coordination, norm compliance and transparency (Spicer et al., 2020). Critical scholars also lament the mainstreaming of neoliberal – mostly vertical – approaches to global health, driven to a large extent by philanthropic foundations but also by the World Bank (Blunt, 2022; Garrett, 2007; Jones & Hameiri, 2022; Schrecker, 2016). While acknowledging some of these drawbacks, other scholars are more sanguine. They highlight that increased actor density has favoured the public salience of health and, as a consequence, led to a spectacular spike in global health funding (Fidler, 2007, 2010). Others add that specialisation can herald complementarity and boost effectiveness and efficiency (Abbott & Faude, 2022, p. 272), with disease-specific programs not implying the abandonment of horizontal strategies (Leon, 2015) and facilitating impact evaluation (Bärnighausen et al., 2012).

Notwithstanding these different interpretations, there seems to be consensus on one point: given the interests of both public and private actors, combined with institutional path-dependencies (Hanrieder, 2015), the complexity of the global health architecture is unlikely to decrease in the foreseeable future. The 21st century has provided plenty of evidence to support this view, although actor density experienced a much more substantial growth rate in the initial decade of the century than in the years that followed – at least when putting the COVID-19 era aside. Fidler's 2010 assessment that the global health revolution had reached a plateau thus proved prescient, partly as a consequence of the severe constraints imposed by the global financial crisis and other geo-economic challenges (Fidler, 2010, pp. 18-19). In 2018, Hoffman and Cole published a taxonomy of the global health system that comprised 203 actors, none of which were founded

after the year 2011.[31] By way of comparison, the global health actors born between 2000 and 2011 amount to as many as 47 (Hoffman & Cole, 2018, pp. 6-11). Since then, efforts have been redirected into consolidating the high-profile initiatives that emerged in the 2000s, as well as into devising strategies to better blend them with more traditional structures and mechanisms of global health governance – an undertaking that has yielded mixed results. On the one hand, a reform agenda launched within the WHO to explore, among other things, how to further integrate non-state actors within its governance framework bore no significant fruits (Velásquez, 2022). On the other hand, differences between vertical and horizontal approaches have been somewhat tempered, with actors becoming slightly more willing to diversify their strategies (Gates, 2022). This led to the popularisation of "diagonal approaches"[32] and the emergence of new initiatives such as UHC2030, which brings PPPs together in support of health systems strengthening (Storeng et al., 2021). This mindset change was also apparent when the Sustainable Development Goals brought explicit health matters into a single, holistic goal – unlike the previous Millennium Development Goals, where health was distributed across three distinct goals.

Returning to Hoffman and Cole's taxonomy of global health actors, it must be noted that it only considers those entities that identify improving health as one of their primary intents (Hoffman & Cole, 2018, p. 3). As I argued above, that is too narrow a conception of what constitutes a global health actor, which results in the exclusion of key entities like the EU, the International Labour Organisation (ILO) and the WTO. When examining the full breadth of the global health regime complex and its evolution over the past decade, we can see some significant evidence of even greater fragmentation, stemming in great part from the dissatisfaction of emerging powers with their roles in traditional, West-dominated institutions. For example, there has been a proliferation of regional or *minilateral* development banks, such as the Asian Infrastructure Investment Bank and the BRICS-sponsored New Development Bank. Both of these China-based institutions have been faulted for taking a less holistic approach to development than the World Bank and for neglecting environmental issues, as well as other determinants of health (Wang, 2017, p. 116). This raises serious concerns in terms of their global health impact. In order to assuage these centrifugal forces, traditional IOs have been forced to adapt. A primary example of this is China's growing clout within the WHO (van Schaik et al., 2020), which has revealed itself in a variety of ways, e.g. through the controversial inclusion in 2019 of traditional Chinese medicine in a WHO global diagnostic compendium (Drieskens et al., 2024).

[31] Their systematic search was conducted in 2014, therefore excluding at least one important global health actor: the Coalition for Economic Preparedness Innovations (CEPI), founded in 2017.
[32] Although empirical assessments revealed that commitment to them was often more rhetorical than practical (Storeng, 2014).

Tensions reached boiling point with the arrival of COVID-19 (Guilbaud, 2023, pp. 61–62). The Trump Administration accused the WHO of failing to properly investigate the origins of the pandemic and, more generally, of caving in to China's political pressures in its response to it. In April 2020, Trump suspended US funding to the WHO. Soon thereafter, he sent a heated letter to the WHO director-general, Tedros Adhanom Ghebreyesus, in which he admonished the organisation for displaying an "alarming lack of independence from the People's Republic of China" (The White House, 2020, p. 1) and threatened to withdraw the US from it. In July 2020, Trump made good on his threat and gave the required one-year withdrawal notice to the UN secretary-general. Throughout much of 2020, rumours circulated about the possibility that the US might lead the creation of an alternative organisation to the WHO (Toosi, 2020), which would have entailed a qualitatively different kind of fragmentation, closer to the one seen in the area of trade with the progressive hollowing out of the WTO. These rumours, however, were not backed up by any specific proposals. In fact, the US withdrawal itself never materialised because Trump's successor, Joe Biden, immediately reversed course upon taking office in January 2021.

While this move lifted some of the pressure off the WHO's shoulders, at times the organisation has also been at loggerheads with the Chinese government, which has repudiated all criticism of its handling of the pandemic (Olcott & Creery, 2022). Moreover, the new US president adopted a rather lukewarm policy towards the WHO and did not show much receptivity to reform proposals involving an increase in assessed contributions. An agreement, however, was eventually reached in the May 2022 World Health Assembly to raise the volume of assessed contributions by 20% in 2024-2025 over the previous budget cycle, and for them "to represent 50% of WHO's core budget by the 2030–2031 budget cycle, at the latest" (World Health Organization, 2022). Throughout the duration of this PhD, the organisation's spotlight was set on two parallel processes: the amendment of the IHR, whose performance in the COVID-19 pandemic was called into question, and the negotiations on an international accord on pandemic prevention, preparedness and response. Both processes were supposed to finalise at the 2024 World Health Assembly, but only the first one did, with the adoption of a pandemic accord being postponed.

Beyond the WHO, the pandemic represented an unprecedented test for a fragmented global health landscape. Some commentators highlight that the overall response, while clearly sub-optimal, showed some promising signs: for instance, they praise the role of pharmaceutical companies in producing COVID-19 vaccines at historic pace (Gates, 2022), with the support of national (e.g. the US's *Operation Warp Speed*) or international PPPs (e.g. CEPI). Others hold a bleaker view, claiming that "the shift away from coordinated global health governance has led to

political conflict and institutional disorder, undermining international cooperation" (Gostin et al., 2020, p. 1617). "Vaccine nationalism", resulting in the highly unequal distribution of COVID-19 vaccines between the Global North and the Global South, is presented as evidence for these trends (Bergner, 2023). There have also been claims that the popularisation of neoliberal approaches to global health hollowed out state capacities, thus compromising preparedness and resilience (Jones & Hameiri, 2022).

The pandemic exacerbated the extraordinary complexity of the global health architecture. Non-state or multi-stakeholder entities like the Gates Foundation and Gavi gained more importance, in some ways contributing to the WHO but also pushing back against key issues in its agenda, such as its advocacy for a waiver of IP rights for COVID-19 vaccines (Banco et al., 2022; Brown & Rosier, 2023). Initiatives launched in response to the pandemic, such as ACT-A and COVAX,[33] have been criticised for lacking in clear leadership and accountability, with the WHO playing a diluted (Guilbaud, 2023, p. 64) or even a secondary role (Banco et al., 2022). Despite their commitments to COVAX, high-income economies – including the EU, through its Commission-led joint procurement mechanism – circumvented this multilateral mechanism and reached advance purchase agreements with pharmaceutical companies, often followed by bilateral donation deals with lower-income countries (Storeng et al., 2021). Even when sharing doses through COVAX, wealthy governments sometimes did so by earmarking their donations (e.g. tying them to a specific recipient), contrary to the initiative's funding principles (de Bengy Puyvallée & Storeng, 2022, p. 7). In terms of funding, COVID-19 has attracted an inordinate amount of resources into global health, but there has been a negligible increase in the volumes allocated to health systems strengthening or sector-wide approaches (IHME, 2023).

Much of the international debate on how to manage the pandemic took place at the WTO, with intense negotiations leading in 2022 to a watered-down agreement on a temporary IP waiver for COVID-19 vaccines, which excluded other medical countermeasures and left many developing countries dissatisfied. In February 2024, a negotiating effort to extend the breadth of the waiver to COVID-19 tests and treatments ended in a resounding failure.[34] These pandemic-induced

[33] According to Storeng et al. (2021), COVAX "is an extraordinarily complex multistakeholder public-private partnership (PPP), co-led by existing PPPs as one pillar of an even more complex PPP, ACT-A. We show that it constitutes an experimental institutional form for dealing with global health crises that we call the 'super-PPP'" (p. 2).

[34] Among EU countries, Germany has been particularly vocal in its defence of IP rights for medical countermeasures. As German health minister Karl Lauterbach said regarding a potential WHO pandemic agreement, "for countries like Germany and most European countries, it is clear that such an agreement will not fly if there is a major limitation on intellectual property rights . . . That is a part of our DNA . . . We need intellectual property security in order to invest into vaccines, invest into therapeutics, diagnostics, and so forth" (see Anderson, 2023).

multilateral negotiations have underscored the impact of trade governance on global health, as well as some of its problematic repercussions. The glaring inequities in the international response to COVID-19 intensified a longstanding debate on the relationship between IP rights and public health (t' Hoen, 2023), even prompting a call to transfer the authority to waive patent rules to the World Health Assembly (Kavanagh, 2024). While there are historical grounds for this proposed "forum shift" (many developed and developing countries excluded medicines from patent monopolies before the creation of the WTO), any such move would be met with fierce resistance from advanced economies. The European Commission, in particular, has made extensive use of its single seat at the WTO to leverage its market size in pursuit of its (mostly economic) interests. This is an example of how the expanded scope and persistent decentralisation of the global health regime complex presents several actors with new opportunities to have a bigger say, but also with new challenges in terms of ensuring policy coherence and attaining widely satisfactory public health outcomes.

1.2 Aims and structure of the PhD thesis

This PhD dissertation was conceived as a response to the proverbial call to "never let a good crisis go to waste". Whether this call was widely heeded, however, is doubtful at best. According to economist Branko Milanovic (2020), the COVID-19 pandemic was "the first global event in the history of mankind", as "it has affected almost everybody, regardless of country of residence or social class". This may well be true, but we still experienced it mostly locally, with profound asymmetries manifesting themselves both in the early responses to it and in the recovery from it. This outcome was not entirely inevitable: while it stemmed from deep-seated global inequities, it also reflected concrete policy choices. Other scenarios were possible and, to some extent, they might still be. Given its global scope, the pandemic had the potential to expand our worldview geographically and temporally, as well as to cement health matters and the provision of global public goods as cornerstones of the international agenda. Harnessing this potential is crucial for preventing future pandemics, addressing other global health issues, and managing transnational crises or disruptions that transcend but also concern global health, such as climate change and the Artificial Intelligence revolution (see Bremmer, 2022).

Against this backdrop, and considering both the EU's burgeoning health policy and its overall significance in global governance, dissecting its role as a global health actor stands out as an essential and somewhat neglected task. As I implied above, any well-rounded "actorness" study must begin with a critical analysis of the state of the art and proceed through an assessment of the EU's capabilities, its unintended impact, its concrete policies and strategies, and its general

achievements and shortcomings. Following a constructivist approach, which "actorness" scholarship is increasingly favouring, I will place paramount importance on the perceptions that both shape and derive from these dynamics, also problematising widespread academic practices and assumptions.

The overarching research questions addressed by the three publications comprising this PhD thesis are the following:

RQ1. To what extent and why have prevailing perceptions on the EU as a global health actor changed as a result of the COVID-19 pandemic?

- **Sub-question: In what ways do the EU's self-perceptions converge or diverge from the perceptions of external observers?**

RQ2. How has the EU's global health policy become integrated into and shaped an evolving EU external action?

- **Sub-question: What does the EU's approach to global health reveal about its engagement with contemporary forms of global governance?**

Both of these research questions, as well as their respective sub-questions, are explored from different yet complementary angles in all components of this PhD dissertation. These consist of three publications: two single-authored journal articles and one book chapter co-authored with Dr. Robert Kissack, from the *Institut Barcelona d'Estudis Internacionals* (IBEI), who is the supervisor of this PhD thesis. **Grid 1** contains relevant information concerning their respective publication formats and outlets, their publication status, their specific research questions, and the degree to which they contribute to answering the two overarching research questions outlined above. The three components, all of which are already published or accepted, were ordered according to the date in which they were first submitted to a journal or academic publisher, as this is a more accurate and organic depiction of the research process than eventual acceptance dates.

Grid 1. *Key details on the three components of this PhD dissertation.*

Publication number and title (authorship details)	**Publication format and outlet (rank quartile)**[35]	**Publication status (date)**	**Specific research questions**	**Engagement with overarching PhD research questions**
1: The European Union's global health actorness: A research agenda for a new age of pandemics (Single-authored)	Standalone, open-access article in the *Journal of Common Market Studies* (Q1)	Published (21/07/2024)	(1) How has the literature conceptualised and assessed EU actorness in global health, and (2) what adjustments would a post-COVID-19 research agenda require?	RQ1 ● RQ2 ◐
2: The European Union's role in global health: Embracing governance complexity? (Co-authored with Dr. Robert Kissack)	Chapter in the volume *EU foreign policy in a fragmenting international order*, edited by Costa et al., and forthcoming (open-access) in Springer Nature	Accepted (10/01/2024) Proofs submitted (04/09/2024)	(1) How did the EU consolidate itself as a global health actor, and (2) how have the EU and its Member States responded to a fragmented global health governance landscape?	RQ1 ◐ RQ2 ●
3: The European Union's securitisation of global health: Was COVID-19 a *Zeitenwende*? (Single-authored)	Article in a Special Issue on "'Zeitenwende' as coming of age? EU foreign and security policy through war and peace", edited by Maurer et al., and published (open-access) in *European Security* (Q1)	Published (16/09/2024)	To what extent did the EU's post-COVID-19 accelerated maturation as a global health actor intertwine with a reinforced commitment to providing "health security"?	RQ1 ● RQ2 ●

The first publication, which sets the tone for the entire PhD thesis, is grounded on a highly comprehensive review of the existing literature on the EU as a global health actor. Said literature review was progressively refined into a more targeted text that deals primarily with the very few

[35] Rank by Journal Impact Factor in the International Relations category of the 2023 Journal Citation Reports (JCR).

studies applying the notion of "actorness" systematically to the EU's global health policy. The article then proceeds to outline a research agenda that seeks to overcome pervasive analytical shortcomings through a series of guiding principles, all of which can be exported to broader literature on (EU) actorness. The goals of the article include challenging some widespread academic assumptions about the EU, in global health and beyond, and contributing to some longstanding debates in the *Journal of Common Market Studies*. It does so by critically engaging with prominent concepts associated with this journal, such as "Normative Power Europe" (Manners, 2002) and the "capability-expectations gap" (Hill, 1993). In addition, the article aims to adjust the concept of "actorness" to today's multifaceted EU external action, as well as to an increasingly dense and diverse global governance landscape. While I set forth a "research agenda" for future scholarship, I do recognise some potential in terms of shaping the policy agenda too. A pessimist would highlight the all-too-frequent disconnects between academic and policy circles, as well as the latter's tendency to exhibit short attention spans and neglect long-term threat prevention – not to mention non-securitised global health issues. Still, the article calls for at least maintaining scholarly momentum on global health research in anticipation of a likely "new age of pandemics", echoing the European Commission's own words (European Commission, 2022a, p. 14).

The second publication takes this research agenda forward by diving into the EU's health policy and its outward dimension, in recognition of the multiple links existing with other areas of EU external action. Attention is paid to the intersubjective perceptions informing the EU's evolving role and to how a securitisation of global health might affect these perceptions. The main focus of the chapter, however, is the EU's acceptance or rejection of governance complexity in global health. This focus reflects the theoretical framework of the edited volume, which explores Europeanist, Atlanticist and nationalist responses within the EU to the fragmentation of the liberal international order (LIO) (Costa et al., forthcoming). Our chapter portrays health as a *sui generis* case study: firstly, health is presented as having a complicated relationship with the LIO and, secondly, the three normative responses envisioned by the editors are adapted in order to enhance their analytical power. We also question some preconceptions about the origins and effects of fragmentation, as well as about the EU's defence of traditional multilateral settings (e.g. the WHO), which is found to coexist with plurilateral impulses in the form of support for *multistakeholder* initiatives. A dissection of EU strategic documents is supplemented with an evaluation of individual Member State perspectives, thereby advancing the polyhedric framework captured by the "Team Europe" approach.

Finally, the third publication making up this PhD draws on the concept of "securitisation" to conduct an extensive empirical analysis of the pre-COVID and post-COVID global health discourse of the EU. This journal article is part of a Special Issue on the maturation of the EU as a foreign and security actor (see Maurer et al., 2024). The article's inclusion in this Special Issue of a security-oriented journal (*European Security*) is revealing in itself. It shows that, after a long history of neglect in studying the firmly consolidated relationship between health and security, mainstream scholarly understandings of security are finally placing global health under the spotlight. The article engages with the different maturation processes and pathways laid out in the theoretical framework of the Special Issue. I make the point that the EU has matured significantly as a result of the recent pandemic, as evidenced by a more varied and robust policy and institutional toolkit, as well as a clearer footprint in the global health scene. However, this maturation has not led the EU to settle on a cohesive identity as a global health actor. This is because a renewed emphasis on health security – while coherent with a turn towards "principled pragmatism" in the EU's external action – has not been evenly and consistently embraced by EU institutions, and clashes with some of the values that the EU supposedly adheres to in the field of global health. Moreover, whereas security rhetoric has often infused the EU's recent documents and statements on global health, the reverse is not occurring. I argue that this amplifies the risks that EU health policy is captured by traditional security interests rather than genuinely redefining high politics. By addressing the (self-)perceptions of the EU as a global health actor and discussing health policy in conjunction with the EU's broader external action, this article interacts equally with the two overarching research questions of this PhD. Thus, it serves as a fitting culmination of the research process.

Ultimately, this PhD sets out to attain a series of interrelated objectives, arranged below from the most specific to the most general (i.e. starting with global health, moving on to European Studies, and concluding with the broader discipline of IR):

1. Ensure that the "cycle of panic and neglect" that tends to characterise policy responses to epidemics and pandemics does not trickle down into scholarly practices.
2. Advocate a non-normative conceptualisation of global health that sheds light on the myriad entities that have an impact on it, for better or for worse.
3. Advance a holistic understanding of health policy, aligned with the concepts of "One Health", "Health in all Policies" and "health mainstreaming" – all of which the EU rhetorically endorses, but has only partially internalised.

4. Challenge the frequent misperception that the EU does not constitute a global health actor, by acknowledging its relevance irrespective of its legal competences and even its intentions.
5. Expand the still nascent literature on health as an area of EU external action. This involves applying enduring concepts such as "actorness" beyond their usual purviews, thus enriching the existing scholarship on traditional internal areas with outward effects.
6. Explore the EU's evolution as an international actor by examining the extent to which some ongoing shifts (e.g. a turn towards "principled pragmatism", a more geopolitical mindset) are also present in its global health action.
7. Provide nuance to some widespread perceptions about the EU's external action, including about its preference for traditional multilateral institutions, its reluctance to act unilaterally and the benefits of speaking with a single voice on the world stage.
8. Treat health policy as a paradigmatic example of modern modalities of global governance, where a plurilateral complexity is the "new normal", and draw some lessons from the EU's experience with the global health regime complex that can inspire future research.
9. Contribute to the well-established scholarship on the social ontology of international relations, by recognising the importance of public discourse and the ideas, values, identities and beliefs underpinning it.
10. Foster a pluralistic view of social science that combines positivist elements with a post-positivist recognition that academic research is not innocuous, but can have significant performative effects and shape the realities described.

This thesis tackles all of the aforementioned goals, but with varying degrees of intensity. Since my PhD project speaks most directly to the European Studies literature, the central goals on the list (in particular, the fourth, the fifth and the sixth) are most prominent throughout, clearly informing all three components of the dissertation. The other goals are addressed more tangentially or remain in the background, reflecting my epistemological, ontological and methodological stance, which I will introduce in the next sub-section.

1.3 Research paradigm and methodological approach

The final two objectives mentioned in the previous sub-section relate to this PhD's overall research paradigm. To a large degree, I take constructivism as my point of departure, with its ontological emphasis on social construction and intersubjective co-constitution, combined with its epistemological leanings towards description, interpretation and understanding. This paradigm is difficult to reconcile with an orthodoxically positivist approach to social science (e.g.

neorealism's and neoliberalism's rationalist approach) that seeks to "explain" the world by asking "why" questions only and by testing the causal effect of independent variables on dependent variables. Indeed, the apparent "abyss" separating positivists, on the one hand, from post-positivists, reflectivists or interpretivists, on the other, led to the late-1980s emergence of the so-called "Third Debate" in IR theory (Fierke, 2002; see also Lapid, 1989).[36] The two camps were hardly homogeneous (Lake, 2013, pp. 570–571), but a clear rift between them did exist, largely predicated on a widespread assumption that a given ontology prescribed a given epistemology and, in turn, a given methodology. Several attempts were made to counter this claim and therefore bridge the two camps, perhaps most clearly by Wendt (1998, 1999), whom many credit – or chastise – for bringing social constructivism into the IR mainstream. Wendt (1999, p. 85) built on King, Keohane and Verba's influential take that explanation (causation) and understanding (description), while distinct, are compatible and mutually supportive. These scholars are adamant that the latter can also be regarded as "science", as long as it involves inferring information about non-observable facts from observable phenomena (King et al., 1994, p. 34). Wendt took this even further, arguing that "non-causal explanation" was possible as well (Wendt, 1998, p. 108, 1999, pp. 86, 373). This subtle but important nuance allowed him to define himself as an epistemological positivist, while maintaining an ontologically constructivist stance (Wendt, 1999, pp. 39–40, 90–91). Ultimately, I concur with Wendt's view (1999, p. 40) that positivists would do well to expand the scope of their questions and methods, whereas post-positivists are too concerned with epistemological matters. I also agree with his observation that IR research should be question- rather than method-driven (Wendt, 1999, p. 40), as well as with Lake's (2013) defence of mid-level theory in a quest to transcend paradigmatic wars. However, since some further reflections on ontology and epistemology can be helpful to understand the methodological approach of this dissertation, I now proceed to address this issue in slightly more detail.

Ontology and epistemology: clarifications and caveats

According to Wendt (1999), "constructivism is not a theory of international politics" (p. 7) – a view explicitly shared by Ruggie (1998), who defines it more precisely as "a theoretically informed approach to the study of international relations" (p. 879). When stripped down to its bare essence, social constructivism can be thought of as being primarily about ontology: in other words, it is concerned with what kind of "stuff" the world – and, by extension, the international system – is made of (see Ruggie, 1998, p. 879; Wendt, 1999, p. 35). This means that constructivism

[36] Or what others refer to instead as the "Fourth Debate" (for a summary of different positions on this definitional meta-debate, see Balzacq & Baele, 2014).

can accommodate realist, liberal, idealist, Marxist or other theories, even if it may clash with many of their basic tenets and share more common ground with some paradigms than with others (see Wendt, 1999, pp. 32–33).[37] A case in point is Waltz's "balance of power", singled out by Ruggie himself (1998, p. 879) as an *actual* theory. Balance of power, a core feature of neorealism, was later refined by Walt (another self-proclaimed realist) as what came to be known as the "balance of threat". This reformulation still rested to a large extent on material factors, but it incorporated some constructivist elements in the form of "perceptions of intent" (Walt, 1985, pp. 12–13), as emphasised by Wendt on multiple occasions (Wendt, 1995, p. 78, 1999, pp. 4, 19).

There are virtually as many ways to classify variants of constructivism as attempts have been made to do so. Ruggie (1998, pp. 881–882) spoke of neo-classical, postmodernist and naturalistic constructivism. Wendt (1999, pp. 3–4) distinguished between modernists (whom Ruggie referred to as neo-classical), postmodernists and feminists. For his part, Adler identified as many as four constructivist streams: modernist, modernist linguistic, critical, and radical. To complicate things further, disagreements also arise over how to categorise constructivist scholars. For instance, Wendt is placed by Adler (and by himself) in the modernist camp (Adler, 2002, p. 98; Wendt, 1999, p. 47), but Ruggie (1998, p. 881) portrays him as a naturalistic constructivist instead. In any case, ontological discrepancies among the different variants are relatively minimal (see Adler, 2002, p. 100), which justifies their inclusion under the umbrella of "constructivism", making it impossible – and pointless – to ignore the overlaps between them. Furthermore, while disagreements over defining categories and placing authors within them are common, they should not be exaggerated. By way of example, speech act theorists inspiring the Copenhagen School of securitisation – extensively referenced in Publication 3 of this PhD – are routinely categorised under neo-classical, modernist, or modernist linguistic labels (see Adler, 2002, p. 98; Ruggie, 1998, p. 881), which can be considered, at the very least, to share a wide array of treats.[38]

If commonalities are so pervasive, why should we then bother to divide constructivism into different sub-schools? That is chiefly because, from an epistemological standpoint, differences between constructivists are much more acute. Following Adler's (2002) terminology, the modernist strand is consonant with the central assumptions of positivism – in other words, it is

[37] Wendt (1999, pp. 32–33) places classical realism in direct opposition to constructivism, because of the former's individualist and materialist foundations, contrary to constructivism's holist and ideational ones. Even so, many studies have drawn on classical realism in combination with constructivism (see Michaels, 2022).

[38] Ontologically, Buzan et al. (1998) define themselves as "radically constructivist" regarding security, but less so when it comes to social relations (pp. 203-206). By recognising a positivist separation between analyst and object of study, they explicitly side with traditional security studies in their epistemological approach (see Buzan et al., 1998, pp. 33–35).

more optimistic about the possibilities of social science to separate the researcher from the object of research and thus learn "objective truths" about the world, similarly to what natural science seeks to accomplish. Modernist linguistic and critical constructivists are more aligned with a post-positivist approach, which does not deny the possibility of attaining credible knowledge but is much more reflexive about the role that researchers play in constructing and re-constructing their objects of study. Finally, radical constructivists are anti-positivist: they embrace postmodernist or poststructuralist viewpoints underlining the importance of power relations and display an interest in fostering ethical progress through their research. Importantly, as Adler (2002) clarifies, "with the exception of its radical postmodern wing . . . constructivism does not challenge science, rationalism and modernity; it merely makes science more compatible with the constructivist understanding of social reality" (p. 96).[39]

Those who see themselves as "consistent constructivists" (Fierke, 2013, pp. 196–199) share Schneider's (2015) view that "if we have a specific idea of the structure of the world, this also shapes the way we study and explore the world" (p. 191). This sort of epistemological determinism, which Wendt objects to, seems rather intuitive: after all, epistemology can be construed as "the ontology of knowledge", in a Hegelian sense (see Solomon, 1974, pp. 277, 280). Schneider's assertion is a good synthesis of "consistent constructivism," but it can be expanded to complete a feedback loop: the way we study and explore the world also shapes, in turn, our ideas of the structure of the world, *as well as of the agents that constitute and are constituted by said structure*. There is nothing inherently novel in this observation, which merely adds agents to the ontological picture and reflects a post-positivist recognition that theories can originate self-fulfilling prophecies (see Larsen, 2020, p. 962). This perspective informs all three components of this PhD, where I show an interest in the "performativity" (Larsen, 2020; see also Austin, 1962; Derrida, 1988) of concepts (e.g. "actorness" and the "capability-expectations gap"), preconceptions (e.g. on the ontology of EU external action) and discursive utterances of a more political nature (e.g. a securitising move in the form of a speech act). My commitment to taking language seriously, however, does not make this PhD a treatise on linguistics – it most certainly is not. Nor do I seek to burn all bridges with positivism (see also Fierke, 2002): in fact, I even apply some methods traditionally associated with it, such as quantitative analysis. My loose, non-dogmatic approach echoes some of the foundational principles of IR constructivism, as established by Onuf (1989) and Kratochwil (1989), who were heirs of a broader "linguistic turn"

[39] For a complementary discussion of positivist, post-positivist and anti-positivist stances within constructivism, see Balzacq and Baele (2014).

in philosophy but did not turn their backs completely on positivism (see Fierke, 2002, p. 333, 2013, p. 194).[40]

Wendt situated himself in a "via media" between rational/materialist positivists and constructivist/idealist post-positivists in IR (Wendt, 1999, pp. 39–40), but I join other scholars in arguing that post-positivism can be seen as the actual "via media" (see McEnery & Brookes, 2024, p. 9). Kratochwil (2000) elegantly outlined this epistemological orientation as follows: "hardly anyone . . . doubts that the 'world' exists 'independent' from our minds. The question is rather whether we can recognise it in a pure and direct fashion, i.e., without any 'description', or whether what we recognise is always already organised and formed by certain categorical and theoretical elements" (p. 91). I claim that acknowledging this, and paying attention to the performativity of research practices, is not revolutionary. Mainstream scholars in IR and European Studies who do not necessarily define themselves as post-positivist often do so too, albeit more implicitly. The following fragment by Hill (2007) on the dynamic relationship between expectations and capabilities is a case in point:

> I have argued elsewhere that expectations have a tendency to outrun capabilities, so that both insiders and outsiders have regular bouts of excessive optimism about what Europe is about to achieve, only to be brought down to earth – often excessively so, through the pendulum effect – by subsequent failure. In periods of Euro-disillusion it may be argued that the reverse happens, whereby attitudes become hyper-realist, with the action and potential of the EU not being fully appreciated. Negative expectations are less common than the usual optimism but *they too can lead to a capability gap, where power is not mobilized, or used too timidly*" (Hill, 2007, pp. 4–5, my emphasis).

As can be seen in the previous sub-section, the vast majority of research questions that I ask in this PhD thesis are not causal, but either constitutive or descriptive. "To what extent", "what" and "how" formulations abound, both among the overarching questions and among the more specific ones addressed in each of the three publications (see **Grid 1**). I do not believe this to be a limitation of my research: on the contrary, I strongly feel that there can be great scientific value in "non-causal explanation" and even description, so long as it goes beyond mere observation. As King et al. (1994) argue from their relatively orthodox epistemological stance, "good description is better than bad explanation" (p. 45, see also pp. 75, 179) and, in fact, "causal inference is impossible without good descriptive inference" (p. 75). Despite a scarcity of causal arguments,

[40] For a thorough historical account of constructivist thinking in IR, see Adler (2002).

therefore, this project is guided by conventional principles of scientific inquiry: striving to ask the right questions about relevant subjects, using deductive and inductive methods strategically, collecting empirical data rigorously and transparently, and pursuing some generalisations that can inform broader theoretical insights.

Methodology of the three publications

As discussed earlier, the links between ontology and epistemology are complex and often debated, but the notion that a given epistemology prescribes a given methodology is less controversial. Orthodox positivists tend to seek "objective" and "generalisable" findings through quantitative methods, whereas anti-positivists favour the knowledge that can be gained through ethnographic research, critical discourse analysis, open-ended interviews and other types of interpretive qualitative methods. From my largely post-positivist stance, I posit that carrying out research focused on contextualisation and understanding is not incompatible with striving for generalisation and objectivity, and thus lean towards a mixed-methods approach that combines quantitative and qualitative elements. Once again, I draw on King et al. (1994), who maintain that "most research does not fit clearly into one category or the other [quantitative or qualitative]. The best often combines features of each. In the same research project, some data may be collected that is amenable to statistical analysis, while other equally significant information is not" (p. 5).

A first illustration of my conviction that subjective or inter-subjective insights can be merged with objective measures is my reliance on a ***systematic literature review*** in Publication 1 of this PhD, from which I derived a critical analysis of the sources found and my suggested research agenda on EU actorness in global health. Through said method, I sought to increase the transparency of my review and make a more convincing case that there was indeed a research gap to be filled. To be sure, there is always a degree of subjectivity involved in designing a search string, choosing a search engine and evaluating the relevance and quality of the studies found. In fact, some of these perceptions are inter-subjectively constructed, reflecting widely established practices and shared understandings. That said, a systematic literature review seeks to at least provide a rigorous explanation of the entire operation and the rationale behind it, as well as some numerical figures (see, for example, Yerramilli et al., 2018). As a result of the peer-review process that Publication 1 underwent, I ended up scrapping a detailed explanation of its methodological approach, but I now go on to offer a summary of it here.

To identify studies on the EU's global health actorness, I conducted Google Scholar keyword-based searches through the Publish or Perish software, used to easily retrieve, organise and store

academic publications on a given subject. While Google Scholar is not a bibliometric database and presents several limitations and errors, it has much better coverage than Scopus and the Web of Science (Harzing & Alakangas, 2016), which minimised the risk of excluding relevant studies. To carry out the searches, I used the string "('EU' OR 'European Union') AND 'global health actor')". This search string yielded 175 results on October 4th, 2022. It was found to most successfully combine accuracy and comprehensiveness, as it could potentially capture not only publications using the term "actorness", but also the closely related "actor capacity" or "actor capability", inter alia. Because of their enduring appeal and versatility (see Drieskens, 2017), the term "actor" and its derivatives or compounds were favoured over others like "effectiveness", "performance", and "presence".[41] From the search outcome, I discarded non-English-language publications, as well as duplicated results and texts lacking analytical substance (e.g. book reviews, bibliographic compilations). The remaining studies were thoroughly inspected by looking at their titles, abstracts and – when necessary – main bodies of text. I found that only one book chapter (Guigner, 2012) and two journal articles (Battams et al., 2014; Rollet & Chang, 2013) contained a systematic assessment of EU actorness in global health. The three selected studies were subsequently dissected, in a section that also references, *inter alia*, the five most cited publications (out of the 175 found through the search string above) with the terms "Europe*" and "global health" in their titles.[42] These are the following, ordered by number of citations according to Google Scholar by October 4th, 2022: Aluttis et al. (2014), Steurs et al. (2018), van Schaik et al. (2020), Kickbusch and de Ruijter (2021), and Bergner (2023).[43]

Another method that this PhD project relies on is ***qualitative content analysis*.** To be more precise, this is not so much a method as it is a family of methods, which I used both in Publication 2 and Publication 3. Qualitative content analysis allows for "the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). The distinction between quantitative and qualitative content analysis is subtler than the basic contrast of numerical figures versus categories. While quantitative content analysis typically involves counting the frequencies of pre-defined codes in a mechanistic manner, it can also be built on categories constructed more qualitatively (Morgan, 1993, pp. 113–114). By the same token, qualitative content analysis can incorporate quantitative elements by utilising numerical data to support qualitative insights, as I will explain below. The key difference between these two approaches revolves instead around

[41] Studies dealing with EU "effectiveness" and "performance" in global health (Battams & van Schaik, 2016; van Schaik, 2009, 2011) overlap significantly in authorship and content with Battams et al. (2014).
[42] This does not reflect a perception that number of citations is an approximate measure of quality. However, inasmuch as this indicator does reflect scholarly impact, albeit imperfectly, I argue that these publications are particularly well-suited to depict the current state of the art on the matter.
[43] Bergner (2023) became available online on October 11th, 2021.

the importance placed on context and interpretation (Morgan, 1993, pp. 115–116). Quantitative content analysis prioritises an objective, dispassionate reading of the text – for example, by relying on methods like automated sentiment analysis, which uses a pre-established list of keywords to measure emotional tone or sentiment (see Fernández et al., 2023). By contrast, qualitative content analysis places a greater emphasis on understanding the meanings and nuances of the text. It involves a more interpretive approach, where the researcher actively engages with the text's content, in view of its context, to identify discursive traits that may not be immediately apparent through quantitative methods. Qualitative content analysis should not be confused with anti-positivist methods such as critical discourse analysis, which is more concerned with the context than with the text itself, seeking to uncover the ways in which discourse is used to construct and maintain social power dynamics (McEnery & Brookes, 2024, p. 12).

A conventional approach to qualitative content analysis is inductive in nature, allowing analytical categories to emerge from the text (Hsieh & Shannon, 2005, pp. 1279–1271). This approach, however, was ill-suited for my purposes. In the case of Publication 2, on the EU's engagement with regime complexity in global health, this is because it was part of an edited volume with an overarching theoretical framework informing each of the chapters. Therefore, our chapter is methodologically grounded on a ***directed content analysis*** (Hsieh & Shannon, 2005, pp. 1281–1283) that employs a series of pre-established analytical categories provided by the editors of the volume; namely, "Europeanists", "Atlanticists" and "nationalists" (see Costa et al., forthcoming). While this may be viewed as a deductive form of content analysis, it did not preclude a critical evaluation of these categories and a subsequent redefinition of them, so as to tailor them to our specific field of study through a more specific list of terms and ideas. We carried out this redefinition *a priori* and, to some extent, also inductively, after having examined and reflected upon the official documents under consideration. One potential limitation of directed content analysis is that it can lead researchers to approach their data with a strong bias (Hsieh & Shannon, 2005, p. 1983). By keeping an open mind about the pre-established categories and refining them in an iterative process involving the two co-authors, we sought to sidestep this issue and foster a more fluid dialogue between our theoretical framework and our assessed documents.

The final method I applied in this PhD – more specifically, in Publication 3, on the EU's securitisation of global health – is ***summative content analysis*** (Hsieh & Shannon, 2005, pp. 1283–1285). Central to this method is the identification and quantification of key terms in the texts analysed, which I conducted mostly in an automated way, by applying a series of referent dictionaries through the Linguistic Inquiry and Word Count (LIWC) software. This falls within the

scope of *manifest content analysis* (Potter & Levine-Donnerstein, 1999) and, in itself, it is a purely quantitative approach. What sets summative content analysis apart, and what justifies its classification as a qualitative method, is that the analysis does not stop there: rather, it also involves *latent content analysis* (Potter & Levine-Donnerstein, 1999), which means that the different codes are problematised and their frequencies are discussed in light of the linguistic and social context of the text. I did so, for example, by reflecting on the meaning of a positive or negative tone characterisation, as well as on the connotation of some terms included in the referent dictionaries. Additionally, I performed a granular analysis of State of the European Union (SOTEU) speeches that enabled me to pinpoint the health-related terms uttered within a security-related context. I also delved into the authors of the respective texts and their motivations for including certain security-oriented terms in them, thus blending a constructivist perspective with a more rationalistic one. By harnessing quantitative and qualitative techniques in an innovative and systematic manner, I aimed to address the prevalent and well-founded concern that methods are "the Achilles' heel of securitisation studies" (Baele & Sterck, 2015, p. 1122).

This dissertation thus blends diverse types of content analysis in what I believe is an original way, allowing different publications to complement one another. However, methodological innovation is best thought of as a by-product of this PhD thesis, rather than as a fundamental purpose. While method-oriented dissertations can certainly possess significant scholarly value, I chose to place methods in an auxiliary role and, following Wendt's dictum (1999, p. 40), let questions guide my research. The only partial caveat refers to Publication 3, where I initially proposed that the research question could best be addressed through semi-structured interviews with EU officials. Although I did interview a few and gained some relevant insights that ended up informing the article, I eventually abandoned the effort due to the insufficient responsiveness of the targeted officials and the time constraints imposed by the Special Issue in which the article is featured. Admittedly, this reduced the overall diversity of my methodology, but I do not think it compromised my ability to answer the research question nor the quality of the article. On the contrary, it prompted me to embrace a summative content analysis that yielded meaningful and informative results, arguably tackling the research question from a more pertinent angle. All in all, I believe that the methods employed accurately reflect my epistemological stance and are well-suited to addressing the research questions of the three PhD components. I now proceed to present these publications in their integrity.[44]

[44] In the public version of this thesis, Publication 2 has not been included due to a contractual right of the editorial to be the first to communicate and make the contribution available to the public in any form or format.

2 The European Union's global health actorness: A research agenda for a new age of pandemics (Publication 1)

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Abstract

Whilst the European Union's (EU's) response to health emergencies has historically been subpar, some suggest that it emerged from COVID-19 as a stronger global health actor. This prompts two interrelated questions: how have International Relations scholars conceptualised and assessed EU 'actorness' in the all-too-often neglected field of global health, and what adjustments are required in anticipation of a potential new age of pandemics? This article revisits the longstanding notion of 'actorness' and dissects the few studies that apply it systematically to analyse the EU's role in global health. After identifying some key shortcomings in the literature, the article formulates a research agenda suitable for the complex and high-stakes nature of contemporary global health endeavours. By further adapting the concept of 'actorness' to a multifaceted EU external action as well as to an increasingly intricate global governance architecture, this research agenda contributes to the broader scholarship on the EU's international outreach.

Keywords: actorness; European Union; external action; global health; pandemic

Introduction

COVID-19 provided further evidence that the European Union (EU) recurrently finds itself on the backfoot when facing health emergencies. Earlier crises – such as the 1990s Bovine Spongiform Encephalopathy (BSE), the 2009 H1N1 pandemic and the 2014–2015 Ebola virus outbreak – had already called into question the EU's preparedness and responsiveness. To various degrees, the agenda-setting impact of these and other shocks galvanised the EU's (global) health policy (Aluttis et al., 2014; Greer et al., 2022). Similarly, whilst EU institutions struggled to react to the

spread of the SARS-CoV-2 virus, co-ordination improved over time (Brooks et al., 2023), leading some scholars to argue that EU 'actorness' increased as a result of the pandemic (Anghel and Jones, 2022). This raises two interrelated questions: (1) how has the literature conceptualised and assessed EU actorness in global health, and (2) what adjustments would a post-COVID-19 research agenda require?

For over 50 years, the concept of 'actorness' has shed light on the EU's role in the world, allowing for comparability across policies and with other entities. Nevertheless, it has seldom been applied to global health. The few systematic analyses of the EU's actorness in this realm, whilst insightful and valuable, date back to about a decade ago and present several limitations. Firstly, they overlook the EU's influence beyond multilateral action. Secondly, they focus on ties with the World Health Organization (WHO), neglecting other global health actors. Thirdly, they conceptualise and operationalise 'actorness' on an ad hoc and sometimes inconsistent basis, which can lead to unclear and contradictory conclusions, not just across studies but even within them. These trends are not exceptional but, in fact, reveal pervasive shortcomings in the broader literature on (EU) actorness.

Whilst resolving longstanding theoretical and methodological discrepancies would be an overly ambitious goal, it is possible to lay out some parameters for a research agenda on the EU's global health actorness that is fit for a post-COVID-19 world. There is growing recognition that global health now constitutes an integral component of the EU's external action – a development that the emerging 'European Health Union' (European Commission, 2020) and the new EU Global Health Strategy (European Commission, 2022) aim to consolidate. For 'actorness' to preserve its analytical teeth, it needs to adapt to the polyhedric nature of today's global governance and EU external action, which makes global health an ideal testing ground. Moreover, in a context marked by frequent and multifaceted health-related disruptions, which may well usher in an 'age of pandemics' (European Commission, 2022, p. 14), whether the literature considers the EU as a global health actor is highly significant. After all, 'the term actor is used as a synonym for the units that constitute political systems on the largest scale [and] the attribution of actorness in this sense will determine what is studied' (Bretherton and Vogler, 1999, p. 18), amongst other eventual performative effects (Larsen, 2020).

This article is structured as follows: in the next section, we situate the EU's role in global health by considering legal competences, praxis and external context. Section II looks back at the prolific history of 'actorness' and reviews those studies that have applied the notion systematically to the EU's global health policy. Section III proposes a new research agenda that seeks to transcend

existing limitations through six key principles, also pertinent to broader actorness literature. The final section offers some concluding remarks.

I. Setting the Scene

The COVID-19 pandemic brought health to the forefront of international relations. To be sure, collaborative approaches have always been necessary to address less conspicuous – but often highly impactful – global health challenges, with past transnational efforts varying in intensity and success. Yet, COVID-19 was a harbinger of a new era: one in which ever-more-critical threat multipliers – such as mass urbanisation, habitat conversion and climate change – accentuate the imperative of global co-operation, urging policy-makers and International Relations scholars alike to devote further attention to health matters. Whilst this mindset shift has been unfolding for years (Fidler, 2010, pp. 5–6), it now demands consolidation.

Before COVID-19, 'global health' was already a popular buzz phrase and field of study. Consensus on its precise meaning, however, has been elusive. Kickbusch and Lister (2006) provided an oft-quoted definition: 'those health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people' (p. 7). A seminal European Commission (2010) Communication on 'the EU role in global health' suggested, from a more normative standpoint, that global health 'is about worldwide improvement of health, reduction of disparities, and protection against global health threats' (p. 2).

In the recent 2022 Global Health Strategy, which updated the 2010 Communication, the Commission declared global health an 'essential pillar of EU external policy' (European Commission, 2022, p. 4). Yet, previous attempts at prioritising health within the EU's agenda yielded mixed results, owing to Member State reluctance and EU institutions' modest supporting role in the 'protection and improvement of human health'.[1] The EU possesses shared competence in addressing 'common safety concerns in public health matters',[2] but binding legislation is only foreseen in a scarce number of areas.[3] Meanwhile, broader 'incentive measures'[4] in support of public health have grappled with budgetary constraints (Greer et al., 2022, p. 78). Past health crises did lead to noteworthy institutional developments, such as the establishment of the European Commission Directorate-General for Health and Consumers in 1999,[5] the European

[1] Article 6, subparagraph (a), of the Treaty on the Functioning of the European Union (TFEU).
[2] Article 4, paragraph 2(k), TFEU.
[3] Article 168, paragraph 4, TFEU.
[4] Article 168, paragraph 5, TFEU.
[5] DG SANCO, the predecessor of the current DG for Health and Food Safety (DG SANTE).

Food Safety Authority in 2002 and the European Centre for Disease Prevention and Control in 2004. However, these and other health-related institutions received relatively narrow mandates and have struggled to gain political and financial weight, much like the treaty-enshrined aspiration to 'health mainstreaming'[6] has struggled to gain real traction (Godziewski, 2022).

EU policies, nevertheless, are far more consequential for global health than is typically appreciated. This becomes clear when accounting for socio-political determinants of health, along with the EU's ability to externalise its norms by virtue of its significant market size (Greer et al., 2022, p. 235). Often, it does so involuntarily, through the so-called 'Brussels effect' (Bradford, 2020). This can be perceived in matters directly or indirectly concerning global health, such as safety standards, environmental issues and data regulation (Bradford, 2020). In line with neofunctionalist predictions, the EU's own health-related integration has been a spill-over effect of the internal market, fiscal governance and other policy realms (Brooks et al., 2023; Greer et al., 2022). The EU's growing awareness of these spill-overs is reflected in its horizontal quest for 'Health in All Policies' (European Commission, 2022). Since its first formulation in 2006, this normative ambition remains frequently cited but largely unfulfilled, as health is always impacted by, but seldom prioritised over, other policy realms (Godziewski, 2022; Rekhis, 2024).

Following this broader conceptualisation of (global) health, its governance architecture can be seen to encompass multiple entities whose primary purpose lies elsewhere, such as the World Bank and the World Trade Organization (WTO). Furthermore, global health governance has moved past a state-centric intergovernmental model due to a proliferation of non-state actors (e.g., the Bill & Melinda Gates Foundation) and *multistakeholder* initiatives (e.g., the Gavi Vaccine Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria). In short, despite its considerable regulatory and co-ordinative powers, the 'WHO [World Health Organization] no longer stands alone in global health governance, nor arguably at its center' (Clinton and Sridhar, 2017, p. 4).

Whereas some studies and taxonomies of contemporary global health actors ignore or belittle the EU (see Hoffman and Cole, 2018), others do refer to it as an 'actor', yet often leaving this term undefined (see Greer et al., 2022, p. 223). On the one hand, the EU is a mere informal observer at the WHO[7]; on the other, it has played a prominent part in WHO-sponsored negotiations (Gehring et al., 2013, p. 858) and is consistently present in all the 'political spaces' that govern global health (Kickbusch and Szabo, 2014, p. 1). 'Presence', defined as the EU's ability 'to exert influence beyond

[6] Article 9, TFEU, and Article 168, paragraph 1, TFEU.
[7] The European Commission (2022) now intends to formalise this status 'as a first step towards full WHO membership' (p. 21).

its borders' (Bretherton and Vogler, 2006, p. 22), 'denotes latent actorness' (p. 211), at the very least. Not only does the EU project its influence in the aforementioned multilateral or *multistakeholder* settings, but also bilaterally or even unilaterally.

The EU's influence may lead to beneficial but also pernicious external outcomes – a reality that is not lost on scholars of the EU's actorness or presence (Allen and Smith, 1990; Ginsberg, 2001) nor on studies of the EU's regulatory, market or normative power (Bradford, 2020; Damro, 2012; Manners, 2002). By contrast, the few available definitions of 'global health actor' usually possess a more positive connotation. According to Hoffman and Cole (2018), a global health actor is 'an individual or organization that operates transnationally *with a primary intent to improve health*' (p. 4, our emphasis). This narrow definition relies on highly subjective yardsticks and obscures the increasingly kaleidoscopic character of the global health architecture.[8] In this article, we will examine how the literature on the EU as a global health actor has dealt with this mismatch.

II. The EU's Actorness: Past Perspectives

Since its birth over five decades ago (Cosgrove and Twitchett, 1970), and especially since Sjöstedt's (1977) landmark contribution to the field,[9] the enduring concept of 'actorness' has been closely – if not quite exclusively – linked to the European Economic Community and later the EU. The notion was born out of a need to account for the 'new international actors' that were gaining influence in the global scene, more specifically, the United Nations, the EU and, to a lesser extent, other regional organisations (Cosgrove and Twitchett, 1970, p. 12). Whilst these are all intergovernmental organisations built by nation-states, they constitute more than the sum of their parts. Through the lens of 'actorness', a wealth of literature has explored the extent to which the international footprint of the EU, in particular, proves this to be true.

Many actorness scholars have broken 'actorness' down into measurable criteria (see Rhinard and Sjöstedt, 2019, p. 8). Some have devised analytical frameworks that apply beyond the EU, whilst others have embraced a more targeted approach aligned with parallel strands of literature on the EU's *sui generis* character (Manners, 2002). The concept of 'actorness' gained vigour in the 1990s and 2000s, largely thanks to the contributions of Jupille and Caporaso (1998) and Bretherton and Vogler (1999, 2006). The former conceptualised actorness as depending on four criteria: 'authority' (legal competence), 'recognition' (by other actors), 'autonomy' (institutional

[8] Fidler's (2010, p. 10) more comprehensive and non-normative taxonomy does include the EU and even tobacco companies.
[9] Sjöstedt (1977) did not actually use the term 'actorness' but notoriously defined actor capability as 'the capacity to behave actively and deliberately in relation to other actors in the international system' (p. 16).

distinctiveness and independence) and 'cohesion' (in terms of values/goals, tactics, procedures and outputs). From a more constructivist perspective, Bretherton and Vogler (2006) focused instead on the EU's 'presence' (in the sense of Allen and Smith, 1990), 'opportunity' (the material and ideational international environment) and 'actor capability' or 'actorness' – i.e., 'the ability to exploit opportunity and capitalize on presence' (p. 2).

Whilst disagreements about operationalisation have been pervasive, the track record of 'actorness' in generating empirical research is remarkable. Its long-lasting appeal may reside in its flexibility and versatility, whose downside is a lack of terminological clarity (Drieskens, 2017, p. 1537). That said, the term 'actor' is at least more easily definable than similar ones, such as 'player'. Hill (2007) argued as much, conceptualising actorness as 'the capacity to act and to influence others without necessarily requiring the attributes of statehood' (p. 4). More recently, the notion of 'actorness' has coexisted with others like 'performance' (Kissack, 2011; Rhinard and Sjöstedt, 2019) and 'effectiveness' (Groen and Niemann, 2013; Niemann and Bretherton, 2013; Thomas, 2012), although these also present some conceptual difficulties, and the former has not ceased to attract academic interest.

Historically, actorness scholarship has focused on hard security and defence, neglecting other areas of external action (Bretherton and Vogler, 2006, p. 11). This trend has been partially corrected over time (Drieskens, 2017, p. 1538): for instance, environmental and climate policies have received growing attention from 'actorness' scholars (Delreux, 2014), as has neighbourhood policy (Börzel and Van Hüllen, 2014), inter alia. 'Actorness' has also articulated multiple analyses of the EU's engagement with other international institutions (Gehring et al., 2013; Groen and Niemann, 2013; Kissack, 2008). The notion thus holds vast potential for comparison between EU policy areas as well as between the EU and other entities. However, this potential remains somewhat unrealised, as the concept has become a victim of its own success. Many scholars have used it rather loosely to frame their research on the EU without paying sufficient attention to external dynamics, analytical precision and generalisability (Rhinard and Sjöstedt, 2019, pp. 9–10). As Drieskens (2017) argues, this calls for 'rethink[ing] rather than abandon[ing]' (p. 1543) the study of actorness by approaching it from a more context-aware and systematic standpoint.

EU Actorness Meets Global Health

The scarce literature on EU actorness in global health illustrates the broad patterns delineated above, calling for similar remedies. In our effort to determine whether this was indeed the case, we set out to identify systematic assessments of EU actorness in global health rooted in a given

analytical framework and criteria-based methodology. Tellingly, we found that only one book chapter (Guigner, 2012) and two journal articles (Battams et al., 2014; Rollet and Chang, 2013) fulfilled this condition. The three selected studies will be dissected below, in connection with other publications that also analyse the EU's role as a global health actor, albeit not from an 'actorness' perspective.

Concerning their ontological approaches, the three systematic assessments of EU global health actorness insightfully acknowledge the complexity of today's global health architecture, but this is not reflected in their case-study selection or other methodological choices. The bulk of their attention is devoted to the EU's multilateral action, mainly through the WHO,[10] with the EU's bilateral action (e.g., the health impact of dyadic ties with specific countries) receiving much less scrutiny. All the studies recognise the global health implications of other policy areas and the EU's promotion of its own norms and preferences in multilateral settings and agreements (see also Bergner, 2023, p. 6; Kickbusch and de Ruijter, 2021, p. 1). Nevertheless, they fall short of mentioning any instance of unilateral norm externalisation as a by-product of the EU's market size (see Bradford, 2020).

An additional ontological question is whether global health actorness presupposes a positive intent (Hoffman and Cole, 2018, p. 4; see also Aluttis et al., 2014, p. 4; Steurs et al., 2017, p. 436). Two of the selected studies take a stance in principle, with both of them subscribing to Kickbusch and Lister's (2006) rather agnostic definition of global health (Guigner, 2012, pp. 7–8; Rollet and Chang, 2013, p. 310). Guigner's (2012) final message is that 'the EU plays a main role on the global health stage, *but whether as antagonist or protagonist remains an open question*' (p. 108, our emphasis). Yet, the rest of the chapter appears to paint adverse forms of external influence as corrosive of said actorness. Similar contradictions are present in Rollet and Chang's (2013) article, which claims that appraising the EU's influence in global health begs 'the question of what an action to *improve* global health is' (p. 313, our emphasis).

Moving on to their analytical frameworks and broader research design, all the selected studies probe EU actorness in global health by borrowing from the classics. For Guigner (2012) and Battams et al. (2014), the departure point is Jupille and Caporaso (1998), whereas Rollet and Chang (2013) draw instead on Bretherton and Vogler (2006). None of the three studies, however, apply these classic analytical frameworks in their full integrity. The demarcation between concepts is not always clear, and the selected assessment criteria are often presented in a convoluted way. In terms of substance, external perceptions of the EU are assessed in a

[10] Steurs et al. (2017) similarly found that 'studies on the EU's role in global health are mostly confined to the European Commission's policy and the EU's representation in the World Health Organization' (p. 435).

particularly tenuous manner. For instance, Guigner (2012) and Battams et al. (2014) evaluate the EU's external recognition on the sole basis of its relations with the WHO. Generally, legal frameworks, official documents, public statements and policy instruments receive considerable attention, whereas the study by Battams et al. (2014) is the only one partly based on some interviews with public officials. Comparisons with other global health actors or with other policy areas are either absent or rather cursory.

The apparent consensus across the three publications is that the EU is a burgeoning global health actor, but not a fully fledged one.[11] However, their overall verdicts often lack consistency and precision. Guigner (2012) claims that 'despite all [its] apparent activity, the EU is at times simply a "decorative element"' (p. 108), adding that it 'nevertheless fulfils actorness criteria' and 'plays a main role on the global health stage' (p. 108). Battams et al. (2014) reach an ambiguous conclusion too, merely noting that 'the EU has developed a more prominent role in global health' (p. 560). Rollet and Chang (2013) deliver the clearest – but still slightly conflicted – judgment: whilst affirming that 'the EU *is* a global health actor' (p. 328, emphasis in original), they label it as an 'actor still in construction' (p. 328; see also Bretherton and Vogler, 2006, p. 22).

As for the main elements obstructing the EU's global health actorness, the three studies point chiefly at cohesion challenges (see also Bergner, 2023; Steurs et al., 2017; van Schaik et al., 2020). Unlike Guigner (2012), Rollet and Chang (2013) admit that speaking with a single voice can at times be 'disadvantageous' to the EU's influence (pp. 326–327), but they still paint a negative picture of the EU's lapses in this regard. For their part, Battams et al. (2014) stress that the EU is also constrained by a more competitive external environment. On the importance of speaking with a single voice, they too send somewhat mixed messages. Not doing so is sometimes portrayed as a significant problem, but the authors also see joint positions as potentially based on the 'lowest common denominator' (Battams et al., 2014, p. 559; see also Chamorro, 2016, p. 257).

III. A Post-COVID-19 Research Agenda

After years of relative neglect (van Schaik et al., 2020, pp. 1148–1149), COVID-19 rekindled policy-makers' and scholars' interest in the EU's role in global health. However, the few post-COVID-19 analyses of EU 'actorness' with a health focus (Anghel and Jones, 2022; Vandendriessche et al., 2023) do not conduct a systematic criteria-based assessment and, in the case of the former, explore internal developments only. Revisiting earlier attempts to

[11] After COVID-19, lukewarm assessments prevail (Bergner, 2023, pp. 6, 9; Kickbusch and de Ruijter, 2021).

systematically assess EU *global* health actorness would enrich this emerging wave of literature whilst contributing to 'put[ting] the house of EU actorness in order' (Drieskens, 2017, p. 1542) and furthering its thematic diversification. A potential added value of this new research agenda is to prevent global health from drifting back into a peripheral policy status (see Bergner, 2023, p. 8; Vandendriessche et al., 2023, p. 33), which in the EU is particularly important nowadays, with a new European Commission set to take office in 2024.

Our proposed research agenda rests on six principles, which seek to overcome some blind spots and clichés present in previous literature. The recommendations concern ontological approaches, analytical frameworks, research designs and general narratives. *Mutatis mutandis*, they all apply to a broader scholarship on EU actorness.

1. Engage with the full scope of the global health architecture

As Kickbusch and de Ruijter (2021) alert, 'in wanting to shape a strong EU role in global health it would be too narrow to only look at those activities labelled "health"' (p. 1). In the same vein, a recognition of all 'political spaces' (Kickbusch and Szabo, 2014, p. 1) governing global health is essential. For instance, the EU's interaction with the World Bank's health portfolio – which rivals that of the WHO itself (Clinton and Sridhar, 2017) – features too sparsely in our selected studies (Rollet and Chang, 2013, pp. 321, 324). More generally, 'what has been lacking is a systematic effort to capture the Union's engagement with the less than "conventional" state actors in the realm of international affairs', including 'transnational policy networks' in global health (Kingah et al., 2015, p. 232).[12] This limits our understanding of the extent to which the EU has fostered and benefitted from widespread power diffusion in global governance (Kissack, 2023).[13] Contrary to the EU's shaky legal standing at the WHO, the European Commission is part of voting constituencies at the boards of Gavi and the Global Fund. To be sure, formal membership is not a prerequisite for actorness (Gehring et al., 2013), but its potential auxiliary effect is worth investigating.

2. Look beyond multilateral or *multistakeholder* action

By focusing chiefly on the EU's interaction with the WHO, the selected studies implicitly reinforce the common assumption that the EU embraces multilateralist external action almost by default.

[12] An article by Rollet and Amaya (2015) on EU–Global Fund interactions is a notable outlier.
[13] Battams et al. (2014, pp. 548, 556, 560–561) touch upon this matter, albeit inconclusively (see also Rollet and Amaya, 2015; van Schaik et al., 2020).

This assumption is not always borne out by the facts (Costa, 2013; van Schaik et al., 2020). Nowadays, the EU pursues alternatives to multilateralism (or *multistakeholderism*) more openly and frequently and leverages its economic might more strategically – a pragmatic turn accelerated by Russia's full-scale invasion of Ukraine. In the context of COVID-19, many EU Member States bypassed the *multistakeholder* COVAX Facility and privileged bilateral vaccine donations instead (van Schaik et al., 2020). Furthermore, the EU has displayed a unilateral global health policy not just through involuntary norm externalisation (Bradford, 2020; Perehudoff et al., 2021; Ruiz Cairó, 2021) but in wilful defence of its values and interests. One such instance came in 1999, when the EU refused to comply with a ruling by the WTO Appellate Body establishing the illegality of its ban on imports of hormone-treated beef (Bradford, 2020, pp. 175–176).

3. Strip global health actorness from any normative overtones

Theoretically, 'actorness' is not concerned with ethical considerations. The EU could be regarded as a global health actor irrespective of whether it is a 'force for good', or where its main motivations lie (see Fidler, 2010, p. 7). It is sometimes difficult to ascertain whether the behaviour of a given entity reflects 'a primary intent to improve health' (Hoffman and Cole, 2018, p. 4). For example, the EU was accused of neglecting global health by opposing a comprehensive waiver of intellectual property rights for COVID-19 vaccines (Bergner, 2023). However, there is no perfect trade-off between global health and economic interests, and some indisputable global health actors also objected to a full-blown waiver (Gates, 2022, pp. 163–164). The eventual WTO compromise aligned closely with the EU's position (Furlong et al., 2022), which is precisely what should draw the attention of actorness scholars, with a normative reading of these implications warranting a separate exercise. In short, definitions of 'global health actor' must be kept as normatively agnostic as possible – e.g., following Kickbusch and Lister (2006, p. 7) – if they are to account for both benign and malign impacts, in line with broader actorness literature.

4. Ensure methodological rigour and richness, with an eye on building scholarly bridges

The concept of 'actorness' is notoriously difficult to operationalise. Attempts to devise and apply assessment criteria have resulted in inconsistencies and overlaps, whilst leaving out important dimensions of EU influence (Drieskens, 2017, pp. 1538–1539). What constitutes an actor may be definable (Hill, 2007, p. 4), but a universal definition will always be elusive. The relationship between actorness and effectiveness is similarly murky: some classical works treat them in

conjunction (Bretherton and Vogler, 1999; Cosgrove and Twitchett, 1970), but more recent scholarship tends to address them separately (Carbone, 2013; Niemann and Bretherton, 2013; Thomas, 2012). Conceptual clarity is key to avoiding misinterpretations, as is aligning ontological considerations with methodological choices. This article's holistic understanding of global health prescribes a set of assessment criteria that is more concerned with contextual factors (e.g., Bretherton and Vogler, 1999, 2006) than with formal prerogatives or mechanisms. The selected criteria should be applicable to other policy areas, thus enabling comparability and further interactions amongst scholars of EU external action (Smith, 2010, p. 329). Despite the EU's *sui generis* character, comparisons with other regional international organisations like the Association of South-East Asian Nations (ASEAN) (see Lamy and Hong, 2012) or with other multi-level governance arrangements (e.g., in federal states) are also possible and indeed desirable. Finally, knowledge accumulation requires a richer empirical analysis (e.g., more interview based) that heeds outside perceptions of the EU – 'a rather underexplored topic in global health studies' (Bergner, 2023, p. 6; see also Ginsberg, 2001, p. 5; Smith, 2010, p. 343).

5. Refrain from treating the state as a unitary actor and using this ideal type to assess EU actorness

EU 'actorness' has often been shorthand for 'resemblance to states', which has already proven controversial (see Bretherton and Vogler, 1999, 2006; Drieskens, 2017; Manners, 2002). An even more problematic practice is to subtly employ some non-essential state attributes – viz., a monolithic international profile – as analytical yardsticks. Federal and/or heavily decentralised states may also struggle in the face of any test presupposing a direct correlation between unity and actorness/effectiveness. Even when effectiveness is removed from the equation, the relationship between coherence (e.g., through EU supranationalism) and actorness is not necessarily direct (Drieskens, 2017, p. 1540). Although plenty of evidence questions the importance of speaking with a single voice (Delreux, 2014; Smith, 2006; Thomas, 2012), the 'one voice mantra' (Macaj and Nicolaïdis, 2014, p. 1067) continues to permeate academic works and official documents, such as the new EU Global Health Strategy (European Commission, 2022, pp. 20, 29). The 'Team Europe' approach to combatting COVID-19 in third countries (European Commission, 2022, pp. 4–5) does see value in conveying 'a single voice though multiple mouths' (Delreux, 2014, p. 1022), but even uncoordinated actions can succeed as long as they preserve a minimum degree of harmony (Niemann and Bretherton, 2013, pp. 267–268). For instance, Member State flexibility in aid provision can enhance recipient ownership and overall effectiveness (Carbone, 2013). Two of our selected studies (Battams et al., 2014; Rollet and

Chang, 2013) acknowledge these nuances but appear reluctant to abandon the idea that intra-EU co-ordination is necessarily positive.

6. Be mindful of an inverted 'capability–expectations gap'

Bradford (2020) rightly objects to the 'nearly constant public commentary about the European Union's demise or global irrelevance that permeates modern public discourse' (p. ix; see also Drieskens, 2017, p. 1540; Niemann and Bretherton, 2013, p. 267). In light of this widespread narrative, Hill's (1993) famous diagnosis that EU foreign policy suffered from a 'capability–expectations gap' – with the latter exceeding the former – calls for an updated opinion. Yet, the notion has been uncritically reproduced in a vast amount of literature on EU external action (Larsen, 2020, p. 967), including global health (see Rollet and Chang, 2013, p. 310). Few scholars note Hill's (1993) own admission that the concept is overly 'static' (p. 322), nor his subsequent warning that 'negative expectations are less common than the usual optimism but they too can lead to a capability gap, where power is not mobilised, or used too timidly' (Hill, 2007, p. 5). To be sure, it may occasionally be useful for the EU to fly under the radar, especially as EU institutions seem increasingly aware of the levers they can pull (Bradford, 2020, p. 21). But low expectations can have detrimental performative effects, obstructing a thorough and balanced evaluation of the EU's actions (Larsen, 2020, p. 973) and leading to a suboptimal division of labour across the EU system.

IV. Conclusion

Against the COVID-19 backdrop, the EU has arguably experienced a 'global health awakening' (van Schaik et al., 2020). However, whether the EU constitutes a global health actor – and, if so, since when and in what sense – is far from settled. Answers to this question can offer a glimpse into prevailing ontological assumptions and shape future scholarly and policy choices (Bretherton and Vogler, 1999; Larsen, 2020), with enormous potential repercussions in a new 'age of pandemics'.

To probe the current state of the art, this article has relied primarily on the well-established concept of 'actorness', showing that very few scholars have used it to systematically assess the EU's activities in global health. The relatively outdated and isolated nature of their respective studies denotes that global health has not been a historical priority of EU scholars or policy-makers. The selected publications, moreover, present some limitations in terms of their ontological approaches, analytical frameworks, research designs and overall narratives.

Post-COVID-19 scholarly momentum can and should inspire a revamped research agenda on the EU's global health actorness. This would require engaging with the full scope of contemporary global health governance, paying more attention to bilateral and unilateral EU action and stripping global health 'actorness' from any normative connotation. It is also crucial to ensure methodological rigour and richness and to dispense with an idealised 'unitary state' as an analytical yardstick. Finally, we caution against the tendency to downplay the EU's ability to shape world affairs, be it for better or for worse. The principles underpinning this research agenda are broadly applicable to all studies on EU actorness, with one ultimate goal: further adapting the concept to today's multifaceted EU external action as well as to an increasingly dense and diverse global governance architecture.

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3 The European Union's role in global health: Embracing governance complexity? (Publication 2)

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Note

In the public version of this PhD thesis, Publication 2 is not included due to a contractual right of the editorial to be the first to communicate and make the contribution available to the public in any form or format.

4 The European Union's securitisation of global health: Was COVID-19 a *Zeitenwende*? (Publication 3)

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Abstract

Almost 30 years since the Maastricht Treaty provided an explicit legal basis in the health realm, the European Union (EU) declared global health an "essential pillar" of its external action. Yet, it is still seeking to "come of age" as a global health actor. This might be facilitated by the securitisation of health, which was evident during the COVID-19 crisis, often framed as a war against a common enemy. However, the literature is yet to establish whether these analogies were systematically embraced by EU institutions, signalling a *Zeitenwende* – or "epochal tectonic shift" – in the EU's health-related discourse. Through an analysis of key strategic documents and public statements, this article determines the extent to which COVID-19 drove the attempted securitisation of global health in the EU. Relatedly, it discusses whether this framing might be conducive to an enhanced EU actorness on the world stage. The article concludes that, after COVID-19 struck, some EU institutions did intensify their "health security" rhetoric in pursuit of an expanded, more "mature" role. While this shift was neither widespread nor enduring enough to be characterised as "epochal", it does denote the EU's turn towards a less altruistic conception of its global health action.

Keywords: European Union; global health; securitisation; health security; COVID-19; actorness

1. Introduction

> The plague originated, so they say, in Ethiopia in upper Egypt … In the city of Athens it appeared suddenly, and the first cases were among the population of Piraeus, where there were no wells at that time, so that it was supposed by them

> that the Peloponnesians had poisoned the reservoirs. … The second outbreak lasted for no less than a year, and the first outbreak had lasted for two years. Nothing did the Athenians so much harm as this or so reduced their strength for war. (Thucydides 1972, pp. 152, 246)

> Before modern medicine, one of the worst imaginable skin diseases was syphilis. … In Russia it was called the Polish disease. In Poland it was the German disease; in Germany, the French disease; and in France, the Italian disease. The Italians blamed back, calling it the French disease. (Rosling et al. 2018, p. 216)

More so than any other recent health crisis, the COVID-19 pandemic was framed as an individual and collective "war" (United Nations 2020, The Covid Crisis Group 2023, see also Varma 2020, Baele and Rousseau 2023). Yet, the construction of (global) health issues as security issues – i.e. their *securitisation* – is hardly a new phenomenon. This is reflected in the Constitution of the World Health Organization (WHO), which proclaims that "the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States" (World Health Organization 1948, p. 1). More typically, however, diseases have been portrayed as threats to *national* security, interpreted in a narrower, "realist" sense (Pattani 2015, p. 167).[1] This is particularly true in the case of infectious conditions thought to have emerged in foreign lands, as the two quotes above illustrate. To be sure, history lends some credence to these concerns: disease outbreaks have brought economies to a halt, shaped military conflicts and even been deliberately weaponised. However, the discursive construction of maladies as "enemies" of the nation carries some problematic political and societal implications (Bayramoğlu 2021, p. 1592, White 2023). As former European Union (EU) High Representative Javier Solana put it in the early days of COVID-19, "if what we are going through can indeed be called a war, it is certainly not a typical one … . The war rhetoric could cloud our judgment, leaving us vulnerable to certain traps" (Solana 2020).

This article contributes to the overall Special Issue on the "maturation" of the EU's external action – broadly understood – through a "securisation" lens, applied to an internal policy with modest levels of integration yet important outward ramifications, i.e. health (see also Drieskens *et al.* 2024, Rieker and Riddervold 2024). The EU's securitisation of global health has already sparked some academic inquiry, both before the COVID19 pandemic (Brattberg and Rhinard 2011,

[1] Security threats have also been conceptualised as health threats (Rosling *et al.* 2018, pp. 114, 239) and the rhetoric of international relations is filled with health-inspired metaphors, e.g. the notion of "state survival" or usual references to the "virus" of terrorism and extremism.

Kittelsen 2013, Reiners 2015, Dijkstra and de Ruijter 2017, Steurs *et al.* 2018, Bengtsson and Rhinard 2019) and after (Bergner 2023, Godziewski and Rushton 2024). Said studies have contributed to and drawn from the broader, fast-expanding scholarship on the symbiotic ties between health and security. While this now constitutes an established field, "International Relations scholars were surprisingly late in coming to recognize the global politics of disease" (Rushton 2019, p. 5). The required ontological expansion only occurred after the fall of the Berlin Wall and subsequent redefinitions of the global security agenda (Davies 2010, p. 1170). As described by the Copenhagen School, conventional, military-based views of national security gave way to more holistic understandings (Buzan *et al.* 1998).[2] These ended up encompassing health-related challenges in the form of specific diseases, as well as novel issues with a direct or indirect health impact, such as bioterrorism and climate change. State-centrism was contested not only by accounting for threats emerging from non-state actors, but through the advocacy of individual-centred normative approaches like "human security", where health also featured prominently (Davies 2010, pp. 1170–1171, Rushton 2019, pp. 165–170). In addition, a new wave of globalisation marked by enhanced movement of people and deeper economic interconnectedness resulted in a more rapid spread of diseases. Cascading shocks such as the 1990s BSE outbreak, the 2002–2004 SARS epidemic and, most recently, the COVID-19 pandemic brought "health security" into the focus of national governments, international organisations (such as the EU) and other governance actors, with academic interest ensuing.

While health has become a centrepiece of securitisation studies (Balzacq *et al.* 2016, p. 507), no scholarly consensus has been reached on two key questions. The first concerns the extent to which health has been successfully securitised and, as a result, promoted into a "high politics" area. Some authors claim that this shift has materialised across the board (Fidler 2005, Kickbusch and Reddy 2015), even if not irrevocably (Fidler 2011). Others counter that the *referent subjects*[3] of securitisation have only been concrete diseases and that health is generally still regarded as "low politics" – or, at least, that was the case before COVID-19 (Youde 2016). A second point of contention revolves around the desirability of health securitisation (Rushton and Youde 2015). On the one hand, as argued by Peter Piot, special adviser to European Commission President Ursula von der Leyen on health security, securitising health issues can raise public awareness and salience, thus contributing to resource mobilisation (Piot 2000, p. 2177). This strategy may also infuse new relevance to the WHO (Hanrieder and Kreuder-Sonnen 2014, Kickbusch and Reddy 2015, p. 841) and help developing countries to legally circumvent the intellectual protection

[2] Although Buzan *et al.* (1998) did not mention health among the main sectors that had become securitised, it "meets the necessary criteria" (McInnes 2004, p. 50).
[3] "The entity that is threatening" (Balzacq *et al.* 2016, p. 495).

rights attached to medical countermeasures (Elbe 2006, p. 113). On the other hand, securitisation can work against the WHO's plea for coordinated global action, e.g. through counter-productive border closures (Pattani 2015, Rushton 2019, pp. 37–46). It may also attract outsized yet fleeting attention to infectious diseases affecting (or potentially affecting) developed countries, thus deprioritising a horizontal, long-term approach (Davies 2010, Youde 2016, Dijkstra and de Ruijter 2017, Steurs *et al.* 2018, Rushton 2019, Bergner 2023). Furthermore, the security frame may prompt excessive state interventions that constrain civil liberties and public debate (Davies and Youde 2016, Rushton 2019, pp. 115–122), as well as turn health into a means to achieve military goals (Youde 2016, p. 162, Varma 2020, p. 377). Health securitisation also risks exacerbating inequalities: elites and military personnel may obtain privileged access to healthcare (Elbe 2006, pp. 129–130), while specific groups and individuals may become further stigmatised or marginalised (Sontag 1998, Varma 2020, p. 377), with women being disproportionally affected (Wenham 2021).

As an emerging global health actor, the EU has become a suitable space to explore some of these controversies. The 1993 Maastricht Treaty did not just create the Common Foreign and Security Policy (CFSP), as widely noted throughout this Special Issue, but also provided the first explicit legal basis for the EU in the health realm. Since then, disease outbreaks (usually triggering *securitising moves*[4]) and spill-over effects from other policy areas have led to its formal and informal expansion.[5] In other words, the EU "matured" as a health actor mainly through the "growth" and "learning" pathways, which refer to institutional changes and contextual adaptation, as described in the introduction to this Special Issue (Maurer *et al.* 2024). That said, before COVID19, the EU still viewed health as "really low politics", to borrow Fidler's (2005, p. 180) terminology. Faced with a deadly pandemic, supranational or quasi-supranational policy entrepreneurs – namely, the European Commission and the European External Action Service (EEAS) – may have been particularly tempted to play the "securitization card" (Elbe 2011) in pursuit of an expanded role (Godziewski and Rushton 2024). That is because securitisation is commonly thought to reduce politicisation and, therefore, to remove obstacles to integration (Buzan *et al.* 1998, Andrione-Moylan *et al.* 2024). A security frame might also help consolidate global health as "an essential pillar of EU external policy" (European Commission 2022a, p. 4, see also Drieskens *et al.* 2024). This sort of maturation would align more closely with the

[4] "A discourse that takes the form of presenting something as an existential threat" (Buzan *et al.* 1998, p. 25).

[5] Legally speaking, EU institutions are generally circumscribed to a supporting role in the "protection and improvement of human health" (Article 6(a) of the Treaty on the Functioning of the European Union (TFEU)). Article 168 TFEU underpins most of the EU's (global) health action. However, much of this action actually takes place outside the confines of this article, via trade- or environment-related provisions (Greer *et al*. 2022, Brooks *et al.* 2023, Fernández, Forthcoming).

"development" and "trait development" pathways, as it would be behavioural and cognitive in nature (see Maurer *et al.* 2024), although not unproblematic from a normative perspective.

These considerations, which echo recent attempts to explore COVID-19 as a "critical juncture" for the EU (Wolff and Ladi 2020), inspire our overarching research question: to what extent did the EU's post-COVID-19 accelerated maturation as a global health actor intertwine with a reinforced commitment to providing "health security"? There is little doubt that the EU has consolidated itself as a global health actor after COVID-19 (Bergner 2023, Drieskens *et al.* 2024, Fernández, Forthcoming) – for instance, in terms of its ability to adjust to new circumstances, make informed decisions and develop salient relations with other actors (Maurer *et al.* 2024). However, from a more ideational standpoint, (self-)perceptions of the EU as a global health actor hinge on the answer to this question. We posit that COVID-19 catalysed a quantum leap in some EU actors' attempted securitisation of global health, in line with a broader turn towards a "darker" rhetoric in EU foreign policy, hastened by Russia's 2022 full-scale invasion of Ukraine. However, the adoption of a "health security" discourse has been inconsistent, even within institutions with supranational characteristics. Therefore, to call this tectonic shift an "epochal" one – or *Zeitenwende* (Scholz 2022) – may be overblown. All in all, this suggests that the EU's identity as a global health actor is not becoming more stable and easily recognisable, as would be expected according to the third maturation process outlined in the Special Issue introduction (Maurer *et al.* 2024).

The article proceeds as follows. In Section 2, I will lay out our understanding of securitisation and the methodology guiding this research. Section 3 will present my findings, distinguishing between selected EU documents on global health, key EU security documents and State of the European Union (SOTEU) speeches by European Commission presidents. Section 4 will discuss these findings together with some of the specific dilemmas that EU institutions face vis-à-vis health securitisation, while drawing on concepts such as EU "actorness". The final section offers some concluding remarks, highlighting the article's contribution to the Special Issue and beyond.

2. Conceptualising and measuring the EU's securitisation of global health

This article addresses securitisation by roughly following the core tenets of the Copenhagen School (Buzan *et al.* 1998). The common ontological bedrock of all securitisation scholarship is a non-essentialist understanding of "security". According to the specific perspective of the Copenhagen School, security issues are intersubjectively constructed as such through a series of securitising moves and their resonance with a given audience. For the Copenhagen School, the

main drivers of securitisation are *speech acts*[6] that explicitly or implicitly reference a given threat. Buzan *et al.* (1998) gloss over institutional developments and actual practices, which have been the focus of later securitisation scholars (see, for example, Bengtsson and Rhinard 2019). While the Copenhagen School's paradigm may be seen as overly reductionist, "the use of [conventional] securitisation theory has been less controversial for studying issues such as global pandemics, where discursive occurrences appear to play an important role" (Balzacq *et al.* 2016, p. 518).[7] In the case of the EU's health policy, securitising rhetoric has already been proven to enable tangible policy changes (Brattberg and Rhinard 2011). We therefore take a speech-act approach to securitisation and postulate that EU institutions can be securitising actors,[8] as acknowledged by Buzan *et al.* (1998, pp. 179–189). EU institutions are prone to engage in existentialist talk (Sperling and Webber 2019), but we do not set the bar so high: it is now widely accepted that, contrary to what the Copenhagen School originally suggested, a securitising move does not require framing threats as existential (Rushton 2019, Sperling and Webber 2019), nor invoking emergency, extraordinary measures (Hanrieder and Kreuder-Sonnen 2014, Balzacq *et al.* 2016, Sperling and Webber 2019).

To gauge the extent to which EU institutions have sought to securitise global health, this article conducts a systematic study of key strategic documents and public statements issued before and after the COVID-19 pandemic. With regard to the EU's role in global health, those strategic documents have been scant. The first of its kind was a Commission Communication (European Commission 2010a) not formally labelled as a "strategy", but informally referred to as such. This document was updated through the recent EU Global Health Strategy (GHS) (European Commission 2022a). The two documents, together with their respective press releases (European Commission 2010b, 2022b) and the Council Conclusions that each of them inspired (Council of the European Union 2010, 2024), will be dissected and contrasted. Searching for securitising moves in more obscure texts would be incongruent with the central assumptions of the Copenhagen School (Buzan *et al.* 1998, p. 177). Furthermore, "it is better to have a limited set of texts and a complete representation of securitization instances than a large set from which the authors pick at liberty" (Buzan *et al.* 1998, p. 178).

A thorough analysis of the securitisation of global health must also consider what may rather be viewed as a "healthification" of security (Wenham 2019, p. 1100). This may manifest itself in an

[6] "It is the utterance itself that is the act. By saying the words, something is done" (Buzan *et al.* 1998, p. 26, drawing on Austin 1962).
[7] For a robust defence of a focus on linguistics in securitisation studies, see Baele and Sterck (2015, p. 1125).
[8] "Actors who securitize issues by declaring something … existentially threatened" (Buzan *et al.* 1998, p. 36).

increased involvement of the military sector in global health security operations (Wenham 2019, p. 1100), but also at a more rhetorical level (Dijkstra and de Ruijter 2017, pp. 615–617). To take this angle into account, we searched for health-related content in the main strategic documents that have underpinned the EU's security and defence policy. The first two are the European Security Strategy (ESS) (Council of the European Union 2003) and its subsequent implementation report (Council of the European Union 2008). The third key security document is the Global Strategy (European External Action Service 2016), conceived as an update of the ESS. Finally, we consider the Strategic Compass (European External Action Service 2022a) – the only EU security doctrine, *stricto sensu*, published after COVID-19. This document is not meant to update but to complement the Global Strategy through a more marked defence focus and, therefore, it is not directly comparable to the other three. Moreover, the content of the document – adopted in March 2022 – reflects the very special context in which it was released: the immediate aftermath of Russia's February 2022 full-scale invasion of Ukraine. That said, the Strategic Compass had been under development since 2020; in fact, a draft version of it leaked in November 2021 (European External Action Service 2021). This draft was also examined to better isolate the effects that Russia's 2022 offensive had on the document (Costa and Barbé 2023, p. 436, Sus 2023, pp. 954–956).

Finally, this article covers all SOTEU speeches given by presidents of the European Commission before the European Parliament. These annual addresses have taken place since 2010, with the only exceptions of 2014 and 2019, when elections to the European Parliament were held. SOTEU speeches are the highest-profile addresses delivered by European Commission presidents, attracting considerable public attention. As such, they represent an ideal resource to assess the extent to which "health securitisation" has taken place through speech acts.

To analyse this corpus of strategic documents and public communications, I used the most recent version of the LIWC (Linguistic Inquiry and Word Count) software. LIWC-22 is a fully automated content analysis tool that enables comparisons of a given text to a predefined list of dictionary terms, establishing the percentage of words that belong to each dictionary. In particular, I ran the EU's broad strategic doctrines through LIWC-22's "health" dictionary (HD) to find evidence of a "healthification" of security. As for the selected EU documents on global health, I ran them through LIWC-22's "positive tone" and "negative tone" dictionaries. This "positive" and "negative" tone disaggregation is helpful, as securitising rhetoric may be associated with a higher volume of tone-coded terms, but not necessarily with a lower overall tone. For instance, in the phrases "humanitarian crisis" and "epidemic intelligence", LIWC-22 codes one of the terms as positivetone and the other as negative-tone, thus cancelling each other out.

Beyond this focus on tone, I searched for more concrete evidence of securitising language in the EU documents on global health. To do so, I turned to LIWC-22's "conflict" dictionary (CD), as well as to two custom-made dictionaries. The first one is the Security Language Dictionary (SLD), developed by Baele and Sterck (2015), which has already gained considerable academic traction (Umansky 2016, Smith *et al.* 2019) and even been used to study securitising semantic repertoires during the COVID-19 pandemic (Baele and Rousseau 2023). The second custom-made dictionary is the Threat Dictionary (TD), designed by Choi *et al.* (2022) to trace threat levels in mass media communications and their correspondence with crises such as COVID-19. All three dictionaries were applied in the interest of comprehensiveness.

For each of the selected documents on global health, the five most frequently mentioned terms were identified and included in at least one of the three security dictionaries, also relying on LIWC-22. In addition, necessary benchmark values (see Baele and Sterck 2015, p. 1128) were obtained by applying the HD to the global health-related documents and running the EU's security doctrines through the security-related dictionaries – an exercise that also allowed us to test some of our theoretical assumptions.

With respect to SOTEU speeches, the proportion of words associated with health were established, with the help of LIWC-22's HD. Thereafter, a contextual analysis was performed to identify the HD terms with an explicit health-related connotation.[9] To do so, I examined the full sentence where the term in question appeared, as well as the adjacent ones, when semantically connected. Finally, an additional contextual analysis served to pinpoint the health-related terms uttered within a security-related context. Said linguistic context was inferred from the presence of at least one security-related term (coded by any of the three security dictionaries) in the same sentence as the health-related term in question, or in either of the adjacent sentences, when semantically connected. This enabled me to identify instances of "health-securitising" rhetoric through a method that, while not completely devoid of subjectivity and not restricted to *global* health, is as transparent and replicable as possible.

For further details on LIWC-22, reference dictionaries and my application of the software, please refer to Appendix.

[9] HD terms such as "recovery" often possess a different connotation, e.g. an economic one.

3. Findings

3.1. Selected EU documents on global health

When dissecting the EU's 2010 global health strategy and its 2022 update, along with their respective press releases and Council Conclusions, we can identify some clear instances of securitising rhetoric. **Table 1** summarises the key findings of the dictionary-based analysis conducted for each document. Averages for the 2010 documents and their 2022–2024 counterparts are presented to facilitate comparisons. Overall averages were also calculated.

Table 1. *Dictionary-based analysis of selected EU documents on global health.*

	LIWC-22 official, built-in dictionaries				Custom-made dictionaries		
	Tone positivity (%)	Tone negativity (%)	"Health" dictionary (%)	A: "Conflict" dictionary (%)	B: Security Language Dictionary (Baele and Sterck 2015) (%)	C: Threat Dictionary (Choi *et al.* 2022) (%)	"Security" average (A, B and C dictionaries) (%)
2010 Commission Communication: "The EU role in global health"	3.70	0.55	4.78	0.28	2.21	1.05	1.18
Commission press release on the 2010 Communication	3.65	0.68	7.03	0.21	1.88	1.25	1.11
2010 Council Conclusions on the Commission Communication	4.71	0.41	5.17	0.12	2.21	1.28	1.20
2010 average	4.02	0.55	5.66	0.20	2.10	1.19	1.17
2022 EU Global Health Strategy	4.43	1.25	5.38	0.42	3.28	1.48	1.73
Commission press release on the 2022 EU Global Health Strategy	5.32	2.20	6.10	1.04	6.23	2.08	3.12
2024 Council Conclusions on the EU Global Health Strategy	3.58	1.43	4.96	0.61	3.31	1.38	1.77
2022–2024 average	4.44	1.63	5.48	0.69	4.27	1.65	2.20
Overall average	4.23	1.09	5.57	0.45	3.19	1.42	**1.68**

The first takeaway is that the share of terms with a negative tone almost tripled between 2010 and 2022–2024. Meanwhile, the percentage of terms with a positive tone (e.g. "cooperation", included also in the SLD) increased as well. Although their increase was less pronounced, they remained more frequent than negative-tone terms. This aligns with our theoretical expectation that the two types of tone-coded terms are prone to co-occur. Consider, for example, the following sentence from the 2022 EU GHS:

> The EU drew the early lessons of the *pandemic*, adopting a *new* Regulation on serious cross-border health *threats* and *improving* preparedness and response in the field of medical countermeasures notably with the creation of the Health Emergency Preparedness and Response Authority. (European Commission 2022a, p. 14, emphases added)[10]

However, on their own, these findings tell us little about the degree to which security-infused rhetoric has permeated the selected EU documents on global health. To dig deeper into this, I

[10] LIWC-22 codes "pandemic" and "threats" as negative-tone terms, whereas "new" and "improving" are categorised as positive-tone terms.

relied on the three security-related dictionaries. Despite all three comprising a similar number of terms,[11] the SLD consistently delivered the highest percentages per document, followed at a significant distance by the TD and, finally, by LIWC-22's CD, which has more of an interpersonal than an international relations focus. Averages of all three dictionary-based security scores were calculated for the six EU documents on global health and, in turn, averages were once again presented for the 2010 and 2022–2024 texts. This revealed a key insight: from 2010 to 2022–2024, the average percentage of security-centric terms almost doubled, from 1.17% to 2.20%.

Out of the six documents, the one with the clearest security orientation is the 2022 Commission press release, with a 3.12% average score of security-related terms. When comparing the actual strategies, it becomes clear that the 2022 GHS presents a markedly higher share of security-laden terms than that of the 2010 Communication: 1.73% versus 1.18%, respectively. In the Council Conclusions, a similar increase was observed, from 1.20% in 2010 to 1.77% in 2024. As expected, the percentage of security-related terms in the 2022–2024 global health documents still pales in comparison with the benchmark value obtained from the EU's key security documents (an average score of 3.88%;[12] see **Table 3** in Section 3.2). However, the fact that this benchmark value is not much higher confirms the significance of the increase observed between 2010 and 2022–2024 in the selected global health documents.

To highlight the type of security-related rhetoric imbuing these texts, the five most frequently mentioned "security" terms in each of them were identified. The findings are summarised in **Table 2**.

[11] Out of the three dictionaries, the SLD comprises the lowest number of terms. However, many of them are word stems, which enhances its actual coverage. This is also the case of LIWC-22's CD. Conversely, the TD does not include word stems.
[12] Overall averages for key EU security documents exclude the 2021 draft Strategic Compass.

Table 2. *Five most frequently mentioned terms included in at least one of the three security dictionaries ("conflict" dictionary, CD; Security Language Dictionary, SLD; Threat Dictionary, TD), by selected EU documents on global health.*

2010 Commission Communication: "The EU role in global health"	Term #1 Security Frequency rank, % of total words T#38, 0.40 Security dictionary(ies) SLD, TD	Term #2 (tied) Challenges Frequency rank, % of total words T#39, 0.35 Security dictionary(ies) TD	Term #2 (tied) Resources Frequency rank, % of total words T#39, 0.35 Security dictionary(ies) SLD	Term #4 (tied) Strategies Frequency rank, % of total words T#49, 0.30 Security dictionary (ies) SLD	Term #4 (tied) Protection Frequency rank, % of total words T#49, 0.30 Security dictionary (ies) SLD
Commission press release on the 2010 Communication	Term #1 Deaths Frequency rank, % of total words T#6, 1.11 Security dictionary(ies) TD	Term #2 Prevention Frequency rank, % of total words T#18, 0.60 Security dictionary(ies) SLD	Term #3 (tied) Fight Frequency rank, % of total words T#39, 0.30 Security dictionary(ies) SLD, CD	Term #3 (tied) Targets Frequency rank, % of total words T#39, 0.30 Security dictionary (ies) TD	Term #3 (tied) Poverty, prevent Frequency rank, % of total words T#39, 0.30 Security dictionary (ies) SLD (poverty); SLD, TD (prevent)
2010 Council Conclusions on the Commission Communication	Term #1 Challenges Frequency rank, % of total words T#15, 0.61 Security dictionary(ies) TD	Term #2 (tied) Strategy Frequency rank, % of total words T#34, 0.40 Security dictionary(ies) SLD	Term #2 (tied) Security Frequency rank, % of total words T#34, 0.40 Security dictionary(ies) SLD, TD	Term #2 (tied) Resources Frequency rank, % of total words T#34, 0.40 Security dictionary (ies) SLD	Term #5 (tied) Protection, strategies Frequency rank, % of total words T#54, 0.30 Security dictionary (ies) SLD
2022 EU Global Health Strategy	Term #1 Strategy Frequency rank, % of total words #7, 0.80 Security dictionary(ies) SLD	Term #2 Cooperation Frequency rank, % of total words T#22, 0.44 Security dictionary(ies) SLD	Term #3 Threats Frequency rank, % of total words T#26, 0.42 Security dictionary(ies) CD, TD	Term #4 Response Frequency rank, % of total words T#28, 0.41 Security dictionary (ies) SLD	Term #5 Security Frequency rank, % of total words T#38, 0.31 Security dictionary (ies) SLD, TD
Commission press release on the 2022 EU Global Health Strategy	Term #1 Strategy Frequency rank, % of total words #3, 4.02 Security dictionary(ies) SLD	Term #2 Threats Frequency rank, % of total words T#5, 1.34 Security dictionary(ies) CD, TD	Term #3 Security Frequency rank, % of total words T#9, 0.89 Security dictionary(ies) SLD, TD	Term #4 Challenges Frequency rank, % of total words T#15, 0.67 Security dictionary (ies) TD	Term #5 (tied) Response, strategic Frequency rank, % of total words T#26, 0.45 Security dictionary (ies) SLD
2024 Council Conclusions on the EU Global Health Strategy	Term #1 Strategy Frequency rank, % of total words #8, 0.90 Security dictionary(ies) SLD	Term #2 Protection Frequency rank, % of total words T#21, 0.45 Security dictionary(ies) SLD	Term #3 (tied) Cooperation Frequency rank, % of total words T#36, 0.36 Security dictionary(ies) SLD	Term #3 (tied) Discrimination Frequency rank, % of total words T#36, 0.36 Security dictionary (ies) CD	Term #5 (tied) Fighting, security Frequency rank, % of total words T#58, 0.27 Security dictionary (ies) CD, SLD, TD (fighting); SLD, TD (security)

Notes: Frequency rank: indicates the position that a given term occupies within the document's rank of most frequently mentioned terms. This, as well as the percentage of total words, excludes function words that LIWC-22 places in its stop list (e.g. articles, pronouns, prepositions, conjunctions, etc.). T: tied for.

In the 2010 global health documents, many of the top security-oriented terms possess an economic or development-focused connotation (e.g. "resources", "targets" and "poverty"). The following fragment from the 2010 Communication is illustrative:

> Health is a *critical* element to reduce *poverty* and promote sustainable growth. The EU policy on health and *poverty* reduction addresses these links. Special attention is given to *poverty*-related diseases and to the *crisis* of human *resources* for health. (European Commission 2010a, p. 4, emphases added)[13]

By contrast, the 2022–2024 documents are more populated by terms conveying a sense of urgency, such as "threats" and "response" – although less so in the Council Conclusions adopted in 2024, when the COVID-19 pandemic had already subsided. The 2022 texts are much more pandemic-centric, but their securitising rhetoric extends beyond this theme, as evidenced by this passage from the press release on the GHS:

> The *Strategy* also seeks to improve global health *security*, thus *protecting* citizens from *threats* by stepping up *prevention*, preparedness and *response*, and early detection. These *threats* can be *chemical*, *biological*, or *nuclear* or pandemics, including the silent *killer* that is antimicrobial *resistance*. (European Commission 2022b, emphases added)[14]

3.2. Key EU security documents

While the previous section presented evidence of an attempted securitisation of global health by the European Commission and the Council, the other side of the coin – a "healthification" of security – is an altogether different matter. **Table 1** captured the health component of the selected EU documents on global health (an average percentage of 5.57%, based on LIWC-22's HD). This is higher than the average dictionary-based security component of the key EU security documents (3.88%). Given these figures and the broader focus of this second set of documents, it would be unrealistic to expect the percentage of health-related terms in them to surpass the percentage of security-related terms in the first set (1.68%). As it turns out, however, the average

[13] All terms in italics belong to the SLD, with "crisis" belonging also to the TD.
[14] CD: "threats", "killer". SLD: "strategy", "security", "protecting", "prevention", "response", "chemical", "biological", "nuclear", "killer", "resistance". TD: "security", "threats". Note that "pandemic" is not included in any of the three security dictionaries, contrary to related terms such as "disease" (in both the SLD and the TD) and "epidemic" (in the TD). Its inclusion would have significantly driven up the dictionary-based security percentages of the 2022 global health documents.

share is *much* lower than that: 0.24%. Even more to the point, it has declined significantly and almost continuously, as shown in **Table 3**.

Table 3. *Dictionary-based analysis of key EU security documents.*

		LIWC-22 official, built-in dictionaries				Custom-made dictionaries		
		Tone positivity (%)	Tone negativity (%)	"Health" dictionary (%)	A: "Conflict" dictionary (%)	B: Security Language Dictionary (Baele and Sterck 2015) (%)	C: Threat Dictionary (Choi *et al.* 2022) (%)	"Security" average (A, B and C dictionaries) (%)
EU: key security documents	2003 European Security Strategy (ESS)	3.29	3.68	0.38	1.63	8.04	4.98	4.88
	2008 Implementation Report of ESS	3.44	1.72	0.21	0.87	6.68	3.17	3.57
	2016 Global Strategy	4.42	1.31	0.22	0.48	5.95	2.51	2.98
	Draft Strategic Compass (November 2021)	3.80	1.64	0.16	0.92	7.69	3.04	3.88
	2022 Strategic Compass	4.31	1.67	0.14	0.89	8.12	3.21	4.07
	Average (excluding draft Strategic Compass)	3.87	2.10	0.24	0.97	7.20	3.47	3.88

Zooming in on these results, we see that the 2003 ESS features the highest proportion of health-related rhetoric, almost doubling that of the most directly comparable document – the 2016 Global Strategy. These findings should be approached with a degree of caution, as the HD includes many terms that do not always have a health-related connotation. However, this drawback is present across the board and did not play a major role in the trends observed. Given the low volume of health-related terms present in the texts in question, a word-frequencies table akin to **Table 2** cannot effectively showcase this. Instead, we performed a contextual reading of the ESS, which confirmed that most health-coded terms do have a health-related connotation, as the italicised words in the following excerpt demonstrate:

> In much of the developing world, poverty and *disease* cause untold suffering and give rise to pressing security concerns. Almost 3 billion people, half the world's population, live on less than 2 Euros a day. 45 million die every year of hunger and *malnutrition*. *AIDS* is now one of the most devastating *pandemics* in human history and contributes to the breakdown of societies. New *diseases* can spread rapidly and become global threats. (Council of the European Union 2003, p. 4, emphasis added)

Another important take away from the data of **Table 3** is that the 2022 Russian offensive against Ukraine caused an increase in security-infused rhetoric at the final drafting stages of the Strategic Compass. Nevertheless, this did not come at the expense of health: compared to the final version of the document, the 2021 draft features only a marginally higher share of health-related terms (0.16% versus 0.14%).

When it comes to the "tone" variables, some insights are worth mentioning. Firstly, out of the EU's key security documents, the 2003 ESS presents the lowest percentage of positive-tone terms and, by far, the highest percentage of negative-tone terms – as well as the highest "security" score. This somewhat dampens the widespread perception of the ESS as a more optimistic text than its 2016 successor (Tocci 2017, p. 488, Costa and Barbé 2023, pp. 435–436). It also shows that the previously discussed co-occurrence of positive- and negative-tone terms is not a given. Sometimes, evidence supports instead the more intuitive notion that security-related semantic repertoires imply a lower overall tone. An additional example arises from comparing the selected global health documents to the key security documents: tone-positive terms are more prevalent in the former, whereas tone-negative terms are more frequent in the latter (see **Tables 1** and **3**).

3.3. State of the European Union speeches

The analysis of the 12 SOTEU speeches delivered thus far – 4 by each of the last 3 European Commission presidents – uncovered some interesting trends concerning their health and health security dimensions. A first finding is that, before COVID-19 struck and the EU was busy navigating other crises also seen as existential (e.g. economic, migratory, Brexit), health was almost completely absent from these parliamentary addresses. During José Manuel Durão Barroso's second term as Commission president (2009–2014),[15] his SOTEU speeches included an overall total of one HD term with a health-related connotation.[16] Those were slightly more common throughout Jean-Claude Juncker's tenure (2014–2019), but their frequency tended to dwindle. Remarkably, the dictionary-based and contextual analysis revealed that, in all of those pre-COVID years, a health security frame was employed on a single occasion.[17]

Figure 1 illustrates the pre-COVID paucity of health-related references, as well as the drastic increase that occurred at the beginning of von der Leyen's mandate. Her first SOTEU took place in September 2020, when the COVID-19 pandemic had unprecedentedly vaulted health into the top of the EU's agenda. The share of HD terms rose sharply, with the vast majority of them now having a clear health-related connotation, and about half of them being embedded in a health security frame. One example is the following fragment from the 2020 SOTEU, which includes multiple words appearing in the HD and/or the security-related dictionaries:

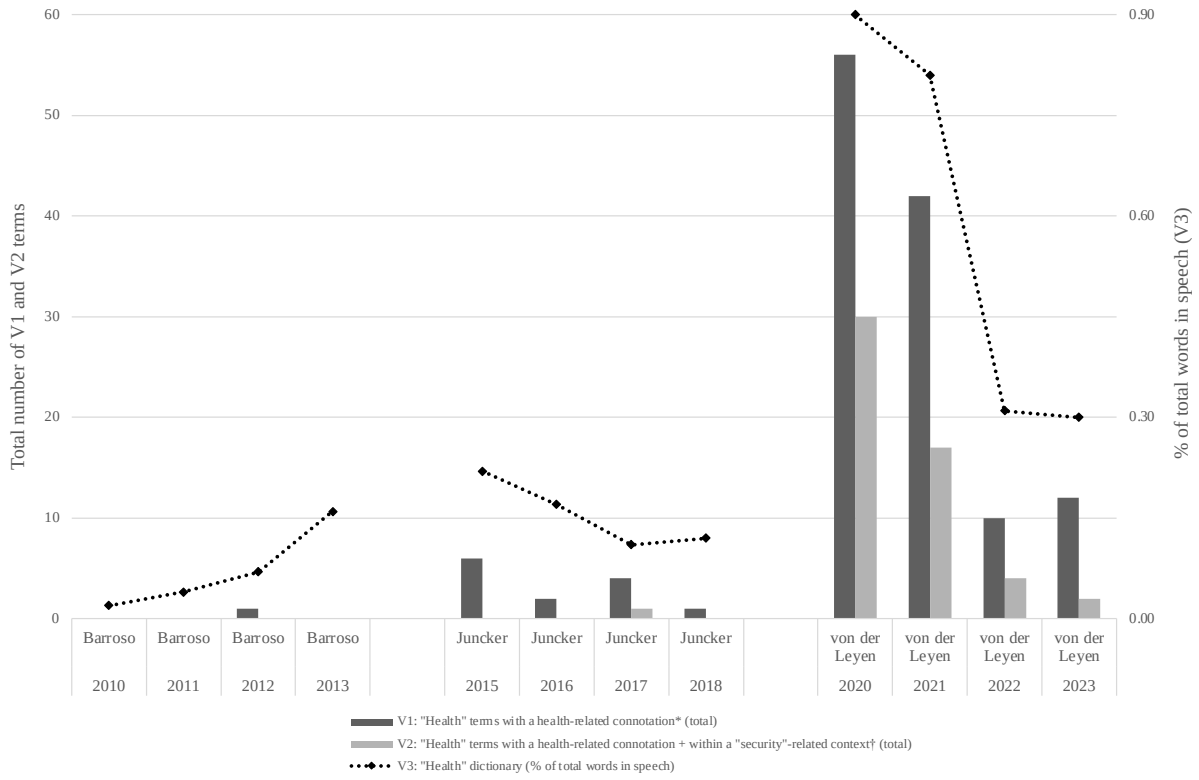
[15] In Barroso's first term (2004–2009), SOTEU speeches had not yet been instituted.
[16] "Europe is a world leader in key sectors such as aeronautics, automotives, *pharmaceuticals* and engineering, with global market shares above a third" (Durão Barroso 2012, p. 5, emphasis added).
[17] "This is why we are working with all Member States to support national *vaccination* efforts. Avoidable *deaths* must not occur in Europe" (Juncker 2017, p. 6, emphases added). In this excerpt, an HD term with a health-related connotation ("vaccination") appears alongside a security-related term ("deaths", from the TD).

> We need to strengthen our *crisis* preparedness and management of cross-border *health threats*. As a first step, we will propose to reinforce and empower the European *Medicines* Agency and ECDC – our centre for *disease prevention* and *control*. (von der Leyen 2020, p. 3, emphases added)[18]

While the 2021 SOTEU also brimmed with health-related content, a larger share of HD terms were devoid of any health-related connotation, and the health security frame featured less prominently. In 2022, the EU's attention turned to Russia's war against Ukraine, with health being relegated to a secondary priority at best – which clearly showed in the most recent SOTEU speeches.[19] To be sure, in von der Leyen's 2022 SOTEU, the health security frame did experience a modest uptick in relative terms, partly in connection with the war.[20] This is a noteworthy development, but a closer reading of her 2022 and 2023 speeches suggests that it is mostly anecdotal. In the latest SOTEU, the health-related content marginally increased with respect to the previous year, whereas the health security dimension – while firmly anchored in Russia's war of aggression[21] – became almost negligible.

[18] HD: "health", "medicines", "disease", "prevention". CD: "threats". SLD: "crisis", "disease", prevention", "control". TD: "crisis", "threats", "disease".
[19] The last three SOTEU speeches were the most security-centric ever, if one considers averages of all three dictionary-based security scores (1.35, 1.29 and 1.27, respectively).
[20] "Fifteen years ago, during the financial *crisis*, it took us years to find lasting solutions. A decade later, when the global *pandemic* hit, it took us only weeks. But this year, as soon as Russian troops crossed the border into Ukraine, our *response* was united, determined and immediate" (von der Leyen 2022, p. 1, emphases added).
[21] "That was before the world turned upside down with a global *pandemic* and a *brutal war* on European soil" (von der Leyen 2023, p. 2, emphases added). "Brutal" can be found in the CD and "war" can be found in both the SLD and the TD.

Figure 1. *"State of the European Union" speeches by European Commission presidents: health and health security dimensions.*



**Health-related connotation: established by the sentence in which the term appears, or in the adjacent ones when semantically connected.*
†Security-related context: established by the appearance of a term belonging to one of the three security dictionaries in the given sentence, or in the adjacent ones when semantically connected.

4. Discussion

4.1. A rhetorical – albeit not epochal – tectonic shift

Much like in the daily lives of EU citizens, COVID-19 left a distinct yet uneven trace in the rhetoric of EU institutions. Our analysis demonstrates that a radical change did indeed occur in the highest-profile EU strategic documents on global health, with securitising language becoming much more prevalent after the pandemic struck. This shift is observable at the highest echelons of the European Commission, as evidenced particularly by the 2020 SOTEU speech of President von der Leyen. Nevertheless, references to health matters in her annual addresses have since faded and the health security frame has experienced an even swifter erosion. Moreover, there is no sign of "healthification" in the key EU security documents, let alone in the recent Strategic Compass. In short: while COVID-19 triggered a "tectonic shift" in some EU institutions' attempted

securitisation of health through speech acts, this shift was neither widespread nor sustained in time. It would thus be an overstatement to call it an "epochal" one – that is, a *Zeitenwende*.

These findings invite a reflection on the specific actors involved in producing the selected documents, as their content can provide some insights about their motivations. While both of the EU's global health strategies – the 2010 Communication and its 2022 update – were authored by the European Commission, their respective drafting processes differed from an intra-institutional perspective. The 2010 Communication was led by the Directorate-General for International Development (DG DEV), with authorship duties being shared with the DG for Health and Consumers (DG SANCO) and the DG for Research (DG RTD) (Steurs *et al*. 2018, p. 439). DG DEV's stewardship might help explain the Communication's light and rather "soft" security-related content – a finding from our research that aligns with earlier scholarly works (Steurs *et al*. 2018, van Schaik *et al*. 2021, p. 4).

In the case of the 2022 GHS, it was the DG for Health and Food Safety (DG SANTE, which replaced DG SANCO) that sat at the helm, with the DG for International Partnerships (DG INTPA, a successor of DG DEV) now playing a less prominent role (see Mersh 2022). The new Health Emergency Preparedness and Response Authority (DG HERA), launched in September 2021, allegedly contributed to the document as well,[22] despite not being officially credited as an author and its relationship with it being fuzzy (McKee *et al*. 2023, p. 1026). While all DGs of the European Commission can be seen as supranational entrepreneurs, DG SANTE operates with a less sturdy legal basis compared to DG INTPA[23] and its involvement in global health efforts is far less consolidated (Greer and Löblová 2017, p. 403, van Schaik *et al*. 2021, p. 3). By the end of Juncker's tenure as Commission president, there was speculation that DG SANTE might even cease to exist altogether (Greer *et al*. 2022, p. 19). This DG, therefore, has a greater incentive to play the securitisation card to reinforce its standing, with past research confirming this inclination and ensuing frictions with DG INTPA (Greer and Löblová 2017, p. 403, van Schaik *et al*. 2021, p. 4). The rationale for HERA to play this card is even clearer, given that its very existence demonstrates and arguably depends on the EU's securitisation of health (Godziewski and Rushton 2024).

Interestingly, the combined security scores of the 2010 and 2024 Council Conclusions are very similar (and, in fact, slightly higher) than those of the 2010 and 2022 global health strategies, respectively. This seems to run counter to Buzan *et al*. (1998), who observed that the

[22] HERA official, interview with author (13 June 2023).
[23] With development cooperation being a competence shared between the EU and its Member States (Article 4(4) TFEU).

Council/European Council "securitizes less for Europe" (p. 180) because it "ultimately works from national perspectives and therefore does not want systematically (only in limited, ad hoc instances) to equip the EU with emergency powers or automaticity" (p. 186). Further research would be needed to determine whether Council Conclusions – always requiring consensus among Member States – are more prone to contain securitising speech acts when adopted in response to a Commission Communication, due to rhetorical inertia. In the case of the 2024 Conclusions, the debate centred to a large extent on provisions on sexual and reproductive health and rights, whose contestation by Poland and Hungary delayed the adoption of the document. This might have further shifted the focus away from securitising language.

Unlike the selected global health documents, none of the key EU security documents were authored by the European Commission. The 2016 Global Strategy and the 2022 Strategic Compass were drafted by the European External Action Service (EEAS), with the latter document being more Member State-led than the former (Latici and Lazarou 2021, pp. 1–2). As for the 2003 ESS and its 2008 implementation report, they both precede the creation of the EEAS and were developed by the Council (Tocci 2017, p. 492). This reflects the intergovernmental nature of the EU's Common Foreign and Security Policy (CFSP) before the Lisbon Treaty introduced some clearer supranational elements in it, e.g. through the establishment of the "hybrid" EEAS (Morillas 2020, Sus 2023). However, our research reveals that the EEAS did not use the 2016 Global Strategy – which transcends CFSP and is therefore more holistic than the 2003 ESS (Barbé and Morillas 2019, pp. 762–763) – to expand its remit of action into global health. Even in the COVID-19 era, the EEAS did not play a substantial role in the 2022 GHS, although High Representative/Vice President Josep Borrell did participate in its public presentation with a highly security-oriented speech (European External Action Service 2022b). An interesting counterfactual is whether the Strategic Compass would have included more health-related content had Member States been less extensively involved in its development. After all, national governments are generally reluctant to establish linkages between policy areas at EU level so as to avoid undesirable authority transfers. Reactions to von der Leyen's centralising efforts during the pandemic (van Schaik *et al*. 2020, pp. 1155–1157) further evidenced Member State resistance to said transfers (see also Drieskens *et al*. 2024).

4.2. To securitise or not to securitise?

So far, the discussion has skimmed over a crucial debate: is it actually in the interest of supranational policy entrepreneurs within the EU to pursue a securitisation of (global) health? Section 1 presented some dilemmas typically associated with health securitisation but did not

address the specific quandaries applying to the EU as a *sui generis* entity. Meanwhile, other authors have explored the normative implications of the EU's practice of "collective securitisation" (Floyd 2019, Lucarelli 2019), although only cursorily in the domain of health. This sub-section builds on our empirical findings to bridge these two research strands, complementing previous scholarly contributions (Dijkstra and de Ruijter 2017, Steurs *et al*. 2018, Bergner 2023). The consideration of normativity is here restricted to its impact on two intrinsic goals of EU supranational policy entrepreneurs: (1) enhancing their authority and autonomy within the EU's legal-institutional framework; and (2) increasing the overall actorness of the EU.

As per principal-agent theory (Pollack 1997), supranational or hybrid EU institutions tend to seek an expansion of the functions delegated to them by their respective principals – that is, EU Member States (see Maurer *et al*. 2024). For EU Commission officials, especially those dealing directly with health policy, securitising (global) health might serve this objective nicely. Framing a health issue as a threat to be collectively managed may resonate well with different audiences (e.g. national governments, public health associations and the wider public). By extricating health matters from "the normal haggling of politics" (Buzan *et al*. 1998, p. 29), securitisation can replace a "constraining dissensus" – which historically prevented EU integration in this sensitive area – with a "permissive consensus" (Hooghe and Marks 2009), or at least with a "permissive dissensus" (Greer and Löblová 2017). The EEAS also has some incentives to play the securitisation card vis-à-vis global health (Dijkstra and de Ruijter 2017, p. 622), although health is not a strong EU policy for it to leverage.

Pursuing a securitisation strategy does not come without risks. Some of these stem from the fact that the audience of securitising moves is less malleable than Copenhagen School theorists implicitly assume (Balzacq *et al*. 2016, p. 499). Since the Maastricht Treaty and the subsequent BSE crisis, whose securitisation played an even more foundational role for EU health policy (Reiners 2015, p. 202, Bengtsson and Rhinard 2019, pp. 351–353, Greer *et al*. 2022, p. 12), a "permissive dissensus" has certainly prevailed. Health integration has largely progressed beneath the scrutiny of mass politics, as illustrated by our examination of pre-COVID-19 SOTEU speeches. Attempting to securitise this policy area further may not free it from "the normal haggling of politics" but submerge it directly into it (McInnes and Rushton 2013, p. 118, see also Andrione-Moylan *et al*. 2024, pp. 29–30), as happened with environmental policy (Buzan *et al*. 1998, p. 91). Joint EU measures may thereby attract accusations of regulatory overreach and democratic unaccountability. A slightly different possibility is that EU policy entrepreneurs will succeed at securitising a health issue, but fail to depict the EU (i.e. its institutions and/or a transnational

polity) as the *referent object*[24] under threat. Securitising moves may thus fuel a national retrenchment instead of EU-wide solidarity, reinforcing Member State executives rather than supranational institutions. At various points, the COVID-19 crisis offered glimpses into both of these scenarios (van Schaik *et al*. 2020, pp. 1155–1157), each potentially heralding a reversal of EU health integration. The fact that even Eurosceptic governments accepted an increase in securitising language in the 2024 Council Conclusions, relative to the 2010 ones, might subtly reveal that these governments do not perceive the link between EU-level securitisation and integration as being necessarily direct.

From a more external perspective, the effects of EU health securitisation are also ambivalent. Following Jupille and Caporaso (1998), EU "actorness" is not defined only by its authority and its autonomy from Member States, but also by its cohesion and other actors' recognition.[25] The heightened security orientation of the 2022 GHS clearly dovetails with the securitisation of other policy areas like trade and technology (Rieker and Riddervold 2024), also bringing the EU more in line with the few existing global health strategies of Member States (Steurs *et al*. 2018, Fernández And Kissack, Forthcoming). This points to an enhanced horizontal and vertical cohesion, although with some important caveats delineated below. In terms of recognition, the EU's pandemic management, combined with the "Team Europe" approach, enhanced its visibility and centrality within global health endeavours. While *de jure* recognition of the EU remained unchanged after COVID-19, as it is still an informal observer at the WHO, the EU's self-perception as a global health actor with agenda-setting power did experience a boost, as did its *de facto* recognition as such (Kickbusch and de Ruijter 2021, Bergner 2023). This is consistent with the fourth maturation process (i.e. "developing salient relations") outlined in the introduction to this Special Issue (Maurer *et al*. 2024).

As suggested by Bergner (2023, p. 9), however, health securitisation can also hamper the EU's cohesion and external recognition as a "normative power" (Manners 2002, see also Drieskens *et al*. 2024), in global health and beyond. Securitising moves may clash with its longstanding goal of projecting a benign, open and multilateralist image on the world stage (Lucarelli 2019, p. 426). A case in point is the EU's protectionist reflex concerning COVID-19 vaccines, which led it to favour short-term interests at the expense of global priorities (van Schaik *et al*. 2020, Bergner 2023, Deters and Zardo 2023). In addition, health security is generally inclined towards disease-specific

[24] "Things that are seen to be existentially threatened and that have a legitimate claim to survival" (Buzan *et al.* 1998, p. 36).
[25] For simplicity reasons, this article abides by Jupille and Caporaso's notion of "actorness", although other authors have rightfully paid more attention to contextual factors (see, for example, Bretherton and Vogler 2006).

interventions, creating a dissonance with the EU's professed preference for holistic, systemic approaches (European Commission 2022a, pp. 9–10). A surge in the public salience of global health – accompanied by increased resources – may vindicate this shift in focus to some degree (Dijkstra and de Ruijter 2017, p. 624), but our analysis of SOTEU speeches confirms that this renewed salience can quickly wane (see also Aluttis *et al*. 2014, p. 5). Once this happens, the EU's external legitimacy can also fizzle out amidst charges of hypocrisy and opportunism, emanating especially from the Global South. Only if the EU engaged in a more unique form of securitisation, closer to a *human* security than to a *national* security approach (Davies 2010), might this eventuality be averted. However, past instances of securitisation involving health (Kittelsen 2013, pp. 88–101, Pattani 2015, p. 167, Rushton 2019, pp. 167–170), also in the case of the EU (Reiners 2015, p. 202), do not hold much promise in this regard. Neither does our finding that, after COVID-19, the EU's security agenda became more present in the global health one, but not vice versa (see also Dijkstra and de Ruijter 2017, pp. 615–618). This substantiates fears that "having bought into another agenda [health policy] may lack the political muscle to shape it" (McInnes and Lee 2004, p. 16).

In sum, a security-driven consolidation of the EU's health policy may prove counterproductive if tied, as seems difficult to avoid, to a transformation into a more self-interested, "realist" global health actor. A form of "ontological *in*security" (Mitzen 2006) might ensue, suggesting that "coming of age" does not always imply the adoption of a more stable identity – the third maturation process outlined in the Special Issue introduction (Maurer *et al*. 2024). To be sure, if we broaden our analytical lens, it can be argued that the EU's post-COVID approach to global health both mirrors and advances the "principled pragmatism" that increasingly articulates its external action, as discussed in this Special Issue (see, for example, Rieker and Riddervold 2024). But even if principled pragmatism may be seen as a sign of maturity, we should not overlook the challenge of building a stable identity on a "catchy oxymoron" (Lucarelli 2018, p. 153), nor the risk that the balance tips more and more towards pragmatism at the expense of long-avowed values and principles.

5. Conclusions

This article has explored the EU's securitisation of global health, while considering the specific dilemmas that some of its key institutions face. The following question guided the analysis: to what extent did the EU's post-COVID-19 accelerated maturation as a global health actor intertwine with a reinforced commitment to providing "health security"? To answer this question, I drew on the Copenhagen School understanding of securitisation (Buzan *et al*. 1998), which relies

on key speech acts by securitising actors. For a comprehensive and rigorous evaluation, it was essential to contemplate both the securitisation of health and the "healthification" of security, before and after the pandemic. On the one hand, I compared the European Commission's 2022 global health strategy to its 2010 predecessor, while also examining their respective press releases and Council Conclusions. On the other hand, I analysed the EU's most prominent security documents, beginning with the 2003 ESS and finishing with the EEAS's 2022 Strategic Compass. As a supplementary effort, I delved into all SOTEU speeches delivered by presidents of the European Commission since 2010.

Using the LIWC-22 content analysis software, these documents were dissected and a series of interesting patterns were found. Within the selected EU documents on global health, the presence of security-infused language rose very significantly from 2010 to 2022–2024. A "healthification of security", conversely, was nowhere to be found: in fact, the health-related content within the EU's key security documents *declined* over time. As for SOTEU speeches, there was a major spike in health-related language in 2020, when President von der Leyen made extensive use of the health security frame. However, as the pandemic subsided, references to health matters became less frequent, and so did their securitisation, with links between health and Russia's full-scale invasion of Ukraine being sporadic. From this evidence, it can be concluded that COVID-19 boosted the EU's rhetorical securitisation of (global) health, but this shift was neither widespread nor sustained in time, and therefore did not amount to a genuine *Zeitenwende*. These findings align to some extent with our theoretical expectations. The Commission – in particular, DG SANTE – has a strong incentive to resort to securitising language, whereas the EEAS is more susceptible to the influence of Member States, which typically (albeit not always) refrain from advocating transnational securitisation.

The analytical framework and methodology underpinning this article present some limitations; chief among them, those arising from our exclusive reliance on the Copenhagen School's theory of securitisation. Securitising moves can be more subtle than speech acts, involving instead non-verbal forms of communication (Kittelsen 2013, pp. 40–41). Moreover, while official discourse can be indicative and indeed facilitate institutional developments and concrete policies, this is not always the case. For example, José Manuel Durão Barroso is generally regarded as a more pro-health Commission president than his successor, Jean-Claude Juncker (Greer *et al*. 2022, pp. 19, 248), whereas their respective SOTEU speeches give the opposite impression. Our study also grappled with some instances of imperfect comparability between the EU's key security documents and with the constraints inherent to LIWC-22's dictionary-based approach.

An additional shortcoming stems from our insufficient engagement with the audience(s) of the EU's securitising moves (see Balzacq *et al*. 2016, pp. 499–501). Unfortunately, available Eurobarometer polls did not permit a thorough study of the extent to which EU citizens have internalised the health security frame. Even if polls captured this, it would be difficult to attribute changes in public opinion to the efforts of EU institutions (Baele and Sterck 2015, p. 1134). Further research avenues could involve collecting original data to shed light on this matter, as well as to gauge in greater detail the responsiveness of Member State governments. Importantly, the outside-in perspective should also be empirically explored. For instance, it would be interesting to establish the degree to which the EU's securitising moves have been inspired, welcomed or resisted by other actors, such as the WHO and countries on the receiving end of development assistance for health.

Notwithstanding its limitations, this article contributes to the current literature on the EU's securitisation of global health by scrutinising the effects of COVID-19 from a broad longitudinal lens and by applying a vanguardist and transparent methodology, which is fully replicable. No study so far had addressed the EU's rhetorical securitisation of global health in such a systematic manner. This research also engages with ongoing debates on EU actorness and with the maturation processes, pathways and dilemmas laid out in the introduction to this Special Issue (Maurer *et al*. 2024). A critical takeaway is that, after COVID-19, some policy entrepreneurs doubled down on the securitisation card to bolster the EU's global health actorness. By latching on to the security agenda without shaping it, however, these policy entrepreneurs risk advancing a narrower, more short-sighted conception of the EU's self-interest. This risk is heightened by Russia's full-scale invasion of Ukraine, which has expedited the EU's adoption of a more geopolitical and pragmatic mindset, as other papers in this Special Issue show. Increased capabilities and resources are enabling the EU to "come of age" as a global health actor, but settling on a cohesive identity – also a sign of maturity – has proven much more elusive.

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Appendix. LIWC-22, reference dictionaries and software application

This article relies on the automated LIWC-22 software to carry out its content analysis, as discussed in Section 2. The primary feature of LIWC-22 consists of establishing the percentage of words that belong to a given reference dictionary. Most of the analysis we conduct is based on LIWC-22's built-in dictionaries, such as the "conflict" one (CD). When applying this dictionary, LIWC-22 scans a text to determine the share of words associated with conflict, based on a dictionary made up of words (e.g. "enmity"), word stems (e.g. "hostil*") and phrases (e.g. "bad blood"). The same process applies with respect to all reference dictionaries. The CD and other built-in dictionaries are automatically available to all LIWC-22 users, but their full content cannot be reproduced here for copyright reasons. For further details on the development and psychometric properties of LIWC-22, see Boyd *et al*. (2022).

As is the case of all computerised content-analysis programmes, LIWC-22 is neither objective nor infallible. All reference dictionaries are a product of choices and are certain to omit pertinent terms, while often including dubious ones. Coding mistakes may result from polysemic words and the use of sarcasm, *inter alia* (Tausczik and Pennebaker 2010, p. 30). However, the use of this automated software has revolutionised securitisation scholarship by eliminating the risk of human error in the scanning of large documents, by advancing a gradual rather than binary understanding of securitisation, and by ensuring full methodological transparency and therefore comparability with other studies (Baele and Sterck 2015, p. 1129).

Details on the LIWC-22 built-in dictionaries that we used are as follows. The "positive tone" and "negative tone" dictionaries encompass 1020 and 1530 entries, respectively. For its part, the "health" dictionary (HD) comprises 715 terms. Finally, the aforementioned CD is made up of 305 terms. As for the two custom-made dictionaries that we employed, which are also available to LIWC-22 users, the Security Language Dictionary (SLD) comprises 226 terms, whereas the Threat

Dictionary (TD) is made up of 240 terms. A full list of terms can be found in Baele and Sterck (2015, pp. 1135–1137) and Choi *et al*. (2022), respectively.

Upon inspecting each of the three security-oriented dictionaries, it became apparent that potential errors may arise both from the inclusion of terms with a rather diffuse security connotation (e.g. "resources", present in the SLD) and from terminological gaps. Some relevant security-related terms are covered by all three dictionaries (e.g. "threat"), whereas others are only identified by two (e.g. "threats") or by one of them (e.g. "hostile", "epidemic" and "surveillance"). For this reason, we decided to apply the three security dictionaries simultaneously.

In terms of format, all our selected texts were harmonised so as to optimise LIWC-22's accuracy and ensure a level playing field for subsequent comparisons. Content outside the main body of the respective documents was removed. This includes, where applicable, title pages, tables of contents, forewords, acknowledgments, annexes, footnotes, headers and footers, and meeting details or other superfluous formal information. Several written versions of SOTEU speeches included sub-headlines, which were eliminated as well. When documents featured pull quotes, they were also removed in order to avoid duplications. Executive summaries, conversely, were preserved because they do not constitute mere content duplications and convey the authors' main messages, thus being particularly relevant from the prism of securitisation theory.

5 Conclusion

5.1 Findings and theoretical implications

In this PhD thesis, I set out to answer two main research questions: (1) to what extent and why have prevailing perceptions on the EU as a global health actor changed as a result of the COVID-19 pandemic, and (2) how has the EU's global health policy become integrated into and shaped an evolving EU external action. The dissertation had a wide array of goals, as outlined in the Introduction. However, three of them were always conceived as preeminent, given that they are most representative of my original motivation and speak most directly to my overarching research questions. These are the following: challenging the frequent perception that the EU does not constitute a global health actor, expanding the literature on health as an area of EU external action, and drawing on global health to explore the EU's evolution as an international actor. To begin with, I sought to demonstrate that misperceptions about the EU's role in global health were indeed prevalent, and I did so by delving into the existing literature on the EU as a global health actor. This effort yielded three key findings. Firstly, that very few existing studies assessed EU actorness in global health, which is revealing in and of itself. Secondly, that those that did reached ambiguous conclusions at best. And, thirdly, that other studies identifying global health actors tend to overlook the EU, at least before the COVID-19 pandemic. As I argue, this is an unfortunate symptom of several underlying assumptions that shape – and often cloud – our understanding of global health as an area of international politics, on the one hand, and the EU's external action in health and beyond, on the other. I propose to discuss some of these assumptions below, in light of the insights obtained from my three publications, and later return to my overarching research questions.

Global health as international politics

Before COVID-19, global health was not widely recognised as an important area of international politics, and it is unclear whether the pandemic has fundamentally changed this. To illustrate the low salience of global health at EU level, one needs to look no further than the Eurobarometer surveys, where questions on this matter suddenly proliferated as a result of the pandemic, but have already started to subside. In April-May 2022, when the peak of the COVID-19 crisis was still fresh in everyone's memory, just 13% of EU citizens polled answered that addressing global

health issues should be one of the top three priorities for the EU in that given year (European Commission, 2022b, QC8). Out of the fifteen domestic and international challenges that the poll presented, only three received fewer votes.[1] In principle, this could mean at least one of two things. The first would be that citizens reject the development of a common EU health policy, which is certainly not the case, as Eurobarometer surveys consistently prove.[2] The second, much more likely explanation is that citizens' interest in the domestic (national or EU-wide) state of public health does not translate into a normative consideration of *global* health as a cornerstone of international affairs and the EU's contribution to the world. Instead, global health is recurrently framed as something that can *ephemerally affect*, rather than *systematically affect and be affected by*, the EU (see White, 2023).

Despite only touching on public opinion sporadically, this dissertation asserts that academic researchers, political commentators, policymakers and the wider public all contribute to the social (re-)construction of shared "ideas, notions, expectations and imaginations" (Allen & Smith, 1990, p. 22). From this constructivist perspective and a post-positivist epistemological stance, I hold that whether and how academics connect health to international relations is significant, as any prevailing understandings can have performative effects and thus perpetuate themselves. I reflected upon the belated scholarly awakening to the "global politics of disease" (Rushton, 2019, p. 5), noting some encouraging signs in IR's recognition of health as a legitimate field of study, but also finding that bursts of academic attention tend to align – and possibly reinforce – the "cycle of panic and neglect" that characterises policy responses to health challenges.[3] Despite the shift from "international" to "global health" bringing more attention and resources to this policy realm, I noted that health systems strengthening and sector-wide approaches have lost much of their appeal, relatively speaking (IHME, 2023, p. 56). I also showed that the term "global health" has been closely associated with a "health security" approach, not without controversy.

My empirical research represents, to some extent, a case study of this shift: I found that the COVID-19 pandemic accelerated the EU's discursive promotion of a health-security nexus, at least

[1] This survey was heavily influenced by Russia's February 2022 full-scale invasion of Ukraine, which explains "defence and security" being identified as the top priority. However, other options that do not relate to the invasion or only do so tangentially also received more votes than global health. These include migration, working conditions and equality, unemployment, environmental issues and climate change, and terrorism. Many of these issues actually have a global health dimension, but this is not often recognised.

[2] Since 2021, support for a common EU health policy has been consistently high, although it has declined slightly and continuously from 72% (European Commission, 2021, QB6.8) to 63% (European Commission, 2024a, QB2.8).

[3] It appears to be no coincidence that the only three publications with a systematic analysis of the EU's global health actorness (Battams et al., 2014; Guigner, 2012; Rollet & Chang, 2013) were released shortly after the first informal EU strategy on global health (European Commission, 2010), which in turn followed a series of health crises.

at some institutional levels. This dovetails with a larger propensity to frame policy domains in security terms – a phenomenon that was already identified by the early securitisation theorists of the Copenhagen School (Buzan et al., 1998). As Drezner (2024) put it more recently, "from climate change to ransomware to personal protective equipment to critical minerals to artificial intelligence, everything is national security now", which reflects a widespread perception that "labeling something a matter of 'national security' automatically elevates its importance". This intensifying trend is eroding the traditional distinction between "high politics" and "low politics", which has lost much of its meaning (see Hill, 2003, p. 4; Kissack, 2010, p. 485; Youde, 2016, p. 157). Having said that, my research also demonstrated that the magnitude and speed of these changes should not be exaggerated. Even if some policy entrepreneurs might be tempted to play the "securitisation card" (Elbe, 2011) to underpin the salience of their respective fields, that does not mean that the foreign policy community will automatically buy into said attempts and internalise the field as one of their own.

Although "global health" is now a consolidated term, agreeing on a precise definition remains difficult. I favoured those interpretations of the concept that remain as "normatively agnostic" as possible – that is, those that are not prescriptive and can therefore encompass all entities that have an *impact* on the health of humanity and the world, be it positive or negative. This is not because I seek to advance a relativistic approach to global health that blurs the line between propitious and harmful actions, as I do recognise that in many cases the line can and *should* be drawn clearly. Rather, it is precisely because I am concerned about deleterious effects that this thesis advocates a broader definition that can bring them into light. I also recognise, however, that positive and negative actions are often difficult to distinguish, as exemplified by some intense debates about how to manage the global response to the COVID-19 pandemic (e.g. on border closures, or on vaccine access and IP rights). If we broaden the analytical lens and look at "health in all policies", as the EU has committed itself to do, the political nature of global health becomes even more evident. This holistic understanding exposes states and other governance actors to a more critical evaluation of their policy priorities, with scholars often pointing, for example, at the EU's neglect of health in its trade policy. In terms of budget allocation, the silver lining for these entities is that the relationship between health policy and other areas (e.g. climate policy) is not to be regarded as a zero-sum one. Another factor to consider is that, as barriers between policy areas crumble down, a health-focused cost-benefit analysis also becomes harder to perform, which can impinge effective policy evaluation.

In this dissertation, and most explicitly in Publications 1 and 2, I took the view that conceptualising global health in a holistic way is not so much a choice as it is a necessity.

Fortunately, IR scholarship is slowly but surely coming to appreciate the countless overlaps between health and other policy domains, which makes global health governance amenable to being defined as a "regime complex" (Raustiala & Victor, 2004; see also Fidler, 2010; Leon, 2015). I described at great length the "hybrid" nature of this complex (Abbott & Faude, 2022), drawing on an evolving understanding of global governance that looks beyond states and traditional, state-based IOs (e.g. the WHO) to consider also non-state actors, PPPs and informal IOs. Despite paying tribute to this academic progress, I confirmed that much work still needs to be done to break down scholarly silos, conduct empirical research on non-conventional actors and diversify geographical perspectives. In addition, I called for letting go of some deeply ingrained theoretical assumptions about international politics – chief among them, the predominance of the "states systemic project", whose state-centrism even mainstream constructivists have been reluctant to overcome (Wendt, 1999, pp. 8–10). Scholarship combining global health (a highly diverse governance domain) and the EU (manifestly not a state) would seem to present a least likely scenario for such predominance. Yet, at times it also falls prey to this theoretical inertia, as we will see in the following sub-section.

EU external action: health policy within a dynamic framework

That EU external action is about much more than just CSDP and CFSP is not a contentious take. Furthermore, even if I have suggested that Hill's (1993) "capability-expectations gap" has sometimes given way to an "expectations-capability gap" that underestimates the EU's global influence, most observers still accept that the EU plays a meaningful role in world politics. For many scholars, in fact, the second point is a corollary of the first. While CSDP and CFSP remain primarily intergovernmental domains where integration has proven elusive, it can be argued that it is mostly through other treaty-based areas of external action – especially through trade, with its supranational character – that the EU leaves its footprint in the world. That is the rationale behind economistic readings of the EU's global impact, such as "Market Power Europe" (Damro, 2012) and the "Brussels Effect" (Bradford, 2020), which frame this impact mainly as an outcome of the EU's significant market size.

This scholarly strand has done much to advance our knowledge on the EU's external action and, consequently, I drew on it extensively throughout this PhD. In her influential book, Bradford (2020, pp. 171–206) even hinted at some reasons why those who study the EU's global health policy should be interested in the "Brussels Effect". However, overly legalistic arguments still prevail. Bradford herself, who sides with neofunctionalists in claiming that policy entrepreneurs or "competence-maximisers" have often succeeded in circumventing treaty-based constraints

(Bradford, 2020, p. 17), somewhat surprisingly observes that "the EU's global regulatory power is limited to policy areas in which the member states have ceded either exclusive or shared regulatory competence to the EU" (Bradford, 2020, p. 37). This, of course, is not the case of health policy, where the EU generally only has supportive competence. But it is precisely this kind of "silo" mentality that, as I contended above, academics should strive to overcome (see also Kickbusch & de Ruijter, 2021, p. 1; Schunz et al., 2018, p. 8), because the EU already does so in practice through a myriad of spill-over effects among policy areas.

My contribution to the literature on the EU's external action was largely anchored in the concept of "actorness", whose prolific history spans over five decades. I share Drieskens' (2017) view that the concept should not be discarded but revisited, partly by clarifying its relationship with other notions such as "presence", "effectiveness" and "performance". In taking this angle, I was inspired by other scholars who have explored the outward effects of internal EU policy areas – especially, by those who have claimed that legal competence is not a prerequisite for actorness (Schunz et al., 2018, p. 240). I noted, however, that global health is very much under-researched as one of those internal policy areas. It is also unfortunate that the few studies taking "actorness" as their point of departure when investigating EU policies in global health do so by reproducing overly legalistic interpretations, to some extent conditioned by their usual reliance on Jupille and Caporaso's (1998) set of "actorness" criteria.

Similarly, I joined some scholarly efforts to provide nuance to other longstanding assumptions about the EU's global influence. These include the "'one voice mantra' correlating 'EU unity' and 'EU influence' in the global arena" (Macaj & Nicolaïdis, 2014, p. 1067). I postulate that this "mantra" derives from state-centric IR approaches that trickle down into EU studies and romanticise conventional state-like attributes (i.e. hierarchical structures) at the expense of more horizontal, polyhedric forms of governance. Another widespread assumption is the EU's supposed preference for multilateral action, which Bradford (2020) and others have examined critically, in the context of COVID-19 (van Schaik et al., 2020) and beyond (Costa, 2013). I add a further caveat: when the EU does pursue a multilateral path, we should not presume that it will champion traditional forms of cooperation, either through states or through state-based IOs like the WHO. This inclination is generally understood to arise from the fact that the EU constitutes in itself a state-based multilateral project. However, I found that the EU's *sui generis* character complicates the picture, as Brussels-based institutions are also receptive to diverse governance models that may allow the EU to have a seat at the table even when lacking exclusive competence (and thus the right of collective external representation, which the European Commission already enjoys fully at the WTO and partially at the FAO). As I show, this is very much true in global health,

where the EU supports the WHO rhetorically and financially, while at the same time backing other partially competing institutions and frameworks that are more amenable to the EU's direct input.

Through the course of this dissertation, I have shown a combined interest in what the EU *does*, what is *says*, and what it *is*, built on the premise that these three dimensions should not be seen as separable but as co-constitutive (see Wendt, 1992, p. 24). I acknowledge, however, that tensions between them – and even within them, as attested by the EU's frequent discursive contradictions – can often arise. Aside from my previous point about the EU's multilateral essence and how said essence translates imperfectly into its external behaviour, another example of this intricate relationship stems from my exploration of the EU's discursive practices of "collective securitisation" (Floyd, 2019; Sperling & Webber, 2019) in the realm of global health. I explained why these practices could clash with the EU's self-perception as a global health actor and its post-COVID-19 resolve to adopt a leadership role, as expressed in its 2022 Global Health Strategy. Moreover, I discussed these findings by considering the EU's broader transition towards "principled pragmatism" in its external action, claiming that this new mindset can be compatible with a "health security" framework, but arguably less so with the EU's long-avowed preference for cultivating a relatively open and benign image on the international stage. I therefore conclude that, while the EU has advanced towards a more mature "sectoral diplomacy" (Schunz et al., 2018, pp. 18–21) in global health, we cannot ignore some manifestations of cognitive dissonance or "ontological insecurity" (Mitzen, 2006) in its global health policy and beyond,[4] making this maturation only partial.

Revisiting my overarching research questions

In the Introduction to this PhD dissertation, I visualised the degree to which my three publications engaged with my two overarching research questions (see **Grid 1**). While none of these overarching questions – nor their respective sub-questions – appeared explicitly in the three publications, I did offer some implicit answers to them. In **Grid 2**, below, I summarise these answers and draw a link to the PhD components that inform them most clearly. The list of answers that the grid provides is not exhaustive, and only includes those that I believe best illustrate the focus of this PhD and its different components.

[4] Ontological insecurity is defined as "the deep, incapacitating state of not knowing which dangers to confront and which to ignore, i.e. how to get by in the world. When there is ontological insecurity, the individual's energy is consumed meeting immediate needs" (Mitzen, 2006, p. 345). The EU's global health policy and broader external action, both often in need for a compass, tend to exemplify this phenomenon.

Grid 2. *Answers to my overarching PhD research questions and their respective sub-questions.*

RQs	Answers suggested in the three PhD components [publication number]
RQ1: To what extent and why have prevailing perceptions on the EU as a global health actor changed as a result of the COVID-19 pandemic?	• External perceptions of the EU as a global health actor are highly diverse. The WHO views it as a close partner, occasionally even on par with Member States, as exemplified by the ongoing negotiations on a pandemic agreement. Governments, especially in the Global South, tend to view the EU as an important but often hypocritical actor – a perception that COVID-19 exacerbated **[1, 2, 3]**. • From a scholarly lens, the EU's impact in global health has been underestimated, as a holistic approach to this field and to EU external action remains rare. COVID-19, however, generated a wave of interest, even if it might be short-lived **[1]**. • The EU's self-perceptions as a global health actor are in flux and institutionally dependent. The Commission used to barely perceive itself as one, mainly because of its modest legal competence. Since 2010, and especially since the COVID-19 outbreak, it has become more assertive and even tried to fashion itself as a leader, but also placed more emphasis on the EU's self-interest **[1, 2, 3]**. • **Sub-question: In what ways do the EU's self-perceptions converge or diverge from the perceptions of external observers?** The EU is not widely seen as a leader in global health, but there is growing internal and external recognition that its economic and diplomatic weight make it a key actor almost by default. External perceptions (academic or otherwise) matter because the EU often responds to expectations about its behaviour and cares about its image in the world **[1, 3]**.
RQ2: How has the EU's global health policy become integrated into and shaped an evolving EU external action?	• Over recent years, the EU's global health policy has been declared and somewhat institutionalised as an integral part of a more variegated EU external action, which nowadays transcends CSDP, CFSP and other traditional areas and comprises a wide array of consolidated or burgeoning sectoral diplomacies. Many of these are often linked (e.g. health and climate change) and framed in security terms **[1, 3].** • The pragmatic and geoeconomic turn of the EU has permeated its global health policy through a renewed emphasis on strategic autonomy and de-risking, which at times can clash with and take precedence over openness **[2, 3]**. • Although supranational policy entrepreneurs have sought to securitise health, other areas of EU external action continue to be prioritised over it, and the EU's foreign policy community is yet to fully internalise this area into its agenda **[3]**. • **Sub-question: What does the EU's approach to global health reveal about its engagement with contemporary forms of global governance?** While the EU has repeatedly called for reinforcing the WHO, it also engages strategically with non-conventional (and more institutionally accommodating) actors conforming today's global health regime complex. Many of these actors are more "liberal" than the WHO, but not always aligned with the EU's substantive preferences **[2]**.

5.2 Limitations

The research conducted for this PhD dissertation contains several limitations, which can be divided into two main categories. On the one hand, there are concrete shortcomings related to the approaches taken, the methods employed and other substantive elements pertaining to each of the three components of this dissertation. On the other, there are broader constraints imposed by key decisions concerning the overall design of the thesis and the publication strategies used for the three components. I label these two types of limitations as "substantive" and "structural", respectively, and I will next examine each category in turn, highlighting some interconnections.

Substantive limitations

A first substantive shortcoming of this PhD is that none of the publications devote much space to discussing their respective limitations. In the case of Publication 1, a list of shortcomings is conspicuous by its absence, whereas Publication 2 discusses a few in passing or mentions them in footnotes. This, however, remains insufficient. In the case of Publication 3, several limitations are grouped together and addressed explicitly within a concluding section, but I disregarded a few important ones. Although, to some extent, these omissions can be attributed to structural constraints discussed in the following sub-subsection (i.e. word limits, or the fact that my articles/book chapter are standalone publications and cannot reflect on their role within a doctoral thesis), the oversight is not entirely justifiable and demands a remedy. The current sub-section seeks to provide it.

In Publication 1, the methodological approach that I took to my literature review – as explained in the Introduction to this PhD – was very comprehensive, but still incomplete. My reliance on Google Scholar, which is not a bibliometric database even if its coverage is remarkable, necessarily influenced my search results. Although any other choice would have also been questionable, an external reviewer noted that results drawn from a database specialising in IR or EU studies scholarship might have lent more weight to my literature survey. Moreover, my search string could have been more expansive, as the same reviewer observed. In response to these objections, I countered that I carried out multiple searches through the "Publish or Perish" software, which retrieves academic publications stored in Google Scholar, as well as other databases like Scopus, Web of Science and PubMed. I tested several search engine and search string combinations, eventually settling on this one because it offered the best balance of accuracy and breadth (175 studies were found). Although I examined the output of other combinations to avoid relevant omissions, it is still possible – if unlikely – that I failed to identify some studies

meeting my selection criteria. These criteria, furthermore, were rather narrow: I could have also reviewed in detail those publications that looked at the EU's global health actorness in a less systematic way (Anghel & Jones, 2023; Vandendriessche et al., 2023) or that approached the subject from the lens of EU "performance" (van Schaik, 2009, 2011) or "effectiveness" (Battams & van Schaik, 2016). For reasons that I will outline in the following sub-section, I conducted my search almost two years ago (on October 4th, 2022), which is not ideal for the purposes of this dissertation. However, I have stayed up to date with the literature and, to the best of my knowledge, no eligible studies have been published since. The only partial exception is a very recent book by Rollet (2024), assessing EU actorness in global health but considering the European Parliament only. A final observation about Publication 1 concerns its very nature: it is a "research agenda" based on a "meta-analysis" of existing literature, rather than an orthodox journal article presenting original empirical research.

Publication 2 does highlight a few limitations, particularly in terms of the availability of documents and parliamentary records. Those will not be repeated here, but I would like to mention some additional caveats. The first is that our analysis of national strategies on global health – circumscribed to France, Germany and the Netherlands – could have encompassed other countries that, despite not having an explicit global health strategy, have published narrower strategic documents with a global health orientation.[5] Furthermore, our search of parliamentary records targeted some EU countries and not others partly because of some previous knowledge about the quality and availability of their respective record-keeping. While we acquired this knowledge rather recently from a parallel research endeavour (Kissack et al., 2022), it was probably somewhat biased and incomplete. Another limitation is that our engagement with civil society was not as wide-ranging as we would have hoped. Instead of grounding our empirical research exclusively on a "shadow global health strategy" released by six NGOs, it would have been pertinent to investigate other forms of input by these and other civil society actors. Lastly, we could have implemented different methods – such as interviews – to gauge the positions of the different stakeholders involved in the strategising process.

As I said before, the Conclusions of Publication 3 recognised several limitations arising from its methodology and analytical framework. To those, I shall add that the period of study was not long enough to evaluate whether COVID-19-related securitising moves are being sustained in time,

[5] Van Schaik et al. (2020, p. 1149) mention Sweden as a country that has published a global health strategy. We were unable to find one, but we speculate that they refer to Sweden's various strategies for cooperation with the WHO, the most recent of which was drafted for the 2021-2025 period (Government of Sweden, 2021).

although this problem was impossible to resolve. A less intractable methodological issue is that, when presenting the frequencies of the different referent dictionaries in the texts analysed, the LIWC-22 software favours relative rather than absolute numbers, therefore controlling for the length of the text. This is the standard approach to quantitative content analysis, and for good reason, as it ensures a proper contextualisation of code frequencies as well as comparability between texts. However, a more complete approach would have entailed presenting the percentage figures together with a raw count, thus opening the black box regarding the length of the texts. From a more theoretical lens, the discussion of my findings could have complemented principal-agent theory with other theories of preference formation that transcended rationalism and were more aligned with my broad social constructivist stance.

In addition to the limitations found in each of my publications, I would like to note four substantive shortcomings that are transversal to this PhD thesis. Firstly, although Publication 3 heeded my own call to use "actorness" as a conceptual tool when studying the EU's activities in global health (see Publication 1), this yielded what can only be described as a modest attempt, with actorness criteria being explained very briefly and explored in a rather shallow way.[6] It would have been desirable to devote a full publication, or at the very least a full section of a given publication, to perform this analysis in a more rigorous and thorough manner. Secondly, despite the European Parliament's secondary role in health policy, I should have paid more attention to it as a global health actor and I salute Rollet's (2024) recent contribution to the scarce literature on this subject.[7] Thirdly, turning to methodological issues, while I have already reflected on my less than productive interview efforts and on how I circumvented this obstacle, I shall add here that many of the interviewees I targeted could have informed both Publication 2 and Publication 3. This makes the opportunity cost higher and my lack of success more unfortunate. Lastly, it is also much to my regret that I did not conduct a case study on the EU's engagement with other global health actors. Looking beyond the WHO, the EU's relationship with the Gates Foundation, for example, is very poorly understood. As I will explain later, this is an avenue of further research that I seek to pursue in the coming years.

[6] Moreover, I did not justify at length my selection of Jupille and Caporaso's (1998) criteria. This choice owed mostly to the lack of available space to properly conduct the contextual analysis that would be required by Bretherton and Vogler's approach (1999, 2006), which I favoured in Publication 1.
[7] The European Court of Justice is another "competence-maximiser" (Bradford, 2020, p. 17) that has helped to solidify the EU's role in public health, but its importance has already been explored to a great degree in the literature (see, for example, Greer, 2006), if not explicitly in this PhD thesis.

Structural limitations

The structural limitations of this PhD thesis have to do, first and foremost, with my strategic choice to pursue a paper-based dissertation. This is not to say that, in hindsight, I would have made a different choice. On the contrary: this decision proved fruitful, as it allowed me to learn how to navigate the publication pathways of academic journals and other scholarly platforms. It also compelled me to frame and present my research more concisely, while exposing me more frequently to feedback from external reviewers.

However, the drawbacks of this approach cannot be ignored. As expected, I found it more challenging to provide this PhD dissertation with a smooth pace and a coherent narrative, even if I strived to weave the pieces as seamlessly as possible and to fill the gaps with the Introduction and this concluding chapter. In addition, some limitations are intrinsic to the usual timelines and peculiarities[8] of academic publishing. Although a cutoff point for empirical analysis is always required, the entire publication process can potentially drag on for months or years. This was the case of Publication 1, where the protracted gap between the literature review and the eventual publication date is due mostly to the time spent in finding a suitable framing and academic outlet.[9] Similarly, Publication 2 does not analyse the Council Conclusions on the EU's 2022 Global Health Strategy because, despite being adopted in early 2024, that was already too late to include them in the book chapter.

Furthermore, space constraints imposed by the different publishers resulted in some unwelcome omissions. This is particularly true, once again, in the case of Publication 1, which was originally conceived as a standard journal article but was later reframed as a research agenda, facing an even stricter word count. Peer-review was a highly rewarding process that greatly increased the quality of my publications. However, it sometimes yielded feedback that I addressed in ways that did not necessarily reflect my best judgment concerning the substance of the publications in question. For example, I resolved to omit methodological details in Publication 1, not in response to a direct request but as a means to circumvent a few objections raised during peer-review, some

[8] A minor limitation concerns the different formatting and referencing styles mandated by the academic outlets to which I submitted my articles and book chapter. I inserted the texts into this dissertation by respecting the formats in which they are published or accepted. As a result, an attentive reader will have noticed some stylistic discrepancies between them. The Introduction and the Conclusion do follow an identical format, with a combined bibliography available in the next chapter.

[9] The publication received two desk rejections by academic journals. The first one was due to the article consisting of a literature review and research agenda that did not introduce novel empirical research, and the second one to the editors' refusal to publish any further COVID-19-related articles.

of which I referred to in the previous sub-section. I remain, of course, fully responsible for these tactical decisions and for any errors or lapses that the three publications might contain.

One of the greatest privileges of this dissertation is that two of its components were developed within broader collaborative endeavors. Publication 2 is part of an edited volume, whereas Publication 3 is featured in a Special Issue. This had tremendous benefits for the substance of my publications, as the editors conceived very robust theoretical frameworks to ground my research on, and the colleagues who joined me in those collaborative projects offered an additional layer of constructive feedback. Notwithstanding that, it must be said that working with pre-established theoretical frameworks somewhat limited the originality and creativity of my own contributions, even though I customised those frameworks to fit my specific research needs. Moreover, both the edited volume and the Special Issue imposed tight deadlines that, at times, prompted me to prioritise pragmatism at the expense of comprehensiveness. As I mentioned in the Introduction, this was the case of Publication 3, where I might have further pursued my interview efforts had time constraints not been a factor.

Publication 2 resulted from an even more intense collaboration, as it was co-authored with the supervisor of this PhD, Dr. Robert Kissack. His involvement greatly enriched the research experience, as he played a critical role in framing the article and carrying out the empirical analysis, as well as throughout the drafting stage. Of course, this is not a limitation of our research output – on the contrary, it only made it stronger. However, inasmuch as this publication is part of a doctoral dissertation, it is only fair to acknowledge that the co-authorship format did limit the extent of my individual contribution in the research work.

5.3 Avenues of further research

While this PhD project always sought to produce a well-rounded body of work that stood on its own, it is also a forward-looking one. My research and its limitations unveiled several lines of further inquiry that I have already decided to pursue in the coming years, or that I hope to pursue at some point in the future and I also encourage other researchers to pick up. I will begin by outlining the ones where preliminary work is already underway and then move on to those that remain more speculative.

As has been said, the research informing this doctoral dissertation was conducted within ENGAGE, a Horizon 2020 project funded by the European Commission. Although the project officially came to a close in June 2024, its output did not: subsequent work includes the

preparation of a Special Issue proposal involving several researchers affiliated with the project. This Special Issue will focus on the following topic: "strategising European security: what can we learn from twenty years of EU strategic documents?". I will be contributing to this Special Issue with an article on the EU's 2022 Global Health Strategy, which will dive into the EU's rationale for adopting said strategy after COVID-19 (thus updating a 2010 Commission Communication) and for establishing the content of the strategy (including its clear links with security matters, as laid out in Publication 3). Methodologically, the article will draw on some interviews that were originally conducted for Publication 3 as well as on additional ones, with an eye on gaining further insights from European Commission policymakers and other actors involved more indirectly in the strategising process, such as NGO and think tank representatives. I will also assess the degree to which this strategy has informed the broader EU policy system – that is, whether/how "health mainstreaming" has taken place and whether/how key actors (e.g. the EEAS) besides the Commission DGs in charge of the strategy have internalised the notion that global health represents a key area of EU external action.

Beyond this outstanding ENGAGE-related commitment, this PhD will transition smoothly into further research endeavours and publishing opportunities, such as another Special Issue proposal on "EU support for global governance in a contested world". My own contribution to this Special Issue is already taking shape, under the provisional title of "Navigating regime complexity in global health: the role of the European Union". I will be considering two interconnected questions: to what extent has the EU fostered regime complexity in global health governance, and to what extent has it benefitted from it? The article will postulate four ideal typical roles for the EU: creative disruptor, self-defeating entrepreneur, inadvertent beneficiary and passive onlooker. I will explore these potential roles by focusing on key EU institutions (e.g. the European Commission and the EEAS) and relying on strategic documents, as well as interviews with officials and experts. Among my primary goals will be shedding light on the under-researched links between the EU and prominent PPPs and non-state actors in global health (e.g. Gavi and the Gates Foundation). In its essence, this suggested contribution evolved organically from Publication 2 of this PhD, and many of the interviews that will be conducted for the article mentioned in the previous paragraph will feed into this article as well.

Aside from these contributions, I will be involved in other research projects that will offer an opportunity to explore many issues that dovetail with this PhD dissertation. These include three reports on global health governance, all of which will pay particular attention to the EU's role in health-related multilateral frameworks and negotiations. The first report will address vaccine access and equity, with a second one focusing on the pandemic agreement currently being

negotiated under WHO auspices, and a final one tackling the reform of the WHO's financing and governance structures. Writing these reports will require regular visits to Geneva, where I will meet with officials involved in the now-abandoned WTO negotiations on IP rights (impacting vaccine access and equity), the WHO-facilitated update of the IHR, and the ongoing conversations about a potential pandemic agreement and further reform of the WHO. From each report, three journal articles will be developed for inclusion in another Special Issue proposal, dedicated to the theme of "global governance transformation".

These commitments will still provide space for the pursuit of additional research avenues that emerged from this PhD. One avenue that I have already begun to explore concerns public opinion. This is an area that I would have wished to investigate further in Publication 3, where the inadequacy of existing polls and surveys – as well as time and space constraints – forced me to overlook citizen responses to the securitising moves undertaken by EU actors in the context of COVID-19. More specifically, I would like to probe into the acceptability of "One Health" as an integral approach to health security that the EU has actively promoted. Health literacy is a critical precondition of a successful One Health strategy: for example, measures aimed at mitigating climate change and rampant deforestation, fighting AMR, curbing wild animal breeding and trade, and promoting healthy and sustainable food chains all demand societal buy-in, within and beyond the EU. Yet, it remains unclear whether public perceptions make the "One Health" strategy socially acceptable. To bypass the lack of suitable polls and surveys, I could rely on survey experiments and/or draw on news coverage of COVID-19 worldwide, assessing the degree to which it embraced a One Health perspective. This could be accomplished by relying on the Global Database of Events, Language and Tone (GDELT), as I did in past quantitative research focused on security and defence in the EU (Fernández et al., 2023), building on a well-established connection between media coverage and public opinion, particularly during crisis times (see Herbst, 1998; Kepplinger, 2007). Furthermore, interviews with policymakers could provide clarity on the public's role in mainstreaming One Health, at both the European and the international levels. By probing into the social resonance of One Health as a key vector of the EU's global health policy, I would contribute to a growing literature on the acceptability of the norms underpinning the EU's external action (see Michaels & Kissack, 2021), where taking an outside-in perspective is direly necessary too (see Keukeleire & Lecocq, 2018).

With a longer time horizon in mind, I propose to dive into two further issues that transcend the realm of global health, but still relate to the EU. Firstly, I see great potential in connecting securitisation studies to theories of European integration, since those links have not yet been fleshed out explicitly. While scholars have identified EU practices of "collective securitisation"

(Floyd, 2019; Sperling & Webber, 2019), some of which I explore in Publication 3, we still know very little about the conditions under which supranational EU actors are successful in playing the "securitisation card" to gain further competences (a mechanism that would be consistent with neofunctionalist theory). It is highly plausible that, under some (if not most) conditions, a transnational referent object remains elusive and the audience of securitising moves interprets them purely from a national lens. This might cause any supranational efforts to securitise an issue to inadvertently underpin the authority of Member State governments – an outcome that would be more congruent with the premises of liberal intergovernmentalism.

Finally, one of the main drivers of this PhD project, from its very inception, has been a critical engagement with Hill's (1993) "capability-expectations gap" in EU foreign policy. I accept that a capability-expectations gap used to prevail or still prevails in some areas of EU external action, but I also claim that nothing in Hill's conceptual framework precludes the opposite phenomenon from arising: what might be called an "expectations-capability gap". As I mentioned both in the Introduction and in Publication 1, Hill himself acknowledged that such a pendulum swing was possible (Hill, 2007, pp. 4–5). On this matter, I fully concur with Moravcsik (2017), who regretfully notes that "sixty years after the Treaty of Rome, many view Europe as a spent force in global politics" and believe that "Europe's role is secondary – and declining". Just as a capability-expectations gap is not innocuous, neither is an expectations-capability gap. To be sure, concealing the extent of its actual capabilities can help the EU to sidestep accusations of "liberal intrusiveness" (Börzel & Zürn, 2021) or regulatory and cultural imperialism (for a summary of these accusations and possible counterarguments, see Bradford, 2020, pp. 247–253). However, as argued in Publication 1, an expectations-capability gap can pose significant dangers, hindering a careful evaluation of the EU's actions abroad and disrupting an optimal division of labour across the EU policy system. It would be highly instructive to conduct empirical research to examine the prevalence of an expectations-capability gap, establish whether this prevalence has shifted due to the EU's response to recent external shocks (such as COVID-19 and Russia's full-scale invasion of Ukraine), and identify which areas of EU external action are more susceptible to this gap. Moreover, there is untapped potential in uncovering the performative role of Hill's 1993 concept – which Larsen (2020) shows that academics have incessantly and uncritically reproduced – in bringing about its mirror image, in scholarly circles and beyond (see Larsen, 2020, p. 963).

5.4 Final remarks

To say that the COVID-19 pandemic was a watershed event in global health governance would be an understatement. It was, by far, the most salient health crisis of our lifetimes, even though we

should never disregard the health implications of military conflicts and economic downturns, and even though other epidemics and pandemics also had colossal effects, decisively shaping today's global health landscape. With this PhD thesis, I embarked on a three-year journey to better comprehend the role that the EU plays within this governance architecture, how this role changed after COVID-19, and what lessons can be drawn from it about the EU's broader external action. The journey was a highly satisfactory and productive one, and I believe I managed to attain my fundamental goals. As I initially expected, the three PhD components underwent continuous adaptations, but I strived not to lose sight of how they spoke to one another and how they could help me answer my overarching research questions. Furthermore, I am under the impression that the EU studies community was receptive to the focus and framing of this dissertation in academic conferences and workshops. I do fear, however, that attention towards this field will be too short-lived, at least until the next high-profile health crisis hits. This is a cause of concern not only because insufficient academic and public interest may leave us unprepared for a looming age of pandemics, but because we must conceive global health as a relentless struggle to prevent and respond to health risks, regardless of their nature. In other words, the EU's health policy should be about the continuous and cooperative provision of (global) public goods, instead of circumscribing itself to scenarios framed as immediate emergencies and threats.

Guided by a holistic understanding of global health, I maintain that the EU has had a significant impact on this area for decades, and that this influence preceded most scholars' and even policymakers' awareness of it. The EU *is* a global health actor and, in a practical sense, it has been one for a long time. That does not imply that it always defines its aims openly and clearly, or that – when defined – these aims are easy to reconcile with its larger foreign policy agenda, or with the priorities and needs of other actors. I have remained rather critical of the EU's role in global health, pointing out its frequent blind spots and contradictions. In hindsight, the management of the COVID-19 pandemic may seem like a relative success. But, at times, it crudely showcased the EU's short-sightedness and its unwillingness to embrace a positive-sum, *enlightened* version of its self-interest. Through this critical lens, I have also sought to dispel some widespread scholarly assumptions that, in my opinion, hamper our grasp of contemporary international affairs and of how the EU actually behaves on the global stage. While this is not a normative dissertation, I also recognise that academic research – like any other kind of social activity – can lead to tangible change, for better or for worse. The world out there may exist independently from our perceptions, but we contribute to its constant reconstruction through our actions and expectations, inconsequential as they may appear to be.

On this note, while I am very much aware of the modest reach that this PhD thesis will have, it was written as if it were to become a blockbuster. It is my hope that this spirit will continue to inspire my follow-up research on global health governance, as well as my future career in academia. I am convinced that the greatest value of this PhD lies in drawing attention to the many things we do not yet know about EU external action and its interplay with global health. At the very least, I remain committed to persevering in my attempts to ask the right questions about this relevant and fascinating subject.

6 References (introduction and conclusion)

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