'Narrativizing' global health: discursive legitimation strategies in the arena of epidemiological surveillance

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Abstract

The goal of this paper is to discuss discursive legitimation strategies in the arena of global epidemiological surveillance. Literature on global health policies has addressed the increased relevance of epidemic surveillance. However it remains to be discussed in depth which discursive strategies are employed in order to legitimate epidemiological surveillance and intelligence. Departing from Leeuwen's work (2008) concerning discursive legitimation strategies this paper intends to debate how health authorities, namely the European Centre for Disease Prevention and Control, use narrative legitimation tools in order to validate its policy options. The legitimation discursive strategies of authorization and rationalization (Leeuwen, 2008) are addressed in order to understand how political narratives increasingly frame global health issues employing normative representations. The global health discourses developed by the European Centre for Disease Prevention and Control are discussed from the perspective of the legitimation discursive strategies mentioned above.

Key words: health, security, legitimacy, rationalization, authority

1. Discourse, security and public health policies

Health public policies are discussed as having increased global relevance (Lakoff, 2010). The existence of global health institutions, namely the World Health Organization (WHO) or the European Centre for Disease Prevention and Control

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(ECDC), demonstrate how health issues are being subject to global and regional policy regulations (Lakoff, 2010; Ingram, 2010). Discursive practices in the global health arena are constructed in order to legitimize the transfer of policy competences and data from the national to the regional/global levels (see Lakoff, 2010). The handover of health data and policy competences are not the only political factors that need to be discursively legitimated since the content of health policies constitutes the main element that has to be argued and justified in the public arena (Ingram, 2010). The goal of this paper is to discuss discursive legitimation strategies (Leeuwen, 2008) in the arena of global epidemiological surveillance.

Methodologically, we will draw on Critical Discourse Analysis in order to address the articulations between language, discourse and power in the health arena (Fairclough, 2013). We discuss the discursive practices that can be found in selected documents produced by the European Centre for Disease Prevention and Control.

In his book, Theo van Leeuwen (2008, pp.105-123) refers four types of discursive legitimation strategies frequently employed in political discourse, namely, authorization, moral evaluation, rationalization and mythopoesis (Leeuwen, 2008, pp.105-106). The legitimation discursive strategies of authorization and rationalization (Leeuwen, 2008, pp.106-110; 113-117) are particularly important in order to understand how political narratives increasingly frame global health issues employing normative representations (on health global narratives see Lakoff, 2010 and Ingram, 2010).

Authorization is a type of discursive legitimation strategy based on the acknowledgement of a relationship of authority between a community of people and a source of institutional authority (Leeuwen, 2008, p.106). Such source of institutional authority may be invested in a diversity of agents, such as custom, tradition, conventions, law, an individual or an institution (Leeuwen, 2008, p. 106). In what

concerns individual authority, several factors may endow a particular personality with social authority (Leeuwen, 2008, p. 106). Following Leeuwen, personal authority is directly related with the status of individual/individuals or with the role such individual/individuals is/are expected to perform within a particular community (Leeuwen, 2008, p. 106). In this context, authority is fundamentally positional and it is discursively materialized through a language of obligation grounded only on the status or role of who produces the utterance of command (Leeuwen, 2008, p.106). In addition to status and role, individual authority may also be based on personal expertise (Leeuwen, 2008, p. 107). Authority may, moreover, derive from impersonal sources (Leeuwen, 2008, p. 106). Normative frameworks, like norms and regulations, tradition, conformity, social habits and generalized patterns of behavior are impersonal sources of authority whose relevance derives from the historical and /or legal institutionalization of a social practice or belief (Leeuwen, 2008, p. 106). In the case of conformity, authority emerges from the individual imposition of a behavioral or belief pattern that is adopted by the majority of the members of a particular micro or macro community (Leeuwen, 2008, p. 109).

A second type of discursive legitimation strategy concerns rationalization (Leeuwen, 2008, pp. 113-117). Following Leeuwen, there is a strict articulation between rationalization and moralization since all forms of discursive rationalization – instrumental rationalization, theoretical rationalization, experiential rationalization and scientific rationalization – convey beliefs about how human beings should behave (Leeuwen, 2008, p.107). In this context, utilitarian rationalization validates social and political practices emphasizing their "goals, uses and effects" (Leeuwen, 2008, p. 113). Theoretical rationalization, on the other hand, corresponds to an attempt to naturalize a social or political practice providing, through discourse, "explicit representations of the

'way things are'" (Leeuwen, 2008, p. 116). Those same representations can be conveyed through discursive utterances based on "commonsense knowledge", namely proverbs and moral sayings (Leeuwen, 2008, p. 116). This kind of discursive representations can be designated as experiential rationalization (Leeuwen, 2008, p. 116). A last form of discursive rationalization is scientific rationalization that uses as legitimating tool discursive references to "systematic bodies of knowledge", namely scientific disciplines or narratives (Leeuwen, 2008, p. 117).

Since it involves individual and collective behaviour, health policies constitute an excellent arena in order to assess discursive legitimacy tools (Vaz and Bruno, 2003). Legitimacy in the health field is particularly important since public health authorities perform a specific role in what concerns social control: they may establish an intrinsic articulation between care and power (Vaz and Bruno, 2003, p. 273). Behavioural practices and beliefs in the health arena are fundamentally dependent on historical and cultural assumptions (Foucault, 2008; Rose, 2007; Dean, 2010; Vaz and Bruno, 2003). Consequently, public health authorities construct legitimacy by representing themselves not as power agents but as care providers and as neutral epistemic agents that can help individuals to better constitute their subjectivity according to social expectations (Vaz and Bruno, 2003, p.273). Health is, hence, a privileged ground for the reification of metanarratives as well as for the use of discursive legitimation tools (Lakoff, 2010; Ingram, 2010; Foucault, 2008; Rose, 2007; Dean, 2010; Vaz and Bruno, 2003).

Legitimacy in the health arena is also constructed through the establishment of articulations between policy areas (Lakoff and Collier, 2008). In this context, the establishment of an association between public health and security has assumed an increased relevance, particularly since the WHO employed the concept of "global public health security" (WHO, 2007; Lakoff and Collier, 2008). The concept of "global public

health security" normalizes the association between very distinct policy arenas (Lakoff and Collier, 2008). Such association imports into the health public policy domain concepts, discourses, technical instruments and policy practices that were developed and traditionally belong to the national security policy area (Lakoff and Collier, 2008). The introduction of the concept of "global public health security" by an international organization like the WHO also means the carving of a new global arena for health policies (Lakoff and Collier, 2008, pp.7-9). Such new global health arena has a fundamental cross-border dimension (Lakoff and Collier, 2008; WHO, 2007), which is important since, as risk sociologists claim, it is mainly at the border that risks are socially perceived and represented (Douglas, 1992). The concept of "global health security" also comprises a temporal shift in health policies since it favours a pre-emptive approach to health threats, namely threats of a biological kind (Lakoff and Collier, 2008).

In what concerns the European Union, the creation of institutional structures like the ECDC reveals the need to problematize health questions at a European level and to devise common policies in the human and public health arena (Lakoff, 2010; Lakoff and Collier, 2008; Randall, 2010; Greer, 2006). Drawing on Foucauldian literature, Ingram argues that in what concerns the health arena, there is a strict articulation between the process of institutionalization and the process of problematization (Ingram, 2010, p. 297). It is the identification and normative definition of specific public policy problems that determines the shape and functions of the institutional structures that are devised in order to manage them (Ingram, 2010, pp. 297, 298).

In this context, it is noteworthy how the Lisbon Treaty, and specifically the Treaty on the Functioning of the European Union (TFEU) has allocated competences in the health arena (articles 4§k, 6 TFEU). The TFEU states that the EU and member-states

share competences in what concerns "common public health security problems" (article 4§k, Treaty on the Functioning of the European Union). However, in what regards the "protection and improvement of human health", the EU is only endowed with complementary competences (article 6, Treaty on the Functioning of the European Union). These legal dispositions signify that not only the European Union establishes an articulation between health and security, but also that the EU defines its own competence in the health arena based on such articulation (articles 4§k, 6 TFEU; Randall, 2010; Greer, 2006).

The articulation between public health and security is, in fact, fundamental for EU law (on EU health policy see Randall, 2010; Greer, 2006). The free circulation of workers as well as the right of establishment can be halted if public health reasons are argued (article 45§3, 52, Treaty on the Functioning of the European Union). The ECDC is instrumental concerning the creation of a European health arena based on the need to manage "serious cross border health threats" (ECDC, 2014d, p. 6). In addition, article 168 of the TFEU defines that the European Union's actions and member-states' cooperation in the public health arena should pay particular attention to cross-border regions which reveals the establishment of an articulation between territorial policies, surveillance measures and health policies (article 45§3, 52, Treaty on the Functioning of the European Union). In the context of our study, the establishment of such an articulation is particularly important.

Surveillance systems are designed in order to provide "real-time" early warning policy responses in the health arena and to ensure that epidemics are territorially contained, namely, when what is at stake is the potential spread of diseases from the southern to the northern hemisphere (Lakoff, 2010, p. 59). Health surveillance is fundamentally represented and constructed as a homeland security question (Lakoff,

2010, p. 60). In addition, the development of a disease surveillance apparatus is argued as only being possible through international cooperation and data exchange (Lakoff, 2010, p. 59). Therefore, what Ingram designates as the "global health security regime" fosters the development of a network of international regulations and health management and surveillance systems based on cooperation (see Ingram, 2010, p. 298).

These health management and surveillance systems are increasingly based on statistics and categorization practices – the "numerical knowledge of populations" – and allow for health policies to be devised from the apparently cold interpretation of numerical data (Sangaraamoorthy, 2012, p. 293). The regime of "global health security" is based on the production of "numerical subjectivities" that represent and reify populations as "objects and subjects of scrutiny" (Sangaraamoorthy, 2012, p. 293). Public health discourses congruent with the "global health security regime" legitimize surveillance practices, namely the collection and interpretation of statistical data, arguing on the need to "know" populations, to "act upon" populations and, in a sense, to "imagine" populations (Sangaraamoorthy, 2012, p. 293).

Narratives and practices based on the "global health security regime" are fundamental since they help to constitute individual and collective subjectivities (Vaz and Bruno, 2003). The articulation between understanding health through a security rationale and the constitution of individual and collective subjectivities is important since public health policies are increasingly guided by risk as a political concept and as a political practice (Vaz and Bruno, 2003). Although being frequently represented as a technical and apolitical, risk is a highly politicised concept (Vaz and Bruno, 2003). In the health arena, the employment of risk as a political concept assumes particular relevance since it determines how policy-makers legitimize public policies and how individuals behave towards themselves and towards others (Vaz and Bruno, 2003).

In what concerns health policies, risk politicization has three main consequences (see Foucault, 2008; Douglas, 1992; Vaz and Bruno, 2003). Firstly, it normalizes the establishment of links and articulations between disparate facts and behaviours, namely health and security or health, migration and risk (Lakoff, 2010). Secondly, it allows for the construction of health security apparatus that target the self through the reification of an ideal of the "prudent self" (Rose, 2007; Dean, 2010; Vaz and Bruno, 2003) as the one who adopts some behaviours in the present in order to lessen future risks (Vaz and Bruno, 2003). As Vaz and Bruno write: "[f]rom the point of view of the practices of the self, a menace is innocuous unless accompanied by cultural recommendations about the means through which individuals are to confront and subject the problematic part of themselves" (Vaz and Bruno, 2003, p. 273). Finally, risk politicization in the health arena constitutes an instrument for the normalization of a politics of exclusion of social groups whose practices may be considered as posing a threat to communitarian well-being (Vaz and Bruno, 2003). The collection of data on the demographics of epidemics leads to the reification of the articulations between particular social and ethnic groups and specific diseases creating what Sangaraamoorthy designates as "ethnic rationalities of risk" (Sangaraamoorthy, 2012, pp. 301, 302).

In the context of epidemiological surveillance, the personalization of risk should be understood as a targeted instrument thought to conduct individuals to take control and assume responsibility for their "risk behaviours" but also as an instrument for social and political control since health authorities construct a narrative on what are the communitarian expectations concerning risk avoidance based on the identification of proper and improper individual conduct (Sangaraamoorthy, 2012; Piot, Plummer, Mahlu, Lamboray, Chin and Mann, 1988). Epistemic claims to expertise are fundamental since it is through epistemic utterances, locations and practices that health

authorities, both at a domestic and at a global level, construct and legitimize their policies (Sangaraamoorthy, 2012). Such authority is seldom based on the already discussed "numerical subjectivities" (Sangaraamoorthy, 2012). In fact, "numerical subjectivities" are fundamental for epidemic surveillance apparatus since they legitimise the constitution of "risky subjects" and allow for the employment of standardization measures and fixed risk categories represented as fundamental regarding epidemic control (Sangaraamoorthy, 2012, p. 306).

2. The European Centre for Disease Prevention and Control: legitimacy and epidemiological surveillance

The ECDC was created in 2005 (ECDC, 2014e). Its mission is to detect, evaluate and communicate "current and emerging threats to human health from communicable diseases" in the European Union (European Parliament, Council of Ministers, 2004, point 7). In Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 it can be read that the Centre should serve as source "of independent scientific advice" and assistance from a trained staff of medical, epidemiological and scientific experts (European Parliament, Council of Ministers, 2004, point 5). The Centre does not possess regulatory powers (European Parliament, Council of Ministers, 2004, point 6). However, the Regulation states that the ECDC should ensure the protection of public health in the European Union (EU) "by preparedness", which implicitly seems to provide the Centre with a sort of pre-emptive competence to act (European Parliament, Council of Ministers, 2004, point 9). Point 7 of the Regulation also states that:

> the Centre's mission should be to identify, assess and communicate current and emerging threats to human health from communicable diseases. In the case of outbreaks of illness of unknown origin which

> may spread within or to the Community, the Centre should be empowered to act on its own initiative until the source of the outbreak is known and then in cooperation with the relevant competent authorities at national or Community level as appropriate. (European Parliament, Council of Ministers, 2004, point 7)

The Centre is, therefore, the Union's main policy instrument in the arena of epidemic surveillance defined by Decision 2119/98 /EC as the "ongoing systematic collection, analysis, interpretation and dissemination of health data" (European Parliament, Council of Ministers, 1998, article 2). The mission of the Centre is to coordinate European action concerning a set of communicable diseases (European Parliament, Council of Ministers, 2004, point 7). Health communication is the crux of the Centre's role in public health policy since the ECDC performs surveillance functions regarding 52 communicable diseases and other related health questions whose surveillance is compulsory for both EU member-states and for states belonging to the European Economic Area (ECPC, 2014e). The compilation, evaluation and diffusion of significant scientific and epidemiological data are ensured through surveillance networks that guarantee the implementation of an "early warning response system" (ECDC, 2014d). The ECDC, therefore, embodies what Foucauldian literature has designated as "new prudentialism", a rationale for both public and private behaviour which empowers health professionals in the area of risk control (Dean, 2010, p. 168).

The 2010 Annual Epidemiological report on communicable diseases in Europe, a document produced by the ECDC clearly states that the Centre is not a "political body" and that it is not its "role to tell countries how to run their national health systems" (ECDC, 2010, p. iii). The document defines the role of the Centre as to ensure that "EU and national health policy-makers have the facts" (ECDC, 2010, p. iii). It also states that

the Centre is responsible for helping policy-makers to identify good-practice (ECDC, 2010, p. iii).

In order to perform such role, the ECDC claims the need to have access to high quality, comparable disease surveillance data as well as "independent public health evidence" regarding the "impact of prevention measures" (ECDC, 2010: iii). In the European context, disease network surveillance relies on a specific technological mechanism: the European surveillance system –TESSy – (ECDC, 2010, p. iii). Such system is defined by the Centre as a "highly flexible meta-data system for the collection, validation, cleaning, analysis and dissemination of data" (ECDC, 2014e, no pagination). Member-states and European Economic Area (EEA) countries allocate relevant data on communicable diseases to the system (ECDC, 2014e). TESSy is the data gathering technology that replaced the former Dedicated Surveillance Networks (DSNs) that, prior to 2005, collected data on a diverse sort of diseases from individual member-state submission to every DSNs through dissimilar "file specifications" (ECDC, 2014e, no pagination). TESSy can, therefore, be represented by the Centre as a "single, unified database" and as the ECDC main instrument in health surveillance networking (ECDC, 2010, p. iii).

The study of the discursive practices of the ECDC demonstrates that rationalization and authorization (Leeuwen, 2008, p.105) are the two types of discursive legitimation strategies more frequently employed in the Centre's political discourse.

In what concerns rationalization, we argue that the construction, diffusion and normalization of a set of risk factors related with certain illnesses may be understood as corresponding to a type of discursive legitimation strategy (on discursive legitimation strategies see Leeuwen, 2008, p.105). In particular, it can be understood as an articulation between scientific and theoretical rationalization since through references to

"systematic bodies of knowledge", the ECDC manages to naturalize a social or political practice providing, through discourse, "explicit representations of the 'way things are'" (Leeuwen, 2008, p. 116).

Regarding the legitimation of surveillance policies, one of the most important discursive practices concerns, in fact, the construction, diffusion and mobilization of a hierarchy of risk factors pertaining to particular diseases (ECDC, 2014a, p. x). In the *HIV/AIDS Surveillance Report in Europe 2013*, it can be read that "HIV is mainly concentrated in key populations at higher risk of HIV infection, such as men who have sex with men, people originating from generalized epidemic countries (mainly sub-Saharan Africa) and other migrants and people who inject drugs (PWID) and their sexual partners" (ECDC, 2014a, p. x). As it is argued by Sangaramoorthy (2012, p. 298), epidemiological surveillance practices insist on highlighting a limited number of risk categories despite the fact that in reality, in what concerns HIV/AIDS, individuals are exposed to a wide range of risks. More important than the mere identification of risk categories is the establishment of a hierarchy among them (Sangaramoorthy, 2012, p. 298). The same *HIV/AIDS Surveillance Report in Europe 2013* recognizes that in the WHO European region, 46% of HIV transmission occur through heterosexual contact and that in Eastern Europe the same mode of transmission accounts for 62,7% of HIV transmission (ECDC, 2014a, p. vii). It is also noteworthy that, and in accordance with the same report, a considerable amount of HIV diagnoses correspond to unknown transmission modes: 18,2 % in Western Europe, 37,9% in Central Europe and 19,7% in the EU/EEA region (ECDC, 2014a, p. vii). The numbers concerning unknown transmission modes are important since they relativize the importance of risk categories and demonstrate how the management of statistical data is made through heuristic interpretations (Sangaramoorthy, 2012, p. 298). As Sangaramoorthy writes:

"[i]ncreasingly, the procedures for investigating NIR (non-identified risk) cases have moved from ascertaining a risk factor for each reported case to estimating risk factor distribution from statistical models and population-based samples (Sangaramoorthy, 2012, p.298).

Migrants are considered as a particular risk category (ECDC, 2014a, p. x). The *HIV/AIDS Surveillance Report in Europe 2013* states that 35% of new cases in the EU/EEA region occur among migrants and that one third of infections by heterosexual contact derive from interactions with individuals from "high endemic countries" (ECDC, 2014a, pp. x,7). However, the Report also declares that "[t]here is increasing evidence that a proportion of migrants acquire HIV after arrival in the EU/EEA region" (ECDC, 2014a, pp. x, 7). Such observation is interesting since there is a purposeful conflation between the origin of individuals and their behavior not being totally clear which of the two – origin or behavior – constitutes the real risk factor (Sangaramoorthy, 2012, p.301).The purposeful conflation between the origin of individuals and their behavior is instrumental for the constitution of migrants as risk factors in the health arena, being also a demonstration of how the creation of "numerical subjectivities" is made through heuristic interpretations (Sangaramoorthy, 2012).

The constitution of "numerical subjectivities" (Sangaramoorthy, 2012) is essential for epidemiological surveillance since it allows the establishment of cross articulations between specific epidemics, namely HIV/AIDS and tuberculosis (ECDC, 2014b). Migrants are represented as constituting risk categories for HIV/AIDS and potential risk categories for tuberculosis (ECDC, 2014b, p.27). However, the 2014 ECDC *Report on Tuberculosis Surveillance and Monitoring in Europe* does not give concrete empirical data on the eventual relevance of migration for tuberculosis in Europe which

demonstrates how, once established, epidemiological risk categories easily flow among specific diseases (ECDC, 2014b: 27; for a discussion see Schiller, 2012).

Another discursive legitimation strategy frequently employed by the ECDC concerns utilitarian rationalization, which normalizes social and political practices highlighting their "goals, uses and effects" (Leeuwen, 2008, p.113). Literature on EU health policy has discussed how the neo-functionalist dynamics seems to explain the expansion of EU competences in the health domain (Greer, 2006). In its discursive practices, the ECDC strongly stresses how its ontological and organizational approach to public health policy strictly derives from the "core functions" that were attributed to the organization (ECDC, 2010; ECDC, 2014d). It is the importance of such functional approach — that underpins an apparently strictly utilitarian rationality – that allows for the establishment of an articulation between health and security in the epidemiological arena (Greer, 2006; Lakoff and Collier, 2008; Leeuwen, 2008).

In this context, it is important to stress how forms of discursive rationalization, namely scientific, theoretical and utilitarian rationalization, constitute forms of moralization for they carry beliefs about how human beings should behave (Leeuwen, 2008, p.107). In the health arena, and specifically in what concerns epidemiological surveillance the articulation between moralization and rationalization is important since the identification of risk categories associated with particular diseases legitimize the development of specific "evidence based" public policy interventions (ECDC, 2014a, p. x).

Authorization is a second type of discursive legitimation strategy particularly important for the legitimation of the ECDC and of its surveillance practices (Leeuwen, 2008, p. 105). In fact, the articulation between scientific and theoretical rationalization is achieved through the employment of authorization discursive strategies based on

claims to expertise (Leeuwen, 2008; ECDC, 2014a). As a discursive legitimation instrument in the health arena, expertise based authorization is fundamental in order to understand the securitization of this policy domain (on the articulation between health and security see Lakoff and Collier, 2008). In fact, there is a strict articulation between securitization and the acknowledgement of positional, role and expert authority (Waever, Buzan & de Wilde, 1998).

The securitization of health is deeply related with discursive legitimation instruments due to the particular characteristics of security as a political concept (Lakoff, Collier, 2008; Huysmans, 2006). Waever et al. (1998, p. 23), argue that "[s]ecurity is the move that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics, or as above politics". Security is a deeply intersubjective concept since it is dependent on how human beings assess their existence within a community (Huysmans, 2006). In this context, to "speak security" allows decision-makers to employ a language of exceptionality and, facing an "existential threat" that requires an emergency action "outside the normal bounds of political procedure" (Waever et al., 1998, p. 24), to take special measures that wouldn't otherwise be taken (Waever et al., 1998).

As we have mentioned before, the concept of "global public health security" reifies the articulation between what used to be very distinctive policy arenas: health and security (Lakoff and Collier, 2008). This articulation is achieved through the transference to the health public policy domain of concepts, discourses, technical instruments and policy practices that were devised and traditionally pertain to the national security policy area (Lakoff and Collier, 2008).

To establish an association between health and security opens a window of opportunity to argue on the existence of "existential threats" that derive from the

conflation between the survivability of the individual physical body and the existential survivability of particular communities (Foucault, 2008; Waever et al., 1998, p. 24). Just like it happens with the articulation between migration and security, the establishment of an association between health and security also creates what security studies literature designates as a space of indistinction between external security questions and traditional internal affairs (Bigo and Tsoukala, 2008).

It is the establishment of such a space of indistinction that, for instance, allows public health authorities to argue on the articulation between mobility, security and health (Bigo and Tsoukala, 2008; ECDC, 2010a). The question is not so much the establishment of a link between mobility and health (ECDC, 2010a), but the framing of such a link through a language of security (Huysmans, 2006). The employment of a language of security materializes the transference to the health public policy domain of discourses and policy practices that traditionally pertain to the national security policy area (Lakoff and Collier, 2008). In the context of the ECDC, it is noteworthy that its main public health functions, namely surveillance, risk assessment, preparedness, epidemic intelligence, "response training" and health communication explicitly demonstrate such transference (ECDC, 2010a; ECDC, 2014c; ECDC, 2014d[1]). In accordance with the already discussed concept of "global public health security", the crux of the securitization practices developed by the ECDC favour a pre-emptive approach to health threats (Lakoff and Collier, 2008; ECDC, 2014c). This explains why the ECDC *Communicable Diseases Threat Report* is published on a weekly basis (ECDC, 2014c).

The securitization of health policies and discourses are dependent on discursive legitimation instruments since "securitization manoeuvres" are strongly based on the

[1] For a discussion on epidemic intelligence and the ECDC see Kaiser, Coulombier, Baldari, Morgan and Paquet, 2006.

recognition of a relationship of positional authority between a community of people and a source of institutional authority (Waever et al., 1998). In the health arena, institutional authority is frequently mobilized and argued through the acknowledgement of expertise (Leeuwen, 2008). This explains why the main goals of the ECDC are mostly related with epistemic construction and epistemic diffusion, namely the increase of the Centre's scientific visibility, the empowerment of its influence regarding EU public health research, the production of relevant knowledge in the public health arena, the mobilization of "scientific advice, guidance, and risk assessment" in the public health domain and also the implementation of "evidence-based prevention and intervention" mechanisms (ECDC, 2014d, p. 21).

In what concerns the ECDC, and as a discursive legitimation strategy, authority is, in fact, achieved and represented through expertise (Leeuwen, 2008, p. 106; ECDC, 2014d). Arguing authority through expertise allows the ECDC to claim that its nature is scientific and, therefore, apolitical (ECDC, 2010, p. iii).

However, and how we have mentioned before, authority may also derive from impersonal sources, namely normative frameworks, tradition, conformity and generalized patterns of behavior whose significance is related with the historical and /or legal institutionalization of a social practice or belief (Leeuwen, 2008, p.106). The discursive legitimacy of the ECDC is also mobilized through impersonal sources of authority (Leeuwen, 2008, p.106). Those impersonal sources of authority are deeply related with the gradual construction of an international cooperation network devoted to epidemic intelligence (Leeuwen, 2008; WHO, 2007). When, in 2007, the WHO introduced the concept of "global public health security" it explicitly articulated the emergence of the concept with the coming into force of new International Health Regulations (2005) whose goal was to strengthen global cooperation in the health and

epidemiological arenas and to "prevent the spread of disease across international borders" (WHO, 2007, p. ix).

Through these International Health Regulations (2005), epidemiological intelligence has gained a new global institutional framework and the surveillance practices and normative frameworks that materialize it may now be understood as institutionalized and generalized patterns of behavior with legal, social and political relevance (Leeuwen, 2008; WHO, 2007). Epidemiological intelligence is discursively argued as embodied with a global authority and, therefore, with a global legitimacy (Leeuwen, 2008; WHO, 2007). In this context, the ECDC has developed an "international relations policy" and has discursively argued that its recognized technical competence has allowed it to be considered as a fundamental pillar of the WHO's global strategy in the arena of health security and, particularly, in what concerns the implementation of the International Health Regulations (ECDC, 2014f, p.8). The legitimacy of the ECDC is, therefore, discursively argued also through an articulation between expert authority and impersonal sources of authority due to the reference in the ECDC's discourses to the normative weight of global, institutionalized and generalized patterns of behavior in the health arena (Leeuwen, 2008; ECDC, 2014f).

3. Conclusion

The goal of this paper was to discuss discursive legitimation strategies (Leeuwen, 2008) in the arena of global epidemiological surveillance. Health discourses developed by the ECDC were discussed from the perspective of two particular legitimation discursive strategies, namely, authorization and rationalization. We conclude that in order to legitimate epidemiological surveillance policies, the ECDC employs an articulation between scientific, theoretical and utilitarian rationalization as well as a combination of epistemic and impersonal sources of authority.

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