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CHAPTER 19 – HEALTH [1]

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Abstract

In this chapter, students will learn why health has not traditionally been seen as a security issue and why this began to change. They will look at the main health issues on the security agenda: the spread of infectious disease, especially to the West; the impact of HIV/AIDS, especially on state stability; and the risk of bio-terrorism. Questions which arise include whether some of these risks have been overstated, whose interests are being served by securitizing health, and whether health should be a concern for security policy or development policy.

Introduction

At the end of 2006, UNAIDS estimated that 39.5 million people were living with HIV/AIDS. In that year alone, between 2.5 million and 3.5 million were believed to have died from AIDS-related illnesses, while an additional 4.3 million people had been infected with the disease.[2] The estimate of AIDS-related deaths is roughly double that of a decade ago, and is likely to double again by 2030. The scale of suffering caused by this single illness is immense and the number of deaths dwarves that of more traditional security crises such as those in Iraq and Afghanistan, or the War on Terror. Moreover, HIV/AIDS is only one of a number of communicable diseases, many of which are preventable, which each year kill millions of people. These include long-established diseases such as malaria and TB as well as new diseases such as SARS and H5N1, which threaten to become global pandemics with the potential to kill millions in a relatively short space of time. Further, non-communicable diseases such as tobacco-related illnesses and cardio-vascular disease again kill millions each year – indeed, tobacco-related diseases account for more deaths each year than any other non-natural cause. In sum, the lives and livelihood of the overwhelming majority of people on this planet are at greater risk from disease than from war, terrorism or other forms of violent conflict. But does this make global health a security issue? Indeed, given the links between poor health and poverty, is global health more properly a subject for development studies than

International Relations? And should it be the focus of government ministries such as the Department for International Development in the UK, rather than the Foreign Office or Ministry of Defence?

For much of the past 50 years the relationship between health and security has been limited and unidirectional: conflict has caused health problems. These problems have been both a direct result of conflict (largely in the form of combat casualties) and indirect (e.g. the destruction of infrastructure affecting the ability of hospitals to keep working, increased prevalence of water-borne diseases as a result of disruption to the water supply, refugee flows leading to the spread of infectious disease or the overburdening of public health systems). But this was not always the case. In the nineteenth century, as trade between Europe and the rest of the world increased, so did the risk of infectious disease being brought into Europe from elsewhere. Disease was viewed as an exogenous threat which had to be dealt with by means of international cooperation and the introduction of internationally agreed health regulations. Thus the origins of international cooperation on public health lie in the security concerns of Europe in the nineteenth century. After the Second World War however, this relationship disappeared for two main reasons. First, health was presented not as a security issue but as a human right. This move was seen in the constitution establishing the World Health Organization (WHO) in 1948 and reached its high point in the 1970s with the WHO's 'Health for All' initiative. Second, during this period the perception grew that infectious diseases were being conquered, especially through the use of antibiotics. The number of deaths in the West from infectious diseases fell dramatically in the early decades following the Second World War, while in the late 1960s for the first time in history a major infectious disease, smallpox, was effectively eradicated. These successes prompted the US Surgeon General in the late 1960s to declare (perhaps apocryphally) that communicable disease had been conquered, at least for the West. What was patently clear was that this was not the case elsewhere, where living conditions and levels of poverty were much worse. Therefore global health became for the West less of a security concern than one of development.

By the late 1990s however this had begun to change. Two examples of this are the 1999 US National Intelligence Estimate on the global threat of infectious disease to the United States, and the January 2000 meeting of the UN Security Council on HIV/AIDS. On the first, in 1999 the Central Intelligence Agency (CIA) identified a number of risks to US security arising from infectious disease, risks exacerbated by rapid globalization and the increased movement of goods and people. These included not only risks to US citizens travelling abroad, but to citizens in the US itself given the potential ease with which diseases could spread internationally as a result of travel and trade. Crucially however the CIA went further than this, arguing that infectious disease also posed a risk to international stability and to economic growth, placing it firmly in the territory of national security (CIA 2000). On the second, at its first meeting of the new millennium, the UN Security Council discussed the threat of HIV/AIDS to Africa and in Resolution 1308 warned 'that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security'. In particular the Security Council drew attention to the effects of HIV/AIDS on social stability and on peacekeeping missions.[3] This debate raised the global political stakes on HIV/AIDS, and in subsequent years HIV/AIDS was framed not only as a humanitarian catastrophe but as a risk to national security and international stability. In the early years of the twenty-first century, health issues began to appear in statements from foreign and security ministers, while global health was discussed at a number of G8 summits, including Genoa, Gleneagles and St Petersburg, in the context both of humanitarianism and security. By the

middle of the first decade of the twenty-first century a variety of health issues were therefore beginning to appear on the foreign and security agendas of Western states. Why was this?

Health as a security issue

Two factors facilitated the emergence of health as a security issue. The first of these was the growing acceptance during the 1990s of a broadened security agenda. The end of the Cold War saw security analysts shift their focus away from threats, especially military threats, to more diffuse risks. This opened the door for a more eclectic range of issues to be considered as security concerns. Further, the shift from threat to risk allowed security's focus to shift from the idea of a 'clear and present danger' to more probabilistic assessments of potential hazards. Both of these moves opened up a space whereby public health issues could be raised as security concerns. Moreover, questions were raised not only over the security agenda – those issues which were to be considered as security concerns – but also over the referent object: whose security was to be protected? Whereas the Cold War had prioritized national security, in the post-Cold War world global and human security began to be considered as legitimate concerns. Although definitions of human security varied, the very idea that risks to the individual from macro-level developments could be part of the security agenda again allowed a space for the inclusion of health as a security issue. After all, individuals generally were more likely to be at risk from new infectious diseases spread as a consequence of globalization than from ethnic conflict, environmental disasters or terrorism.

The second facilitating factor was human agency. A number of prominent individuals used their positions of power and influence to place health on the foreign and security policy agenda. Two examples of this are the former head of the World Health Organization, Gro Harlem Brundtland and President Clinton's ambassador to the UN, Richard Holbrooke. As WHO's Director General, Brundtland emphasized the changing nature of public health in a globalized world, and argued that global public health could not be divorced from broader social and political trends.

Significantly it was during Brundtland's tenure that WHO coined the term 'global health security'. The second example of individual agency is that of Richard Holbrooke, who is widely acknowledged as a key player in the securitization of HIV/AIDS. According to Barnett and Prins (2006: 360), when visiting Africa in 1999 Holbrooke realized not only the scale of the HIV/AIDS pandemic but also that existing aid-based approaches were failing to deal with the crisis. Moreover the potential social consequences of the pandemic were beginning to become apparent, including state instability. On his return to New York, Holbrooke was instrumental in placing HIV/AIDS on the Security Council's agenda. What is unclear is whether Holbrooke saw his actions as motivated solely by security concerns, or whether he saw the securitization of HIV/AIDS as a way of achieving greater political prominence and global action to help deal with the crisis. This potential for the securitization of health to act as a Trojan Horse for greater attention and assistance to the most needy is an important theme in the debate over health and security.

Neither the broadening of the security agenda nor individual agency however can explain the emergence of health as a security issue. If it was simply a by-product of the broadening agenda, then this move would have been

BOX 19.1 BRUNDTLAND ON GLOBAL HEALTH AND SECURITY

In a speech to the US Council on Foreign Relations in 1999, Gro Harlem Brundtland, Director of the World Health Organization, argued that 'With globalization – on which [the US's] prosperity so much depends – all of humankind today paddles in a single microbial sea – and we have to conclude: there are no health sanctuaries. . . . The levels of ill-health in countries constituting a majority of the world's population pose a direct threat to their own national economic and political viability, and therefore to the global economic and political interests of the United States and all other countries. Territorial dispute is no longer the prime source of conflict. It is increasingly rooted in human misery, aftermaths of humanitarian crises, shortage of food and water and the spreading of poverty and ill-health. So investing in global health is investing in national security. (Brundtland 1999)

expected in the early to mid-1990s when the broadened agenda was being developed, not the late 1990s/early twenty-first century when it did eventually appear. And agents cannot act successfully without issues of substance with which to make their case. Rather three substantive health issues contributed to the emergence of health on the security agenda: the spread of infectious disease; the HIV/AIDS pandemic; and bio-terrorism. Moreover, these three issues continue to dominate the thinking of security analysts with regard to health, though not necessarily public health specialists.

The spread of infectious disease

New infectious diseases have been emerging at an accelerated rate over recent years, averaging one a year for more than two decades. These new diseases include HIV/AIDS, SARS and H5N1, all of whose impact has been, or has the potential to be global in nature. Although this phenomenon of increased numbers of new diseases may be a by-product of the increased speed of movement of goods and people and their interaction over wider geographical areas, it may also be that changes are occurring in the microbial world which are independent of these social forces. In addition to new diseases, previously contained diseases have begun to spread and have been seen in the West. Over the past decade, for example, the USA saw its first cases of ebola, West Nile virus and monkeypox. Finally, new strains of diseases are appearing which are resistant to existing drugs, including antibiotics. Perhaps the most serious of these is TB, with cities such as New York already experiencing epidemics of this new form of the disease.[4]

But why have these developments triggered concerns in the security community? There are broadly three reasons for this. First, the spread of these diseases could pose a direct threat to the health and well-being of the very people that states are there to protect, and for the first time in perhaps half a

BOX 19.2 INFECTIOUS DISEASE AND GLOBALIZATION: SARS

The outbreak of SARS (severe acute respiratory syndrome) in 2002 to 2003 is a good example of the extent and speed with which new diseases can spread. The disease appears to have originated in Guangdong province in southern China in November 2002 and began to spread internationally in February 2003. The World Health Organization issued global alerts on 12 and 15 March 2003, by which time the disease had already spread from China to Taiwan, Singapore, Vietnam and Canada. By the time the disease came under control in August 2003, 8,422 cases had been identified in 29 countries with 908 fatalities (WHO 2003).

century, this includes the populations of Western states. Estimates of the impact of an outbreak of avian flu transmitted from human to human suggest that perhaps 25–30 per cent of people living in the West could contract the disease, with perhaps 300,000 in the UK dying.[5] Infectious disease therefore poses an exogenous threat to the people of a state. Second, a pandemic may cause social disruption and threaten the stability of a state: confidence in the state may be reduced if it cannot provide a basic level of protection against disease; social inequalities may be highlighted as the rich or privileged obtain access to better drugs or healthcare, potentially leading to public disorder; if large numbers of people die or are unwilling/unable to go to work, public services may be placed at risk threatening the functioning of a state; violence and disorder may appear if the authorities become unable to cope and if groups feel they have nothing to lose. Thus a state may begin to fail threatening its own security. Moreover, as the US *National Security Strategy* put it, 'America [and the West] is threatened less by conquering states than we are by failing ones' (White House 2002: 1). Third, a large-scale epidemic may also contribute to economic decline by: forcing increased government spending on health as a percentage of GDP; reducing productivity due to worker absenteeism and the loss of skilled personnel; reducing investment (internal and external) due to a lack of business confidence; and by raising insurance costs for health provision. For the state involved, the costs may be highly significant, but in a globalized world the effects may be felt around the world. The relatively short-lived SARS outbreak of 2002 to 2003 led to less than a thousand deaths – individually tragic but, compared to annual deaths from HIV/AIDS, TB or malaria, statistically relatively insignificant; but the loss in trade and investment was calculated to be as much as \$100 billion for the economies in Asia. The macro-economic effects of a major epidemic may therefore be very significant, threatening to make the relatively affluent poor and the already poor poorer, with a consequent impact upon the ability of states and individuals to provide for their security and well-being.

HIV/AIDS as a security issue

The HIV/AIDS pandemic has not only led to widespread humanitarian concerns, but – uniquely for a single disease – has been identified as a security issue, most significantly by the UN Security Council. The claims made in 2000 by the Security Council in Resolution 1308 have set the agenda for the subsequent debate on HIV/AIDS as a national security issue: that HIV/AIDS poses a risk to stability, to uniformed militaries and to peacekeepers, and that the spread of HIV/AIDS is exacerbated by conditions of violence. On the first of these, the effects of the disease on economies and on

governance have been consistently highlighted. HIV/AIDS poses particularly severe economic problems due to the cumulative effects of the disease over a number of years; because its full effects are postponed as those infected become ill only gradually but then pose an increasing economic burden on society; and because of its disproportionate impact upon workers in what should be the most productive period of their lives (ICG 2001: 9–13, UN Secretariat 2003: xiii–xiv). Such economic decline may increase income inequalities and poverty, exacerbating or creating social and political unrest. HIV/AIDS may also lead to social and political problems. HIV infection rates are unusually high among skilled professionals (including civil servants, teachers, police and health workers) and young adults, threatening ‘the very fibre of what constitutes a nation’ (ICG 2001: 1). Democratic development may be harmed if societies become polarized as a consequence of HIV/AIDS, if disaffection with the political process sets in, or as a consequence of aid-dependency. The stigma of AIDS may also lead to exclusion from work and/or society, creating alienation, fatalism and anger among people, especially young people, living with HIV/AIDS. These people may become prone to criminal violence or to following violent leaders (CIA 2000, Justice Africa 2004).

The second concern focuses on the high rates of HIV infection among security forces, including the military – typically cited as being up to five times that of the general population. In sub-Saharan Africa in particular, infection rates among the military are often cited as being especially high, with a number of militaries experiencing rates above 50 per cent, those of Malawi and Zimbabwe believed to be in the order of 75–80 per cent, and elements of the South African military believed to be perhaps 90 per cent. Moreover, during periods of conflict it is believed that the risk of infection may be as much as 50–100 times that of the civilian population. The consequences of this include its impact on combat readiness and military performance. Of particular concern appears to be the potential loss of experienced military and technical specialists with 8–15 years service, the ‘middle management’ and technical glue which holds an organization together. Morale may also deteriorate as workloads are increased to cover for the ill; as the progressive deterioration of comrades due to AIDS is witnessed; or due to the fear of infection and the stigma associated with it. The pool of recruits may diminish as HIV+ youngsters are turned away, while the cost of treating those in the military may pose a major burden on defence budgets. If military effectiveness is reduced as a result of HIV/AIDS, or even if it is perceived to have been affected, then states may be at greater risk from internal conflict or external aggression. Moreover, there is some evidence to suggest that conflicts may be prolonged either to defer the return of HIV positive troops, or to enable them to gain sufficient money (legally or otherwise) to allow them to purchase anti-retroviral drugs to combat the disease (Elbe 2002, 2003, Heinecken 2003, ICG 2001, UNAIDS 2003).

The third concern is the impact of HIV/AIDS on peacekeeping. Peacekeepers may be at increased risk from HIV since many of the world’s conflicts are in regions with a high prevalence of HIV. They may also act as vectors for the spread of the disease, especially since the top 10 contributory nations to peacekeeping operations include states with high HIV prevalence rates (such as Kenya, Nigeria and Ghana), as well as a number perceived to be at high risk (such as Ukraine, Bangladesh, Pakistan and India) (UNAIDS 2003: 6). HIV may also make it difficult for some armies to deploy peacekeeping forces, especially at short notice. In particular the attempt to devolve peacekeeping to regional powers may be hamstrung by high HIV prevalence, particularly among key African armies such as South Africa and Nigeria (Elbe 2002, Heinecken 2003).

Finally, there is a concern that conflict acts as a vector for the spread of HIV/AIDS. Soldiers, already a high-risk group, are willing to engage in even more risky behaviour in conflict regions; incidents of sexual violence increase in conflict; combat injuries may be treated in the field with infected blood; health education and surveillance may be poor in zones of conflict; soldiers returning from conflicts may bring HIV with them; conflicts create migration which may facilitate the spread of HIV; and refugee camps may have poor health education and access to condoms, but are also areas where sexual violence is rife. In addition, HIV/AIDS may act as a disincentive to end conflicts because of fears that troops from low prevalence areas may act as a Trojan Horse for the spread of the disease on their return (UNAIDS 2003).

By the middle of the first decade of the twenty-first century however, the evidence supporting these four concerns had begun to appear less clear cut, more complex and case sensitive. For example, evidence began to appear that conflict might also constrain the spread of HIV/AIDS by limiting the ability of people to move; with the exception of Sierra Leone, there appeared to be little empirical evidence linking UN peacekeeping missions with high HIV prevalence; and AIDS awareness programmes in the military have significantly reduced the disparity in infection rates (de Waal 2005, McInnes 2006). Moreover, the causal links between HIV/AIDS and insecurity appear less robust. It is unclear how high HIV prevalence will transform societies; what intervening variables will determine the nature of such transformations; and how significant such transformations will be. Nor is it apparent that the weakness of a state's armed forces is a causal agent in either internal or external aggression. It appears far more likely to be a contributory factor, and even then secrecy over combat readiness and HIV prevalence may limit the impression of weakness.

It is tempting to argue that some of the dangers identified have been averted through preventative action, not least AIDS awareness programmes; but in retrospect the case made in 2000 was somewhat speculative, while worst case thinking and snowballing subsequently led these concerns to a position of orthodoxy which now appears less assured. This is not to say that HIV/AIDS does not create security problems. Indeed, as Laurie Garrett has commented, 'the lack of demonstrable proof of a security threat currently in place against any given state, regional, or transnational system does not mean the danger is nonexistent, or that it will not emerge as a pandemic'(Garrett 2005: 15). Rather it is to suggest that the case is at the very least more complex than originally articulated, that the threat may be less direct.

Bioterrorism

The idea of using biological agents (or pathogens) to cause disease as a weapon of war goes back several hundred years, and was a major source of concern not least during the Cold War. Following the terrorist attacks of 11 September 2001 and the mailing of anthrax spores in the USA later that same year, the possibility of a major terrorist attack using biological or chemical weapons has loomed large in the minds of Western security analysts. In its assessment of risks to the USA through to 2020, for example, the CIA concluded that a terrorist attack using biological weapons represented a major threat (CIA 2005). This risk has forged a close link between public health and national security. The covert and potentially global nature of terrorist activities, the relative ease with which materials to produce such weapons can be acquired, and the comparative simplicity in their use, have created new risks. These cannot be addressed by military means alone and have led to a flurry

of national, regional and international activity aimed both at preventing the development and use of such weapons, and at improving policy responses should they be deployed. Crucial to the latter has been the development of a closer relationship between national security and public health, using public health both as a defence against such attacks and conceivably as a deterrent to the use of such weapons.

Renewed concerns over biological weapons began to emerge in the early to mid-1990s, supported by intelligence reports of a potential proliferation of materials to produce such weapons following the breakup of the Soviet Union. Political and economic instability in the region, accompanied by growing lawlessness and the rise of organized criminal groups, raised fears that materials were being sold to terrorist organizations and 'rogue states' such as Iraq, Iran, Libya, Syria, Cuba and North Korea. Suspicions were already rife that Iraq had been stockpiling anthrax, botulinum toxin, smallpox and other agents prior to the Gulf War of 1991 to 1992. Of particular concern were the relatively low costs compared to other 'weapons of mass destruction' and their comparative ease of use, making them not only a cheap alternative to nuclear weapons for states but also accessible by sub-state groups including terrorist organizations. Moreover, the use of biological weapons by Iraq against its Kurdish population in 1988, the attempt by followers of Rajneesh Bhagwan to spread salmonella in the USA, and the attack on the Tokyo subway using sarin by the Aum Shinrikyo cult in 1995, suggested a willingness to use such weapons.

Even before the events of 11 September 2001 there was a growing discussion, in the USA and other major Western countries, between the public health and security communities, of the need to improve measures to prevent and respond to a major bio-terrorist attack. Efforts continued both to strengthen the 1972 Biological and Toxin Weapons Convention (BWC) and to gain intelligence, not least on potential suppliers and their customers. Attention however was also focused on public defence: on how to improve response measures, recognizing that 'we will not be able to prevent every act of BW (biological weapon) terrorism' (Simon 1997: 428). Measures included drawing up contingency plans, identifying key targets, stockpiling vaccines and training key personnel.

The use of anthrax spores in letters to US news media and congressional offices shortly after 9/11 however brought into sudden focus the potential risks from terrorists wielding biological weapons. Initially anthrax preoccupied popular attention, but fears of other infectious agents were soon raised. High among these was smallpox, already a concern of the US government which had ordered 40 million doses of vaccine in April 2001. These heightened concerns led to a step change in activity. At the national level, Western states examined their procedures for dealing with such attacks, most significantly with the 2002 signing of the US Public Health Security and Bioterrorism Bill formally placing public health in the realm of homeland security. US efforts to improve domestic capacity included improved inspections of food entering ports, tracking biological materials, strengthened communication networks, stockpiling vaccines, and the development of new medicines (Bush 2002). Other states including the UK, Canada and Australia explored similar domestic strategies. International cooperation was demonstrated by a series of meetings addressing response and preparedness, while the WHO encouraged states to strengthen both regional and global surveillance and response measures through the Global Outbreak Alert and Response Network (GOARN, later used successfully during the 2003 SARS outbreak). In addition, a wide range of studies were commissioned by governments and other organizations into how best to meet a

bioterrorist attack. The unifying themes of these actions were that the risk of attacks on the West had greatly increased, and that public health would play a key role in defending against such attacks.

Three problems however have emerged in responding to the risk of bioterror. First, there have been clear tensions between an internationally versus domestically focused strategy. Following the anthrax attacks, the USA stepped up its stockpiling of the smallpox vaccine, soon joined by other countries including the UK. Given the large-scale purchasing by a few states of the vaccine, supplies worldwide were soon scarce. Similarly, worldwide supplies of the antibiotic Cipro used to treat anthrax rapidly became scarce. This national strategy of stockpiling vaccines raised international concerns over hoarding by a few states to the detriment of others. Tensions also arose over the US government's decision to pull out of negotiations on the BWC. The priority of the USA appeared to be to focus on domestically based security measures, while others argued that a more international approach would yield better results.

This tension is also revealed in the second problem – whether it is better to try to prevent such attacks from happening or whether the priority should be on defence. The former suggests that attention should be given to international cooperation on intelligence and to the use of diplomatic efforts (including arms control) to make the supply and production of such weapons more difficult. In this, public health would be important in monitoring and surveillance of activities, but not the key element in an international strategy. The alternative approach however accepts that attacks are likely to be attempted and that a much more nationally focused strategy would be more appropriate. This would use domestic counter-terrorist agencies and 'at the border controls' to prevent biological weapons from entering the country, but would also make much greater use of public health systems in defending against such attacks.

The third problem is whether the risk has been overstated. Despite the comparatively recent use of such weapons in Iraq, Japan and the attempt to use salmonella in the USA, there remain doubts both over how easy it is for sub-state groups to gain access to or produce effective weapons and over how easy it is to use them in a manner which may cause significant loss of life. The failure to discover such weapons in Iraq only added to doubts over whether the extent of the problem had been overstated. Moreover, as Malcolm Dando has pointed out, using biological agents as weapons of mass destruction would require their use as an aerosol over large areas. The means to do this – especially against Western states – is almost wholly the preserve of states with relatively advanced militaries, not small terrorist groups (Dando 2005).

A not so perfect partnership?

Health affects every one of us – our state of well-being affects individual life, lifestyle and livelihood. Moreover, our health is often intertwined with that of the communities in which we are located, either geographically or as part of a socio-economic group. Poor communities, for example, are more likely to be at risk from TB; malaria is common in certain parts of the world but not in others. Thus health officials have long understood that well-being is as much socially determined as it is a bio-medical condition. These social determinants have an international dimension – infectious diseases, for example, can cross state boundaries. But the process of globalization has raised awareness that this international dimension is becoming more important and that the ability of

national health services to protect their populations is partial in the face of such change. Health is therefore increasingly globalized (Lee 2003). With this recognition has come an increased interest on the part of the public health

BOX 19.3 DANDO ON BIOTERRORISM

There can be little doubt that a terrorist group at the present time could carry out some small to medium-scale biological weapons attacks. The situation in regard to a massive WMD aerosolised attack is quite different. All the technical literature and opinion maintain the view that although the problems of production and dissemination have been solved in state programmes in the past it is presently unlikely that a sub-state group would have the necessary capabilities and resources. (Dando 2005: 40)

community in foreign and security policy – an awareness both of shared interests between these different communities and the possibilities of health issues gaining increased attention and resources through ‘piggy-backing’ on foreign and security policy. Simultaneous to this, security communities have become increasingly aware of health issues as security risks, most notably the three issues identified above. Thus the prospect has developed of a mutually beneficial partnership between health and security. For those on the security side of this partnership, health (and in particular public health) brings valuable tools and expertise to a range of novel problems; for those on the public health side, securitizing health raises its political profile, leading to the prospect of greater resources being devoted to urgent health needs.

This securitizing move is not unproblematic however. Three issues in particular have proved worrying, especially for the health side of the partnership. The first of these is: Who controls the agenda? At present it is clearly security policy, with global well-being lagging as a policy driver. The debate at present is dominated by those health risks which are seen as threatening the national interest, regional stability or international security; it is not about promoting a healthier world. Thus diseases which kill millions each year – including TB, malaria and diarrhoeal diseases – are not considered security risks, while bioterror (which does not rank on the list of major causes of nonnatural death) dominates. Moreover, it is an agenda dominated by the West – how international health issues threaten the security interests of the West – even though the majority of those who die of preventable illnesses do so outside the West. This is not to say that Western policy more generally does not have a humanitarian dimension, though the impact of policies tends to be limited. Rather it is to say that in securitizing health, the national security interests of the West have been prioritized over the human security of the poor elsewhere.

The next two problems both follow from this control of the agenda. The second is the relatively narrow range of issues which are considered part of the global health security agenda. Infectious diseases such as TB and malaria, as well as non-communicable diseases such as tobacco-related illnesses and cardiovascular disease, are not considered to be part of the agenda despite the fact that they kill millions each year and may be mitigated by concerted international action. Tobacco sales, for example, have increased dramatically as a consequence of Western-prompted policies on

the liberalization of international trade. The UK MP Frank Dobson has referred to tobacco as a 'weapon of mass destruction', but the Framework Convention on Tobacco Control provides only limited controls on the promotion and sale of tobacco. This is partly the result of the lack of an agreed conceptual basis for what is and what is not a global health security issue. But it is also a consequence of the third problem, that of the referent object – whose health is at risk and whose security? Despite health being a risk to individuals, the human security dimension has not been dominant. Rather, national security perspectives have prevailed. Tobacco is not considered a global health security issue because, despite the number of individuals who die from tobacco-related illnesses each year, there are no national security implications. On the other hand, although deaths from bioterrorism are speculative rather than real, the risk to national security is such that it is clearly entrenched on the agenda.

Conclusion

Over the past decade health issues have begun to appear on the security agenda. This has been aided by the post-Cold War shift away from military threats which pose a 'clear and present danger', to more diffuse and conceivably long-term risks. To date this attention has focused on three health-related risks: the spread of infectious disease, HIV/AIDS, and bioterrorism. With the possible exception of bioterrorism, none of these yet dominate security agendas in the West, and indeed there are still debates there over whether global health security is more of an issue for international development policy than for national security; but elsewhere in the world, particularly in those areas where HIV/AIDS prevalence is high, the risk to states is much more serious, while from a human security perspective, health risks rank among the highest causes of non-natural death. The agenda to date however has been dominated by national security concerns, and particularly those of the West, such that the WHO's term 'global health security' is in danger of meaning the national security of Western states from health risks rather than the promotion of wellbeing globally.

Notes

[1] I would like to thank Kelley Lee for her advice and willingness to discuss with me many of the issues discussed in this chapter.

[2] UNAIDS produces an annual update on HIV/AIDS infections available on its website, <http://unaids.org/en/>. Estimating the number of cases of HIV infection is notoriously difficult, not least because of the social stigma associated with the disease in many parts of the world.

[3] The Security Council session was followed by a special session of the General Assembly on HIV/AIDS in 2001.

[4] In 1991 New York City Hospital reported a series of nosocomial outbreaks of multidrug-resistant TB (MDR TB). The city had already been experiencing a growth in TB associated with high numbers of people living with HIV/AIDS and immigrants to the USA.

[5] Estimates at this stage are very uncertain and depend both on the effectiveness of public health responses and the nature of the mutation allowing the disease to spread – most mutations reduce the potency of a virus.

Further reading

Stefan Elbe, *The Strategic Implications of HIV/AIDS* (Adelphi Paper 357. Oxford: Oxford University Press for IISS, 2003). A classic orthodox account of HIV/AIDS as a security problem.

David Fidler, 'Fighting the axis of illness: HIV/AIDS, human rights, and U.S. foreign policy', *Harvard Human Rights Journal*, 17 (2004): 99–136. Compares US strength and global leadership with its failure to address the HIV/AIDS pandemic in Africa, and raises the question of material might and the responsibility to protect others against illness.

Ilona Kickbusch, 'Influence and opportunity: reflections on the US role in global public health', *Health Affairs*, 21 (2002): 131–141. Influential article arguing that the USA could use health as a tool of 'soft power' in addition to its humanitarian benefits.

Kelley Lee, *Globalization and Health* (Basingstoke: Palgrave Macmillan, 2003). An excellent introduction. Although its focus is an examination of how different aspects of globalization have impacted upon health, its utility is much broader than that.

Colin McInnes and Kelley Lee, 'Health, security and foreign policy', *Review of International Studies*, 32(1) (2006): 5–23. Begins by examining the rise of health as a foreign and security policy issue before critiquing its narrow focus and questioning who is served by this move.