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THE ESSENTIALLY CONTESTED NATURE OF HEALTH SECURITY

Paper for Annual Convention of the International Studies Association

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This paper examines four terms widely used in debates over global health security: global (public) health security, national security, human security and bio-security. It takes as its starting point the observation made by Buzan amongst others that security is not a straightforward concept but is rather 'essentially contested' – that is, a concept which generates unsolvable debates about its meaning and application (Buzan 1991: 7). The paper therefore attempts to illustrate how health security is similarly essentially contested. Crucially the chapter suggests that these four terms are not mutually transferable, but have different implications both for the range of health issues involved and for whose security is at risk. The meaning of each term is constructed for a particular purpose, including promoting a certain agenda and privileging certain interests over others. The object of this paper, therefore, is not to suggest that there are criteria whereby a health issue may or may not be considered a security issue, or that there is a single agreed definition of health security when used in the global context. Instead, it is to reveal how, like other forms of security, it is essentially contested and not amenable to a single set of agreed criteria. The lack of an agreed definition is not due to lack of effort, but because in its different uses and terms it reflects different interests and agendas.

(i) National and International Security

National security is often characterised in a narrow manner: that the referent object of security is the state; that the main concerns are direct threats, usually military in

nature; that the context is one of an anarchic international states system where self-help is the order of the day; and that stability (both state and international) is privileged over issues such as rights and justice. Security therefore depends on the state protecting itself from threats, and a social contract is entered into whereby citizens forsake some of their individual freedoms to secure the greater collective good. The risk, however, is that the social contract is undermined by the increasing power of the state, which may become willing to sacrifice the freedoms and rights of the people it is supposed to protect in order to preserve its own power. It is this fear which has led to many health practitioners – concerned with protecting and promoting the well-being of individuals and communities – to be wary of national security.

National security's traditional focus on military threats however has, over the past two decades, been replaced by a more diverse range of risks. This broadening of the security agenda has created a space where issues such as health can be considered part of national security. But understandings of the state and state power have also changed. Of particular significance for health security is the shift away from sovereign power and towards governmentality. Both Stefan Elbe and Alan Ingram have argued that power is no longer oriented self-referentially towards preserving the power of the state (sovereign power) but rather towards improving the welfare of citizens (governmentality). Although they acknowledge that this shift applies predominantly to Western states, as these states have set the agenda for health security, the significance is considerable (Ingram 2010; Elbe 2009: 86-107).

National security's interest in health has been longstanding in that the physical condition of military troops affects their operational performance. Diseases such as cholera and dysentery have historically caused significant numbers of casualties during military campaigns. From the late 1990s on, however, interest in a broader range of health concerns began to develop within a number of key policy circles. In so doing, the foreign and security policy community maintained a robustly state-centric approach in prioritising the national interest and international stability when discussing health security issues (for example Cook 2000:2; Downer, 2003; FCO 2003: 13; US State Department 2004: 76). 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 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 globalisation and

the increased worldwide movement of goods and people. These included not only risks to US citizens travelling abroad, but to citizens at home given the potential for certain infectious diseases to spread globally. Crucially, however, the CIA went further than this, arguing that infectious disease also posed a risk to international stability and even economic growth, thus 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' (UNSC 2000b; see also UNSC 2000a; McInnes & Rushton 2010). In particular, the Security Council drew attention to the effects of HIV/AIDS on social stability and on peacekeeping missions. In both cases, the interests of the state appeared paramount, whether in terms of stability or the protection of its citizens or soldiers (peacekeepers).

Three issues have dominated national security's interest in and engagement with health: acute and severe infectious diseases of epidemic potential; HIV/AIDS; and bio-terrorism (for an overview, see McInnes, 2012). What is missing, however, is a rationale as to why some health issues might be considered national security problems but not others. Health issues are not identified as national security risks by reference to an explicit set of criteria, but have rather arisen in an ad hoc manner and agreed inter-subjectively by key national and international actors. Although it is possible to identify three broad sets of reasons suggesting an implicit agenda, these are also problematic, as will be seen below. The first of these reasons is the potential of a health issue to threaten international stability, because: health crises may have dramatic effects on the global economy; poverty and poor health may lead to migration which risks spreading disease and destabilising a region; that security forces may be at increased risk from some diseases; and because the risks associated with certain diseases (in particular HIV/AIDS) may affect the willingness of states to send (or receive) troops on peacekeeping missions.

The problem with these arguments is that the causal relationship between an adverse health effect and international stability is questionable, and/or the empirical evidence to support the claim is suspect or missing. For example there is no credible evidence that international stability is affected by the macro-economic effects of health crises. Neither sudden outbreak events such as SARS and pandemic influenza, nor chronic diseases such as malaria and (increasingly) HIV/AIDS have affected

international stability because of their macro-economic effects; nor have SARS and pandemic influenza demonstrated significant long term macro-economic effects. Similarly, although there is an awareness of migration as a security issue (for example, see Weiner 1992-3; Huysmanns 1997; in contrast see Graham & Poku 2000), health status does not appear to be a key driver in people leaving their homes. Rather, poverty, famine and conflict appear to be much more significant causes of mass migration. Although there was some evidence in the early years of the millennium that militaries were more susceptible to HIV infection, empirical evidence is no longer so clear cut, while HIV/AIDS awareness campaigns have helped to reduce the risk of infection (McInnes 2006; ASCI 2009). Equally, the link between a military weakened by disease and state instability/insecurity is also unclear and lacking empirical evidence, while research on the global spread of HIV/AIDS does not support the argument that peacekeeping is an important vector in the spread of the disease or that peacekeepers are especially susceptible (UNAIDS 2005; UN DPKO 2005).

The second broad set of reasons offered as to why health issues might be a national security problem concerns their ability to affect the internal security of a state (see for example ICG, 2001; CIA, 2000). If the domestic economy is damaged, then divisions between rich and poor may be exacerbated. Increased levels of poverty may, in turn, breed social discontent and provide a fertile ground for entrepreneurs of violence. Moreover, confidence in the government, or in the state more generally, may be damaged if public health services are unable to cope. What is again lacking, however, is the empirical evidence to support these arguments. With HIV/AIDS, in particular, a number of states have had very high levels of infection for more than a decade, especially in sub-Saharan Africa. These are also among some of the poorest countries on earth. Yet there is little evidence to date that high HIV/AIDS prevalence has created destabilising pressures threatening the security of the state.

The third set of reasons concerns high morbidity and mortality rates. When the number of people at risk reaches exceptional levels, then this moves into the realm of national security, both because of the responsibility of the state to protect its citizens and because the effective operation of the state may be at risk. The level at which an event becomes sufficiently extraordinary to be considered a security issue, however, is not definable for example as a percentage of the population; rather it is determined inter-subjectively on a case-by-case basis. But a key feature, for the

purposes of this section, is that the cause can be represented as an exogenous threat. Three health issues seem both to meet this necessary condition of externality, and breach the threshold of being outside the ordinary: the spread of existing diseases such as Ebola or West Nile virus to new geographies; the emergence of new, potentially pandemic, diseases such as SARS or a novel strain of influenza; and bio-terrorism. Of these, probably only the second has the potential to kill very large numbers of people within a state. But it is not only the level of morbidity that matters, but the sense of risk felt within high-income countries. Thus in the 1990s, when the Ebola virus first appeared in the US, the level of concern and attention far outran what might have been assumed from the number of people realistically at risk from the disease (see for example Garrett, 1994; CIA, 2000). Similarly, concerns over bioterrorism may be overstated with doubts 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 might cause significant loss of life. But this does not mean that the threat is not *considered* to be very real and of high political salience, resulting in substantial resources being allocated to allay those fears (see for example Graham, 2008).

(ii) Global Public Health Security

The term 'global public health security' (sometimes abbreviated to 'global health security') is largely associated with the WHO and its interest in how risks to public health have been globalised (eg WHO, 2002; Baker and Forsyth, 2007; Rodier, 2007). Although the impact on public health is not WHO's only concern here - 'global health security, or lack of it, may also have an impact on economic or political stability, trade, tourism, access to goods and services and, if they occur repeatedly, on demographic stability' (WHO 2007a: 1) – it is the main focus. In its 2007 *World Health Report* (WHO, 2007a), WHO discussed its understanding of global health security explicitly in terms of public health security. For WHO, 'Public health security is defined as the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations. Global public health security widens this definition to include acute public health events that endanger the collective health of populations living across geographical regions and international boundaries… [it] embraces a wide range of complex and daunting issues, from the international stage to the individual

household, including the health consequences of human behaviour, weather-related events and infectious diseases, and natural catastrophes and man-made disasters' (WHO 2007a: 1).

The background document accompanying the 2007 *World Health Report* provides a list of eight health security *issues* as identified by WHO: emerging diseases; economic stability; international crises and humanitarian emergencies; chemical, radioactive and biological terror threats; environmental change; HIV and AIDS; building health security; and strengthening health systems (WHO, 2007c: 3). This list, and the manner in which WHO then describes each of the issues, is important because it reflects a perspective of health security as being primarily a public health concern rather than, for example, a threat to the state. More generally, WHO's identification of global health security *risks* may be placed into three somewhat broad categories.

- Infectious disease, motivated not so much by the continued existence of diseases, such as malaria, which are endemic to large parts of the world, but by new diseases or new variants of known diseases which pose new risks and hazards.
- Food safety, especially risks arising from the industrialisation of agriculture exacerbated by the global nature of the food industry, as seen for example in the 2011 outbreak of *e. coli* in Germany.
- Catastrophes affecting the natural environment, whether deliberate, accidental or natural in origin. These include industrial accidents (such as toxic spills, the dumping of chemicals, and nuclear incidents such as Chernobyl and Fukushima); the release of pathogens through breaches of laboratory safety protocols or their deliberate use by terrorists; and extreme natural events (such as the European heat wave in 2003 or the Japanese earthquake and tsunami of 2011).

What is interesting here is the manner in which health security is broadened to include food safety and industrial issues, concerns traditional to public health but which do not feature in other understandings of global health security.

What is also clear is that, from WHO's perspective, global health security is a call for action. Its analysis of global health risks leads to a very clear prescription to

develop 'collective international public health action [to] build a safer future for humanity' (WHO 2007a: ix; see also Wilson et al. 2008: 48). Indeed WHO *defines* global health security in terms of actions:

> global health security is defined as the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries. (WHO 2007a: ix).

This prescriptive dimension can also be seen in some of the academic literature on global health security. Collier and Lahoff (2008: 7), for example, talk of an attempt to bring together previously distinct fields of health and politics to effect change. Fidler writes of a 'transformational moment' in public health as a governance activity (Fidler 2006: 196). Because of this, the use of the term 'security' begins to appear less of an analytical tool and more of a strategic or pragmatic practice. In other words, the term is used not to describe a condition but to increase awareness and encourage action for change by adding a sense of urgency and importance (Balzacq, 2005:172; Vuori, 2008). If so, then global health security is not an objective condition, but something constructed to promote health, a traditional task of health services nationally but now taken by WHO onto a global stage with added urgency.

(iii) Human Security

Although the contemporary origins of human security lie in the 1990 and 1994 Reports of the UN Development Programme (UNDP, 1990, 1994), its roots lie much deeper in classical liberalism's emphasis upon the individual. The 1994 Report in particular argued that security

> has for too long been interpreted narrowly: as security of territory from external aggression, or as protection of national interests in foreign policy…. Forgotten were the legitimate concerns of ordinary people who sought security in their daily lives…. For many of them, security symbolized protection from the threat of disease, hunger, unemployment, crime, social conflict, political repression and environmental hazards.... For most people, a feeling of insecurity arises more from worries about daily life than from the dread of a cataclysmic world event. (UNDP 1994: 22).

The 1994 Report explicitly identified health in general as a component of human security (UNDP, 1994: 24), while disease in particular runs through the Report as a threat to human security. By the turn of the millennium, human security was receiving considerable attention, not least because of the efforts of a small number of key advocates including then Canadian Minister of Foreign Affairs Lloyd Axworthy (1997, 2001), Nobel laureate Amartya Sen (2000) and academics Lincoln Chen and Caroline Thomas (Thomas, 2000; Chen at al. 2003; Chen 2004). The highpoint perhaps came in 2003 with the report of the Commission on Human Security, an initiative supported by UN Secretary General Kofi Annan and chaired by Sen and former UN High Commissioner for Refugees Sadako Ogata (Ogata & Sen 2003). In this report, Ogata and Sen argued that human security was about freedom from want, freedom from fear, and the capacity of individuals to take action on their own behalf.

At the heart of human security is a shift in the focus of security from the state to people. A strong and often explicit normative bias is common - that the world can and should be run in a different, better way by putting people first. Perhaps unsurprisingly then it is strongly linked to the promotion of human rights (for example, Ogata & Cels 2003: 274) and is also emancipatory in that it attempts to free people whether from fear, want or other forms oppression. However, most advocates of human security do not see it as replacing but complementing state security, not least because a stable state may be a pre-requisite for human security (Ogata & Cels 2003: 275). Thus human security *expands on* rather than replaces the idea of security as threats to the state. It addresses those risks and actors which threaten individuals and communities, and includes the idea of 'empowering people to fend for themselves' (Ogata & Sen 2003: 4).

That health is a human security issue appears to be unchallenged. To some extent, this is because health fits into human security's view of the emergence of transnational threats which states are no longer able to mediate but which affect the lives of individuals (Curley & Thomas 2004: 19-20). However, not all health issues are also risks to human security. Rather the Commission on Human Security suggested four criteria:

- 'The scale of the disease burden now and into the future.
- The urgency for action.
- The depth and extent of the impact on society.

- The interdependencies or "externalities" that can exert ripple effects beyond particular diseases, persons or locations.' (Ogata and Sen, 2003: 97)

More commonly, commentators have tended to focus on two of human security's key freedoms: freedom from want and freedom from fear. On the former, the link is not only about the manner in which health is fundamental to an individual's quality of life and dignity; it is also and more importantly about the relationship between health and poverty (Ogata & Cels, 2003: especially 278-9). This relationship may be characterised as a feedback loop: poverty leads to poor health, which in turn increases levels of poverty. In contrast, improved health may lead to economic growth as people become better able to work and less dependent upon health services. A generally good standard of health among the population may lead to economic stability and development which, in turn, would feed back into individual security through reduced fears over health and economic survival (WHO, 2001). On the second of human security's key freedoms, the freedom from fear, for health security this has been constructed in terms of more traditional state stability and military security (for example, Brower & Chalk 2003: 8-9; Ogata & Sen 2003: 97; Chen 2004: 4-5). Three concerns are commonly raised: that health crises may affect confidence in a state and the social order if the state is failing in its duty to protect its citizens from health threats; health crises may affect regional stability if they prompt population movements, either due to large-scale migration or the spread of disease via migration; and finally military security may be affected by placing troops at risk from disease, including STIs.

Despite the interest generated in human security in some quarters, and its apparent complementarities with the increased interest in humanitarianism and poverty relief at the turn of the millennium, human security has failed over the last decade to establish itself as the main security narrative. To a significant extent, this may be due to the manner in which Western governments have been able to construct terrorism both as the dominant security concern after 9/11 and as a national security problem. This, in turn, suggests the continued power of states to construct the dominant security narratives - in spite of human security's emphasis on states being as much the problem as the solution, and the inability of states to deal with new risks. Yet it is also, to some extent, the product of human security's vagueness as a concept. As Roland Paris comments,

> everyone is for it, but few people have a clear idea of what it means… [definitions] tend to be extraordinarily expansive and vague, encompassing everything from physical security to psychological well-being, which provides policymakers with little guidance in the prioritization of competing policy goals (Paris 2001: 88)

For critics such as Paris, human security is 'slippery by design' (2001: 88), a concept which is kept deliberately vague to ensure maximum support from diverse constituencies, but which then makes it ultimately little more than a slogan. Moreover, in its expansive articulation of security as encompassing social, economic and cultural well-being, it becomes difficult to see the difference between cause and effect: the causes of insecurity (poverty, poor health, economic deprivation) are also the effects of insecurity (Paris 2001:93). As a consequence, human security has not had the impact which its proponents have hoped for.

(iv) Bio-security

Although 'bio-security' has become an increasingly common term over the past 15 years, its meaning remains vague covering almost everything from threats arising from biological weapons (eg Fidler and Gostin, 2008) to more general risks to public health (eg Collier and Lahoff, 2008). This creates no small amount of confusion since the first is clearly suggestive of a national security approach, while the second appears almost identical to global health security. This section however focuses on a narrow and specific use of the term concerning the risks posed by the development of new micro-organisms in science laboratories. These risks include both the deliberate and the inadvertent release of pathogens outside controlled laboratory environments. Enemark (2010) points out that even trusted laboratory scientists may pose security risks: the main suspect of the US Federal Bureau of Investigation (FBI) for the 2001 release of anthrax spores in letters addressed to US congressmen and the media was Bruce Ivins, a government scientist with high security clearance levels who then committed suicide before his arrest. As the numbers of these laboratories and scientists involved increases, matched by increases in the numbers of biological agents and potential pathogens held in such locations, and in the movement of these pathogens internationally, so the risks appear to escalate.

This creates what is known as the 'dual use dilemma' where research and techniques developed in laboratories for medical benefit may also be used for harmful purposes (WHO, 2007b: 4). In 2005 for example, *Science* and *Nature* published research conducted by, amongst others, the US Centers for Disease Control (CDC), which successfully reconstructed the highly pathogenic 1918 Spanish Flu virus. CDC acknowledged that this research might be used for bio-terrorist purposes, but justified its publication on the grounds that it made health interventions easier should the disease recurr. Similarly in 2001 the *Journal of Virology* published results of an Australian attempt to produce an infectious contraceptive for mice, but which had the unforeseen side effect of increasing the virulence of mousepox. The publication of the technique used by the Australian team alerted others engaged in similar work to these possible side effects, but also raised concerns over whether it might be deliberately used on other orthopox viruses such as smallpox for harmful purposes (WHO, 2007c).

This use of the term biosecurity is important to this paper because it suggests two things. First, it highlights the continuing potential for tension between health and security *as well as* its complementarity. The dual use dilemma demonstrates that, for all of the initiatives and discussion over the past decade and a half, the two remain uncomfortable bedfellows and at times in opposition. Second, that the focus of global health security can be very narrowly defined – in this instance on the security of laboratories handling or developing dangerous pathogens, and on the right to publish these results. The wider risks to populations if these pathogens are used for harmful purposes gives the issue salience, but is not the primary security concern.

Conclusion

This paper has shown how the links between health and security now encompass a wider range of issues and vulnerabilities than previously. This new development is generally cast in terms of a response to exogenous developments, that new risks have emerged and have acquired added salience in the context of accelerated globalisation. At the same time the broadening of security's horizons beyond the narrow defence of the state against (usually) military threats, to include a more diverse range of risks from novel directions, has created a space whereby health issues can more easily become a part of the security agenda. That much of the discussion over health and security focuses on a similar range of issues – usually severe and acute epidemic infectious diseases, HIV/AIDS and bio-terrorism – has helped to create the sense that

this is a coherent picture where there is agreement over the landscape. What differences do emerge are therefore deemed second order issues concerning how to respond to such risks, rather than the first order scene-setting issues of what is being discussed within the realm of health security in the first place.

This paper however suggests that health security is essentially contested with a number of identifiable terms each reflecting a particular perspective and with its own narrative of health security. Crucially these narratives, which attempt to explain the social world, are not objective accounts of observed phenomena, but help to construct social reality by promoting particular understandings. In this context, the health-security nexus is not a coherent field, but one where there are key differences which are obscured by superficial commonalities. The paper identifies four distinct ways of seeing the health-security nexus, each of which is different in what it privileges. Health issues tend to figure on the *national security* agenda if they are seen as a potential threat to the internal security of the state, have an impact on international stability, or cause exceptional levels of morbidity and/or mortality. Its perspective remains heavily state-centric with the interests of the state (and indeed certain powerful states) privileged over those of individuals or communities within the state. What is notably important is how the national security agenda on health has been constructed with limited empirical evidence to support it, suggesting the ability of narratives to construct social realities based on discourse and inter-subjective understandings. The fact that there has been no health crisis leading to state failure has not prevented health issues appearing on national security agendas. *Global (public) health security* is concerned with health promotion on a global scale. It is motivated by a belief that risks to public health have been globalised, requiring a response beyond that which individual states are capable of. Its focus is on the emergence of global threats to public health and security, and its primary goal is therefore the well-being of individuals and populations in the face of these threats. *Human security* appears similar in that it is concerned with individuals and communities. Its focus however is not on health, but on freedom from fear and from want. Health is thus only a part of the human security agenda, not the focus of it, and other issues may be prioritised especially poverty alleviation. Both human security and global health security privilege individuals and populations, but they differ over what they are protecting them from. Finally, although *biosecurity* is used in a number of different ways, when referring to the risk of laboratory-created pathogens

becoming more widespread it demonstrates not only how definitions can be dramatically narrowed, but also how tensions between different perspectives remain.

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