

HEALTH, FOREIGN POLICY & SECURITY

TOWARDS A CONCEPTUAL FRAMEWORK FOR RESEARCH AND POLICY

Edited by
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Foreword

This second working paper in the UK Global Health Programme builds on earlier work providing an overview of the intellectual and policy landscape around issues of health, foreign policy and security. It develops this work to frame questions for examination by four further projects being undertaken by our partners at the London School of Hygiene and Tropical Medicine and the Department of International Politics at the University of Wales at Aberystwyth.

The UK Global Health Programme itself builds on the earlier interest of the Nuffield Trust in the implications of globalisation for the health of the people of the United Kingdom and the contribution the UK makes to improving global health. The rationale for the Programme is based on three main developments. The first is the way that health issues have become increasingly salient in foreign and security policy, while broader developments in these policy fields have at the same time many implications for health both in the UK and globally. Secondly, the blurring of boundaries between the domestic and the foreign as a result of globalisation means that the way we think and act in relation to health policy must adapt accordingly. Finally, links between health, foreign and security policy and development are increasingly being made, lending further impetus to the effort to understand the place of health in the policy agenda and ensure that health issues receive appropriate consideration.

The UK Global Health Programme will, through this work and its associated programme of conferences, seminars and consultations, continue to explore further the connections between health, foreign policy, security and development in the light of globalisation and the shifting international debate. The Programme aims to improve understanding of these connections, develop the evidence base and share its findings in dialogues with policy makers, researchers, the health sector, NGOs, foundations and the wider public in the UK and other countries.

John Wyn Owen CB

Director

UK Global Health Programme

August 2004

List of Abbreviations and Acronyms

BMJ	British Medical Journal
BOND	British Overseas NGOs for Development
CME	Commission on Macroeconomics and Health
CSS	Critical Security Studies
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DFAT	Department of Foreign Affairs and Trade (Australia)
DFAIT	Department of Foreign Affairs and International Trade (Canada)
ERID	Emerging and re-emerging disease
EU	European Union
FAO	Food and Agriculture Organisation
FCO	Foreign and Commonwealth Office (UK)
FCTC	Framework Convention on Tobacco Control
G8	Group of Eight Countries
GATS	General Agreement on Trade in Services
GATT	General Agreement on Trade and Tariffs
GHSAG	Global Health Security Action Group
GM	Genetically Modified
GNI	Gross National Income
HHS	Department of Health and Human Services (HHS)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IHR	International Health Regulations
IPR	Intellectual Property Right
JAMA	Journal of the American Medical Association
MCA	Millennium Challenge Account (US)
MDG	Millennium Development Goal
NATO	North Atlantic Treaty Organisation
NGO	Non-governmental organisation
OECD	Organisation for Economic Cooperation and Development
SARS	Severe Acute Respiratory Syndrome
SPS	The Agreement on the Application of Sanitary and Phytosanitary Measures
TB	Tuberculosis
TBT	Agreement on Technical Barriers to Trade
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UNAIDS	United Nations joint Programme on AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USTR	United States Trade Representative
WHA	World Health Assembly
WHO	World Health Organisation
WMD	Weapons of Mass Destruction
WTO	World Trade Organisation

1.0 Introduction

Alan Ingram

This second working paper is the result of the first of five projects commissioned to provide insights into the relationships between health, foreign policy and security. It builds on the UK Global Health Programme's first working paper (*Health, Foreign Policy and Security: a discussion paper*), which reviewed the broader research and policy context. Initial work quickly suggested that international development must also be considered as an essential part of the evolving landscape of global health, and this is reflected in this second paper. It also highlighted the extent to which a concern with security dominates Western policy, and this is reflected in a foregrounding of security in the discussion.

The development of the conceptual framework will continue for the duration of the Programme. At this initial stage the framework is largely descriptive. It is intended to provide a good first approximation within which other research projects carried out by the Programme can be situated and related to each other. The findings of these projects will, in turn, contribute to further iterations of the framework, a final version of which will underpin the resulting recommendations for policy. In practice, dissemination and networking are continuing throughout the Programme, with associated events run by the Nuffield Trust and Nuffield Health and Social Services Fund providing a range of opportunities for cross-fertilisation with related initiatives.

The first working paper identified a diverse set of issues, questions and empirical fields within the scope of an interest in health, foreign policy and security, which were then grouped around 12 gaps in knowledge and practice. The lack of theoretical and conceptual thinking about health, foreign policy and security was identified as the first of these. As McInnes and Lee argue in this second paper, a coherent conceptual framework is needed for three main reasons: the poor and variable definition of key terms; reliance on assumed or implied rather than demonstrated causal relationships between them, and a need to identify the key questions.

Each of these tasks is of more than academic significance in the context of current policy shifts. Increased concern among policy makers about the state of global health is clearly necessary and welcome. Recent developments have offered the possibility of enhanced resources and action, and health issues are more prominent now on the global political agenda than in a long time. One important challenge is to translate this prominence into a lasting commitment to global health. At the same time, the broader policy environment offers risks as well as opportunities. Health is often encompassed as part of a range of factors that are variously seen as contributing to human security or representing 'new' threats to national security, but is not always foregrounded as the central object of consideration or reference point for discussion. This is a matter of concern for health workers, researchers, managers and policy makers in a wide range of settings who do take health as their starting point. Because national security and economic development are of central interest to the state, their imperatives can exert great influence on efforts to promote and protect health and deliver health services. How then do rationales based on security and national interests sit with ideas

of the human right to health or the allocation of priority based on need rather than on threat or interest? Do emerging trends represent a welcome transformation and broadening of the idea of security to include health issues, or a misleading and possibly harmful diversion from core principles?

These are some of the issues explored in this working paper, drawing on insights from a range of sources: foreign policy documents, security studies, development, trade and the World Trade Organisation, and public health itself. All the authors took part in a workshop on key questions and developments in these fields, and background papers were written on each, focused around the concept of global health security. Lee and McInnes then drew on these papers in writing the conceptual framework.

The papers each aimed to respond to the same three questions:

- Whom or what is to be protected through the practice of global health security?
- Which health issues are legitimate security issues and which are not, and how do we decide?
- How should health, foreign and security policy interrelate?

The first background paper, by Feldbaum and Lee, considers relationships between public health and security. The definition of health itself has important consequences, and the authors refer to an ‘uneasy relationship’ between public health and medicine. Public health is ‘the collective action taken by society to protect the health of entire populations’, which may be defined in various ways and at a range of levels, of which the state is only one. They note that insecurity can be a risk to public health, and public health problems may constitute a risk to security, and offer a decision tree that describes current public health thinking on global health security. Attitudes to foreign and security policy communities within public health tend to fall into two broad categories: those that see the engagement of these communities as an opportunity to secure increased resources and political will; and those that are suspicious that foreign and security priorities are set by self interest rather than the humanitarian objectives that are central to public health. Political division and analytical fragmentation within public health on security and foreign policy questions therefore present challenges in developing a cohesive framework.

The second background paper, by Colin McInnes, focuses on the stated foreign policies of the US, UK, Australia and Canada as expressions of the rationales, aims and strategies underpinning action relating to health. These official policies shed light on how problems are constructed by policy makers, which in turn shapes the way they go about pursuing particular objectives. It is also interesting to compare stated foreign policy with its actual implementation. As McInnes shows, foreign policy in each country has recognised a global agenda, the blurring of domestic and international divides, and the importance of values, but the term health is rarely mentioned. ‘Disease’ is more common, and often grouped with other ‘global issues’ such as the environment. While health issues are becoming more prominent, they occupy a rather lowly place in relation to more traditional concerns, and are more strongly linked with international development. Interagency issues also loom large in all four

countries. One notable difference between them is that the US is alone in not claiming human rights as an explicit cornerstone of its policy.

The third background paper, also by Colin McInnes, offers insights from the field of security studies. There is no agreement on the definition of the term security itself within the field, and ideas of security have been broadened, deepened and developed in a number of directions beyond the earlier implicit consensus that security was a matter of protecting the state from threats through military force. Work exploring the processes by which issues are constructed as security problems emerges as being particularly useful. Security issues are not simply a matter of objective recognition of threatening phenomena but are defined socially by constellations of powerful actors. Much depends on the way relationships between individuals, communities and states are construed and the level of risk at which something qualifies as a security issue.

The fourth background paper, by Preeti Patel, Kelley Lee and Owain Williams, surveys debates about security within development studies and their implications for the idea of global health security. In particular, they note a range of critical responses to the apparent 'securitisation' of development or merging of development and security. While battles have been fought to untie aid, focus on poverty reduction and preserve humanitarian space, the War on Terror threatens to divert policy from criteria of need to criteria of threat, with inequitable and possibly counter-productive consequences. Security, it is argued, cannot be purchased at the price of development, and development should not be seen primarily as an instrument to achieve security. The relationship between health and human security may be central to overcoming these concerns but much work remains to be done. Finally, more sustained engagement with the implications of globalisation is necessary to reflect an increasingly plural global system and the growth of transborder flows.

The fifth background paper, by Owain Williams, examines the implications of World Trade Organisation (WTO) agreements for global health security. It is argued that four agreements in particular have the potential to change the architecture of global health governance significantly. These agreements have direct implications for public health communities and national health systems, and can be expected to threaten the health security of those communities whose states do not assert their interests in the arena of global governance. This appears to be at variance with the aim of improving global health. Although the effects of WTO agreements are likely to be incremental and cumulative, putting economic policy before public health may ultimately have negative implications for everyone.

The conceptual framework draws on these papers to set out a number of issues for the remaining projects in the programme. These projects will examine four areas:

- case studies in health, foreign policy and security: HIV/AIDS, bioterrorism, tobacco control, and migration
- health and risk
- health and conflict, and
- health impact assessment

While it recognises the interplay between them, the conceptual framework places public health and communities at the centre of concern rather than foreign and security policy, or the national interests of states. Despite differences across these fields, the authors identify three determining concerns in global health security: severity of risk, immediacy of timeframe and geographical reach. A number of potential roles for public health in relation to foreign and security policy are also outlined; each carries a mix of risk and opportunity; the role of independent actor, acting where necessary in partnership with other communities, is proposed as the only viable one.

Table 1: UK Global Health Programme structure

	Academic Programme				Associated events
Phase 1	Development Broad review of research and policy context				Ongoing conferences, seminars and consultations
Phase 2	Research Five linked research projects				
	Conceptual framework				
	Case studies of health, foreign policy and security	Health and risk	Health and conflict	Health impact assessment	
	Review of conceptual framework and development of recommendations				
Phase 3	Dissemination Conference, seminars and publications				

2.0 A conceptual framework for research and policy*

Kelley Lee and Colin McInnes

A conceptual framework for research and policy is needed for a number of reasons.

- First, it is readily apparent from our review of the growing literature on health, foreign policy and security in the first working paper of the UK Global Health Programme (*Health, Foreign Policy and Security*) that a number of key concepts and terms – including ‘health’ and ‘security’ themselves – are either poorly or variably defined. This lack of clarity is reflected in contemporary scholarly and policy debates, leading at times to vagueness of focus or talk at cross purposes. For this Programme we need clear and agreed definitions to ensure that our different projects are consistent in subject matter and comparable in their findings.
- Second, there are important causal relationships to be explored between health, foreign policy and security that have so far been assumed or implied, rather than empirically demonstrated. What those causal relations are and how they are to be analysed within this programme of work requires their location within an agreed conceptual framework.
- Third, we need to identify what questions we are trying to answer and how we are answering them. This is a fundamental intellectual question, but it also has direct practical implications. The starting point of the Programme is that there are certain issues arising that cross the realms of health, foreign policy and security. Our task is to define what those issues are: what makes a health issue also a foreign and security policy issue?
- Finally, we need to have an organising (heuristic) framework to guide research in a systematic way.

It is important to recognise that the conceptual framework serves two key functions. First, as presented in this paper, it is initially a **descriptive framework** describing what the links among the various policy communities are. It seeks to describe, for example, what health issues have been focused on, how certain debates have been carried out, what role different actors have played and so on. In this process, the current discourse is taken as given.

Second, following completion of our empirical research we will revisit the conceptual framework at the end of the programme to try to develop a **prescriptive framework** concerning what *should* be the links between health, foreign policy and security. This will seek to critique the current discourse and suggest an alternative understanding of the subject. Some elements of this normative framework may already be inferred. These will develop and

* The authors would like to acknowledge the support of John Wyn Owen, Sir Denis Pereira Gray and Alan Ingram at The Nuffield Trust, the authors of the following background papers, and members of the Programme’s Advisory Board for their advice and support in developing this work. In addition, Olga Bornemisza and Egbert Sondorp provided useful advice and resource materials.

become more explicit over time and therefore encourage debate and discussion in the hope of developing a policy consensus. A conceptual framework such as this is therefore intended not only to act as the basis for future studies within the Programme, but to enable better policymaking by clarifying the link between health and foreign and security policy.

This paper sets out the descriptive conceptual framework that will inform the four remaining projects of the work programme. It is based on the five background papers in this volume:

1. Public Health and Security
2. Health and Foreign Policy
3. Health and Security Studies
4. Health, Development and Security
5. The WTO, Trade Rules and Global Health Security.

As should be apparent, we take a broad view of ‘foreign and security policy’, to include development and trade. We acknowledge therefore that we may need a better term to cover a variety of policy and academic communities (not least for UK policy purposes, where development is not only a separate Department of State, but one which has traditionally paid much more attention to global health than the Foreign Office). However we are also aware that elsewhere these functions may fall under a single foreign ministry and we do not wish to be overly UK-centric. We look for feedback on this.

Each of the background papers addresses three core questions from their own perspective:

- Whom or what is to be protected through the practice of global health security?
- Which health issues are legitimate security issues and which are not, and how do we decide?
- How should health, foreign and security policy interrelate?

We bring together the analyses of these questions from each of the papers. We highlight any differences but focus on finding common perspectives that bring the fields together and thereby provide the beginnings of a conceptual framework. This framework is intended to evolve, not least through the iterative process of the Programme itself, but also through comments. Feedback to the authors is therefore welcome and encouraged.

What is health?

The concept of health has a wide variety of meanings. Traditional biomedical approaches to health focus on the absence of a medically-defined and certified disease. By contrast, health can be seen broadly as an ideal state, as adopted in the preamble of the WHO Constitution (1946): ‘Health is a state of complete mental, physical and social well-being and not merely the absence of disease or infirmity.’ How health is defined or used as a concept can have a major impact on policy debates. For example, the Programme’s first working paper found health used in terms of disease, whether intentionally spread through bio-terrorism or emerging in the form of acute epidemic infections, leading to a restrictively narrow focus. A second important distinction, in the context of global health security, is between clinical

medicine and public health. Clinical medicine concerns the health problems of individuals while public health is action taken by society to protect and promote the health of communities.

For our purposes, we adopt the broader WHO definition of health, rejecting other definitions as too narrow to encompass the full range of concerns. The concept of global health security also implies a public health perspective as the starting point in its concern with protecting (but perhaps not promoting) the health of populations.

Whom or what is to be protected through the practice of global health security?

Each of the various disciplines and policy communities involved in this debate has a different perspective and starting point on this question, and some even have a lack of consensus amongst themselves. For example, within the academic discipline of International Relations, and its sub-discipline security studies, debate over what is to be protected by international security remains intense. As described in Background Paper 3, traditional approaches to security studies identify the state as the object of security protection. This perspective has come under sustained pressure over the past two decades, resulting in a broadening of the field to include new forms of security.

While it is not possible to reconcile all of the different perspectives on this issue, the UK Global Health Programme seeks to build on some common ground. One point of agreement is the need to go beyond an exclusive preoccupation with the state. It is widely recognised that causes and effects that cross, and even circumvent, state borders are a key feature of global health security, while developments within states may have global health impacts or may arouse the concerns of external actors. The exception to this consensus appears to be foreign policy. The four case studies examined in the background paper reveal considerable consistency in prioritising the national interest. This would seem to suggest that, for foreign policy, the object to be protected is unproblematically the state. However, the national interest is not seen simply as the promotion of a narrow self-interest, but tempered by other factors. First there is a strong sense that globalisation means that states can no longer divorce their interests from wider global concerns. Second, values, albeit national values, figure prominently. Further there is a general sense of the importance of the global good, and of humanitarian obligations which may, on suitably extreme occasions, transcend the national interest. Although some might deny that there is a dichotomy between humanitarianism and the national interest, most see a potential for tension and what remains unresolved is the issue of when a humanitarian obligation may ‘trump’ national interests. So, although the state remains the primary referent object in foreign policy, there is a sensitivity to both global and local (even individual) concerns.

A second point of agreement is that global health security concerns the health of populations rather than the individual. Security suggests protecting the interests of social groups or communities rather than the furthering of individual self-interest. In public health, communities are not necessarily coincident with the state but are defined by the health issue under consideration. Communities can vary in size and characteristics, ranging from the

global community, the state, regional groups, or groups defined by occupation (eg mine workers) or behaviours (eg smokers). As Feldbaum and Lee write in Background Paper 1:

Although individuals are not the main focus of public health, they do play a major, and at times, complex role in public health activities. Like clinical medicine, public health constantly engages with the collective outcomes of individual thoughts and behaviours. However, unlike clinical medicine, public health's engagement with individuals is guided by the goal of protecting and promoting the health of the community.

Although the state may constitute a community in public health terms, this does not axiomatically mean that, for our purposes, the state should be the focus of public health. It is the public health issue, not the political interest, which defines the community. Sometimes – as with bio-terror – that community may be the state, but at other times it may not.

Development's traditional focus on human needs points towards a human security approach and the interests of communities rather than states, but this has been complicated by recent trends. The first of these is the discussion over the relationship between development and security. Background Paper 4 draws attention to work which examines links between development and security and the assumption that 'achieving one is now regarded as essential for securing the other'. Not least, many policy actors have stressed that development is assisted by stability and interest has increased in the state's role in providing a stable environment. Thus the general condition of the state or of a society may constitute a legitimate focus for security concern. Second, since 11 September 2001 development has been subsumed by some states into a broader political agenda as part of the War on Terror (see for example the US *National Security Strategy* (White House 2002) and OECD Development Assistance Criteria guidelines (OECD 2004)). Although the main focus of the resultant debate is the relationship between development and security, this does support our contention that individuals are not the appropriate focus of concern. It also throws light on the often complex relationships between communities and states, and human security and national security, within which policy communities operate.

In conclusion, we agree with Barry Buzan (1983) that the individual remains the 'irreducible basis' for security but that it is usually only when issues have broader implications for a community that they have political legitimacy as security issues. Although individual security matters, our focus here is not the individual but communities. Furthermore, although the state may form a community, communities with distinct health security issues may exist within a state or across states. (In this sense, 'community' is used in the public health sense rather than Buzan *et al*'s (1998) 'societal security'.) What makes a health issue a global issue and part of the international agenda is agreement that it cannot be resolved at the national level or that it has implications beyond national borders. Thus global health security is about protecting communities where there is agreement that an issue has implications beyond, or cannot be resolved by, an individual state.

Which health issues are legitimate security issues and which are not, and how do we decide?

The Background Papers find that there is a growing consensus that certain health issues can also be described as security issues. However, there are no explicit criteria used to define which health issues are legitimate global health security issues and which not. In some cases, the criterion has been the cross-sector nature of an issue such as bioterrorism. In other cases, the public health community has wanted to attract the attention of other policy communities to such issues as HIV/AIDS and other communicable diseases. Furthermore, different policy communities answer this question differently. What the security policy community see as a global health security issue is not necessarily regarded as such by the public health community. Setting the policy agenda is, at times, a highly political process.

Background Paper 2 concludes that the foreign policy community tend to assess health issues in an ad hoc and pragmatic way, rather than systematically. A number of factors may help a global health issue to secure a place on the wider international agenda:

- when a global health issue becomes a humanitarian catastrophe, or when one is threatened;
- when economic development is threatened;
- when regional stability is at risk; and
- when health issues are part of trade negotiations.

In the public health community, the approach is more systematic. Feldbaum and Lee, in Background Paper 1, find that there an issue is considered a global health security issue if it meets all of the following criteria:

- *population rather than individual health* – it impacts on the health of populations rather than individual health;
- *high rather than low level of morbidity/mortality* – it causes a high incidence of death or disease;
- *acute rather than long-term health impact* – it represents a ‘clear and present danger’ to population health (eg bioterrorist attack using smallpox) rather than a long-term impact (eg ageing); and
- *crossborder/transborder rather than intra-border* – its impact is experienced across more than one country.

In terms of security policy, a natural assumption might be that health becomes an issue when there is a belief that disease may be used consciously to inflict harm for political goals. This is mirrored to an extent in security studies, where the focus is on existential threats, particularly to the state. However the state is no longer necessarily the focus of concern and there has been considerable conceptual thinking over the nature of security and what makes an issue a security issue. In Background Paper 3, McInnes suggests the following criteria, derived from work by the Copenhagen School, for determining whether an issue has credibility as a global health security issue:

- it must be perceived as an *extreme threat* to social well being, going beyond the individual to the community;
- it must have *substantial political effect*;
- it cannot be dealt with nationally or has *implications beyond national borders*; and
- it has *legitimacy* as a security issue – a claim is made that the issue can be presented as a threat in security terms.

By contrast with the security studies focus on existential threats to states, public health and development are focused more on securing the well-being of communities and not all threats to the well-being of communities may be regarded as security issues by policy makers. Those that do qualify tend to exceed certain thresholds of significance, here designated as ‘extreme’. We do not believe an objective measurement of ‘extreme’ can be determined but a number of the criteria outlined above are likely to be engaged, accompanied by inter-subjective agreement that an issue merits such a description and the consequent attention.

Despite differences in opinion across policy communities on what issues constitute a global health security threat, and recognising the unavoidably political nature of how policy agendas are set, it is possible to identify some common ground in terms of the criteria presented used:

- *severity of the risk* – There is agreement that the severity of the risk to social well-being (ie health status, economy) distinguishes those issues that require cross-sectoral attention from those that do not. Within public health, this is measured by the impact on morbidity and/or mortality. In security studies, this is measured in terms of extreme versus non-extreme impacts on social well-being.
- *immediacy of the timeframe* – There is agreement that those issues that present a relatively immediate risk should be defined as a global health security issue. This explains why acute infections and biological weapons are perceived as such, while ageing and childhood obesity are not.
- *geographical reach* – There is agreement that those issues that pose a potential risk across national boundaries (crossborder and transborder) should be defined as a global health security issue. In the existing literature, those infections that pose a threat to social well-being in more than one country have been given attention.

How should health, foreign and security policy interrelate?

Background Paper 3 suggests that what is developing is a ‘homogenous security complex’ where the pattern of relations between the various involved parties is unique to this issue (although health may also be part of a ‘heterogeneous’ security complex as one of a number of inter-linked security issues within a specified geographic area). Background Paper 2 also highlights the interagency tendency of modern foreign policy, and that foreign policy can no longer be considered the sole preserve of foreign ministries. We suggest a number of possible relations between health and foreign policy (broadly defined to include development and security):

Supplicant

Paper 3.1 notes how some in the public health community have seen an opportunity for increased funding in a relationship with other communities, notably by making the case of the benefits of health investments for stability and economic growth. Such relationships might also secure the political leadership required to help resolve global public health issues. Thus public health is a supplicant looking to other policy communities for assistance.

We believe this to be an unsatisfactory relationship as the agenda is likely to be controlled by other communities: policy will not be driven by the interests of global public health but of stability and economic development, with the possibility that this may be negative for public health. Although the promotion of stability and economic development may at times be beneficial to public health, it may not always be so. Prioritising these issues may not necessarily allow the most urgent public health issues to be dealt with, while policies to alleviate human suffering may be at risk from power politics. Moreover, having gained some resources, public health now has to demonstrate quick gains to justify more; the strategies for such gains – such as the Global Fund and Presidential Emergency Plan for AIDS Relief etc – may actually interfere with some of the longer term and broader goals of global public health.

Trojan Horse and Trojan Mice

In a Trojan horse relationship, public health plays to the traditional concerns of foreign policy to secure a ‘place at the table’. Thus it emphasises the risks of certain public health issues for national security – such as communicable disease and bio-terror. Once it has secured a seat at the table, it can then begin to promote its own agenda, or enjoy spin-offs and collateral gains. The risk of this strategy is that public health will be unable to expand the agenda beyond the narrow confines of national security. Having bought into another agenda it may lack the political muscle to shape it.

A related alternative is that of ‘Trojan mice’: small issues may creep onto the agenda at the margins but slowly lead to a paradigm shift. To succeed in this strategy however, public health must either be part of a broader movement where it constitutes the ‘tipping point’ in an extant debate, or be willing to play a long (conceivably very long) game. We are not convinced that an extant debate exists for public health to act as a tipping point, and believe that there is no time for a long game.

Partnership

This relationship is one in which the tools and skills of various policy communities – development, security, public health and foreign policy – are brought together for the greater good. An example of this is WHO’s ‘health as a bridge for peace’ initiative. In this, no one policy community is necessarily privileged. This however raises a variety of questions. Whose responsibility is it to bring the communities together? On what issues are they brought together? How are disputes between policy communities resolved?

Public Health as an independent actor

Whereas the position of supplicant is one of ‘what can public health do for foreign and security policy’, this scenario turns the tables to ask what can be done for public health. For example, on the Framework Convention on Tobacco Control, public health advocates approached the foreign policy community and requested their influence to solve a problem, arguing that it would be in their interest, and providing advice on what to do. This is an approach which the foreign policy community may welcome because it is clear, goal-oriented, can be factored into the policy process and is amenable to negotiation. It also maintains established, comfortable sectoral identities rather than insisting on difficult new mergers or partnerships.

In conclusion, a number of relationships are possible. We do not find the first two options compelling, but recognise that the logistics of equal partnership remain under-explored and public health may occasionally be most effective acting independently. The Programme’s empirical case studies will analyse examples of these types of relationships in order to draw policy lessons across the respective communities involved.

Summary

This paper began by stating that there is no agreed understanding between interested bodies of health or security. We therefore propose the following:

- that security is concerned with threats or risks to social well-being of an extreme nature;
- that health is concerned with mental, physical and social well-being and that for our purposes a public health perspective is appropriate – actions taken by society to protect and promote the health of communities.

In answer to the three questions which have underpinned this paper and the background papers:

Whose security?

Although individual security matters, the focus of concern for our purposes is the community. Though the state may form a community, communities with distinct health security issues may exist within a state or across states. Thus the focus cannot exclusively be the state. Issues are only global health issues if there is agreement that they have implications beyond, or cannot be resolved by, an individual state.

What are the issues?

The following criteria are suggested for determining whether or not an issue is a global health security issue.

- *severity of risk* – assessed by the impact on morbidity and/or mortality or in terms of extreme versus non-extreme impacts on social well-being.

- *immediacy of the timeframe* – issues that present a relatively immediate risk should be defined as a global health security issue.
- *geographical reach* – issues that pose a potential risk across national boundaries (crossborder and transborder) should be defined as a global health security issue.

What is the relationship between the policy communities?

A number of relationships are possible. We do not find those which attempt to present public health as part of another policy community's agenda satisfying and therefore recommend partnership or public health acting independently.

The UK Global Health Programme will now use the above draft conceptual framework to organise and inform the four remaining projects, after which the framework will be finally revised in the light of that research.

References

- Buzan B (1983) *People, States and Fear: the National Security Problem in International Relations* Harvester/Wheatsheaf
- OECD (2004) DAC Criteria for Evaluating Development Assistance www.oecd.org
- The White House (2002) *The National Security Strategy of the United States*
- WHO (1946) *Constitution*

3.1 Public Health and Security

Harley Feldbaum and Kelley Lee

This background paper aims to shed light on the increasing engagement between public health, foreign and security policy communities. In particular, it will answer the following questions from a public health perspective:

1. Whom or what is to be protected through the practice of global health security?
2. Which health issues are legitimate security issues and which are not, and how do we decide?
3. How should health, foreign and security policy interrelate?

Whom or what is to be protected through the practice of global health security?

To define whom or what is to be protected by global health security from a public health perspective we need to begin by clarifying core concepts. ‘Health’ has a wide variety of meanings. Traditional biomedical approaches to health focus on the absence of a medically-defined and certified disease. By contrast, health can be seen broadly as an ideal state, as adopted in the preamble of the WHO Constitution (1946): ‘Health is a state of complete mental, physical and social well-being and not merely the absence of disease or infirmity.’ As Beaglehole and Bonita (1997) have pointed out: ‘The chosen definition of health has important implications for health policy. It determines whether the emphasis is on a multi-sectoral approach to improving health or whether the focus is on selected diseases and technological solutions.’ The review of the existing literature on global health security in the first UK Global Health Programme working paper found health defined in terms of disease whether intentionally spread through bioterrorism or emerging in the form of acute epidemic infections.

A second important distinction, in the context of global health security, is between clinical medicine and public health. Clinical medicine concerns the health problems of individuals. Public health is ‘the collective action taken by society to protect and promote the health of entire populations’. Hence, epidemiology, the most important science contributing to public health, focuses on the causes of disease at the population level and the methods for their control (Beaglehole and Bonita 1997). The concept of global health security implies a public health perspective as the starting point in protecting (but perhaps not promoting) the health of populations. As such, the focus of global health security (more commonly known as public health security) is populations or human communities. These communities can be highly varied and may be referred to as, for example, risk groups, demographic groups, classes or cohorts. Groupings of people by socioeconomic status, race, gender, location, occupation, and behaviour (for example intravenous drug users) are examples of the characteristics that define communities and their health status. These characteristics, in turn, are typically used to understand differential health risks. For instance, smokers were found to be at increased risk for lung cancer because of their behaviour (Doll and Hill 1952). In occupational studies, agricultural workers are found to be at increased risk of pesticide poisoning and other work-related hazards (Thompson *et al* 2003; Kirkhorn and Schenker 2002). Importantly, communities can overlap and studying their various characteristics leads to a complex, yet

more accurate, picture of a given community's health status. For example, an occupational study of asbestos workers who also smoke reveals a synergistic effect between asbestos exposure and smoking that greatly increases lung cancer risk above the risk of either smoking or asbestos exposure alone (Hammond *et al* 1979).

Populations or communities can also be defined at different levels. These include as an individual state, such as the Acheson Report which investigated the status of health inequalities in the UK (Acheson 1998); or regionally/internationally in aggregate (for example *World Health Report*), transnational ethnic groups (nations) such as Kurdistan stretching across Iraq and Turkey; or subnational groups such as the Navajo Nation within the US.

Although individuals are not the main focus of public health, they do play a major, and at times, complex role in public health activities. Like clinical medicine, public health constantly engages with the collective outcomes of individual thoughts and behaviours. However, unlike clinical medicine, public health's engagement with individuals is guided by the goal of protecting and promoting the health of the community. Garrett (2000) writes that early public health pioneers could be antagonistic with the medical profession if a physician placed individual health above the health of the community. She writes that '[p]ublic health fought on behalf of the community, placing special attention on the poorest, least advantaged elements of that community, for it was amid conditions of poverty that disease usually emerged.'

The different referent objects of public health and medicine have created at times an 'uneasy relationship' between the two health fields (Institute of Medicine 1998). Public health's focus on the health of communities, and the health of the public over the rights of the individual, is codified in the legal systems of many countries including American constitutional law. In the classic 1905 case establishing US public health law, *Jacobson vs Commonwealth of Massachusetts*, Henning Jacobson refused a mandatory smallpox vaccination. The US Supreme Court upheld the mandatory vaccination policy, arguing that Mr Jacobson could not benefit from his neighbours being vaccinated without assuming the risks of vaccination himself. This case established the power of the state to act against the individual for the benefit of the public's health (Joseph 2003). The requirement for certain infectious diseases to be 'notifiable', under the International Health Regulations (IHR) and national public health acts; Article XX(b) of the General Agreement on Trade and Services allowing 'each contracting party to set its human, animal or plant life or health standards'; and the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), which affirms the primacy of the urgent public health needs in some developing countries over intellectual property rights, all give recognition to the principle that the collective good of public health should take precedent over the rights of individuals, individual countries or individual companies.

Because public health works with diverse communities of varying size and characteristics, it might be expected that it encounters conflicts between the health needs of different communities. For example, actions that improve the health of one community might

compromise health in another. However, this is rarely the case. Public health's ability to prevent disease in one community, notably communicable disease, can create health benefits in other communities. This is increasingly so given the increased interconnectedness of communities throughout the world through communication and transport links. Efforts to revise the IHR in recent years, based on the concept of 'public health emergencies of international concern', reflects recognition of the emerging global context of public health. The concept of 'global public health goods', which encourages investment in, for example, immunisation and disease surveillance because of their positive externalities, also recognises the increased risk of health 'spillovers' in a global world. The 20th century's greatest public health achievement, the global eradication of smallpox, was achieved by ring vaccination campaigns in affected communities. The cost of identifying and vaccinating the final communities was large, and some concerns were raised about coercive measures taken, but the collective global benefits of eliminating the disease and reorienting health spending to other public health needs have been enormous (despite the subsequent risk of the use of smallpox in a biological attack). The need for the Framework Convention on Tobacco Control (FCTC) arose from the increasingly globalised nature of the tobacco industry and thus the need for collective action.

In summary, an understanding of the concept of global health security from a public health perspective begins with a focus on the health of populations. Public health is concerned with social collectives or groups, defined in various ways and at various levels.

Which health issues are legitimate security issues and which are not, and how do we decide? In the existing literature, the public health community has not yet critically engaged with the contested conceptions of security (as described in Background Paper 3.3). Yet there is growing use of the term 'security' and, in particular, 'public health security'. Whether health issues are considered to be security issues within the public health community is understood in two complementary ways – whether insecurity is a risk to public health, and whether public ill health is a risk to security.

Insecurity as a risk to public health

First, traditional security issues, such as military conflict and weapons, constitute a potential threat to the public health. A substantial literature addresses the public health consequences arising from conflict situations (*MMWR* 2003; Salama *et al* 2001; Goodyear and Hynes 2001; Hankins *et al* 2002). While focused on conflicts between states, this literature is predominantly concerned with how conflict causes ill health. Conflicts themselves and causes of conflict are rarely the subject of public health research.

State-based security has been discussed in the editorial, commentary and non-clinical sections of a number of leading public health journals. *The Lancet*, the *BMJ* and the *Journal of the American Medical Association* (JAMA) have all engaged in discussions of the public health impacts of the conflicts in Iraq, Afghanistan, former Yugoslavia, Rwanda and other areas (see, for example, Ashraf 2003; Dyer 2003; Vastag 2003). This attention suggests a strong recognition that public health can be directly affected by wider strategic security issues. However, the relative lack of published research that empirically studies the public health

implications of state security, or the broader interactions between foreign policy, security and public health, suggests a difficulty in applying the traditional analytical tools of public health. Expressing this argument, the editor of *The Lancet* Richard Horton writes that the ‘traditional biomedical approach to illness inhibits wider interdisciplinary, specifically political, studies of violence prevention’ (Horton 2001). While he argues that engaging in politics is a necessary part of public health, there has been some backlash against the debate of political issues in medical journals (Whiting 2004).

A related use of the term ‘security’ in public health is predominantly in reference to human security considerations, particularly food security (Rosegrant and Cline 2003; *The Lancet* 2003; de Waal and Whiteside 2003). The Food and Agriculture Organisation (FAO) defines food security as existing ‘when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life’ (www.fao.org). Factors affecting food security include crop yields, water scarcity, agricultural practices and climate change (Rosegrant and Cline 2003). De Waal and Whiteside (2003), for example, argue that Southern Africa is undergoing a new variant of famine and food insecurity due to high HIV infection rates in the region.

The conceptualisation of public health security in human security terms appears due to two considerations. First, public health and human security share similar humanitarian values and an interest in the well-being of individuals worldwide. Second, the definition of human security includes promoting and protecting health status. There is thus normative and conceptual overlap between the two areas. These factors keep much of the public health security research firmly focused on human security considerations.

Public health as a risk to security

The second and far more limited way in which health and security issues are conceptualised in the public health literature is the extent to which selected health issues pose a threat to state-based security. Direct calls for addressing health needs as security concerns are infrequent in the health literature. However, there are three main areas where this has been argued.

First, in a 1992 report the Institute of Medicine (IOM) outlines the threat emerging and reemerging diseases (ERIDs) pose to the American people (Institute of Medicine 1992). A central message of this report is that ‘in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected.’ It considers the factors causing ERIDs to spread, and argues that these diseases pose an increasing threat to the US. While the report does not specifically argue that ERIDs are a national security threat, it does mark a growing inclination to frame them in this way. Lederberg, for example, argues that infectious diseases are a threat to global health and security (Lederberg 1996). Laurie Garrett, a science journalist for *Newsday*, similarly writes that ERIDs, as well as biological weapons, pose serious risks to the US and international community (Garrett 1996). Schoeman argues that ERIDs have political, military and security relevance (Schoeman 2000). In 2001, the revision of the IHR began to be described at the World Health Assembly (WHA) in terms of ‘global health security.’ The proposal to shift

reporting beyond specific diseases (ie plague, yellow fever and cholera) to ‘syndromes’ was later not adopted. However, it was accepted that there needed to be a better way of ‘determining whether a public health risk is of urgent international importance and, if so, in helping decide which public health measures should be applied’. The development of a decision tree to define ‘public health emergencies of international concern’ is thus currently proposed (WHO 2001). In December 2002, the newly-formed WHO Scientific Advisory Committee for Global Health Security met for the first time ‘To assist advancing [the Division of Communicable Disease Surveillance and Response] strategy on global health security – epidemic alert and response (www.who.int)’.

The second, and related, issue seen as linking health and security is HIV/AIDS. Following the first UN Security Council meeting on HIV/AIDS in January 2000, UNAIDS established the Office on AIDS, Security and Humanitarian Response in July 2000. Both UNAIDS and this office increasingly argued, in international meetings and policy documents, that HIV/AIDS constituted a ‘threat to security’ (UNAIDS 2000, 2003). The concept of security implied in this literature spans both state-based and human security concerns. It has focused on how the inexorable spread of the disease is decimating military capacity, and thus having destabilising effects on armed forces and peacekeepers. By depopulating countries, notably the most economically productive sectors of societies, HIV/AIDS is undermining state capacity and thus causing potential regional and even global instability. The disease is also impoverishing millions and destroying social structures which, it is argued, can be prerequisites to state insecurity.

The third health issue receiving attention, within the context of global health security, is bioterrorism. Bioterrorism, or the intentional use of biological weapons by terrorist organisations, has been seen by the public health community as a clear public health and security threat since the mid 1990s. Three events in the mid-1990s brought the threat of bioterrorism into the public health discourse. In 1995, Iraq confirmed that it had produced weapons containing *Bacillus anthracis* and the botulinum toxin. The same year the Japanese Aum Shinrikyo cult attacked the Tokyo subway with Sarin gas (Olson 1999). This was followed by a series of revelations, following the end of the Cold War, about the extent of Russia’s biological weapons programmes. Realisation that these programmes were more extensive than previously believed caused great concern within the international community (Henderson 1998). These events led to large scale efforts and collaboration between the public health and security communities to enhance response preparedness and surveillance for biological weapons (see, for example, Mitka 2003; Frist 2002; Ashraf 2002). In response to a call by US Secretary of Health Tommy Thompson for countries fighting bioterrorism to share information and coordinate their efforts, the Canadian Minister of Health hosted the first G7+ (Canada, France, Germany, Italy, Japan, Mexico, US and the UK) ministerial meeting of the Global Health Security Initiative in late 2001. It was agreed that ministers would form a partnership to work together in the following areas:

- procurement of vaccines and antibiotics, particularly smallpox;
- research capacity and development of regulatory frameworks;
- emergency preparedness and response plans;

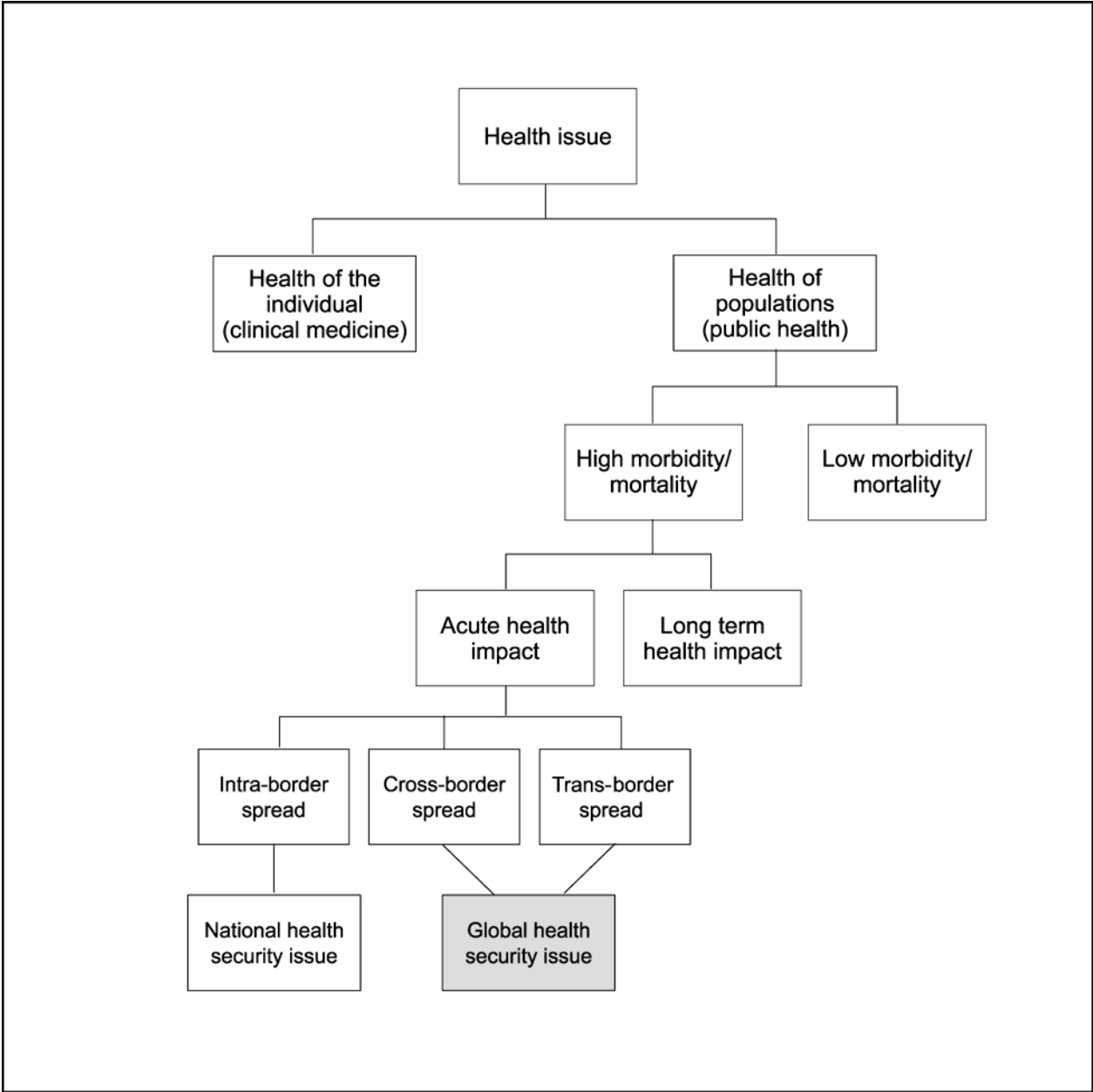
- risk assessment and language on risk communications;
- laboratories, including level four laboratories;
- disease surveillance;
- preparedness and response to radio-nuclear and chemical events; and
- food and water supplies.

A Global Health Security Action Group (GHSAG) and various working groups have been formed to develop proposals and concrete actions, and follow-up ministerial meetings have been held.

Returning to the question of what health issues are legitimate global health security issues and what are not, we can see that the public health community has so far focused on infections, spread intentionally or otherwise, as the key health risk to security. This is understandable given that communicable diseases, by their nature, pose a potential health risk to wide-ranging populations. However, it is important to note that not all communicable disease and indeed not communicable diseases exclusively, have been deemed to be a security risk. Attention has been focused on health issues with certain characteristics. Identifying these characteristics can assist us in differentiating what is seen as a global health security risk, from a public health perspective, and what is not. Figure 1 shows a decision tree that can be used to categorise health issues along a number of parameters:

- *population rather than individual health* – it impacts on the health of populations rather than individual health;
- *high rather than low level of morbidity/mortality* – it causes a high incidence of death or disease;
- *acute rather than long-term health impact* – it represents a ‘clear and present danger’ to population health (eg bioterrorist attack using smallpox) rather than a long-term impact (eg ageing); and
- *crossborder/transborder rather than intra-border* – its impact is experienced across more than one country.

Figure 1: Current thinking within public health on global health security



This decision tree shows the process by which certain issues are deemed to be global health security issues. For example, the problem of childhood obesity is a clear challenge but it is not considered, within current discourse, to be a global health security issue because its health impact is long term. Finally, it is clear from this approach that certain health issues that are considered global health security issues, from a public health perspective, may not be seen as such by the security and foreign policy communities (as described in Background Papers 3.2 and 3.3). Indeed, while there is some overlap in policy agendas, there are some major public health issues that meet the criteria above (such as tuberculosis and tobacco control) but have so far been omitted from foreign policy and security consideration.

How should health, foreign and security policy interrelate?

There are two competing views of the foreign policy and security communities within public health. The first perspective looks to the foreign policy and security communities as a source of greater funding and political will. Politically-savvy public health leaders such as Kenneth Shine, Richard Feachem, Gro Harlem Brundtland and Peter Piot have argued in favour of increased investment in public health partially through appeals to the self-interest of wealthier countries. The WHO Commission on Macroeconomics and Health (CME) is the most prominent example of the use of economic utilitarianism to justify increased resource allocation. The Commission argued that investing in health was an essential component of ensuring macroeconomic development and long-term stability (Sachs 2001). Similarly, Feachem and Piot have both argued that the HIV/AIDS pandemic represents a threat to national and global security as part of their efforts to increase political attention and public expenditure to fighting the disease. This perspective follows Bill Foege's maxim to '[t]ie the needs of the poor with the fears of the rich. When the rich lose their fear, they are not willing to invest in the problems of the poor.' (Gellman 2000)

The second perspective is found in more informal discussions of the relationship between the health, foreign policy and security communities. This perspective feels disdain for the great power politics that place wealthy nations' self-interest above human suffering. Many in public health feel that the field should be funded based on its humanitarian merits alone, and not because of its benefit to the security and economic growth of wealthy nations. As Paul Farmer laments, '[a]t best, those of us working in places like Haiti can hope for trickle-down funds if the plagues of the poor are classed as "US security interests"' (Farmer 1999). These two perspectives coexist within public health with little open debate between them.

The UNAIDS Office on AIDS, Security and Humanitarian Response provides one example of how public health can engage in the security implications of a disease. The Office's HIV prevention activities have three main foci: peacekeeping operations; uniformed services; and humanitarian responses. Their activities involve the use of public health tools to monitor rates of HIV and implement prevention activities. In this example, UNAIDS has simply applied public health programs to new communities involved in security. Other relationships between the public health, foreign policy and security communities can be envisaged where public health critically evaluates the risk certain health issues pose to national and international security, or the effect of the security and foreign policy community's involvement in addressing health issues. Constructing a relationship between the fields must involve public health scrutiny of foreign policy and security involvement health affairs.

In summary, the field is currently divided politically and fragmented analytically. There is no cohesive framework within the public health community linking it with security and foreign policy concerns.

References

- Acheson D (1998) *Independent Inquiry into Inequalities in Health* The Stationery Office
- Ashraf H (2002) 'Bioterror and HIV dominate infectious disease meeting' *Lancet* 360
- Beaglehole R and Bonita R (1997) *Public Health at the Crossroads: Achievements and prospects* Cambridge University Press
- de Waal A and Whiteside A (2003) 'New Variant Famine: AIDS and food crisis in southern Africa' *Lancet* 362
- Doll R and Hill AB (1952) 'A study of the aetiology of carcinoma of the lung' *British Medical Journal* 2
- Dyer O (2003) 'Poor security is biggest impediment to health care in Iraq' *British Medical Journal* 326
- Farmer P (1999) *Infections and Inequalities: The modern plagues* University of California Press
- Frist B (2002) 'A Time for Preparedness: With funding on its way, hospitals need to get ready for bioterror attacks' *Modern Healthcare*
- Garrett L (2000) *Betrayal of Trust: The collapse of global public health* Hyperion
- Garrett L (1996) 'The Return of Infectious Disease' *Global Issues* 1.17
- Gellman B (2000) 'Death Watch, Part 1: The belated global response to AIDS in Africa' *The Washington Post* 5.7.00
- Goodyear L and Hynes M (2001) 'Integrating reproductive health into emergency response assessments and primary health care' *Prehospital and Disaster Medicine* 16.4
- Hammond EC, Selikoff IJ and Seidman H (1979) 'Asbestos exposure, cigarette smoking and death rates' *Annals of the New York Academy of Sciences* 330
- Hankins CA, Friedman SR, Zafar T and Strathdee SA (2002) 'Transmission and Prevention of HIV and Sexually-transmitted Infections in War Settings: Implications for current and future armed conflicts' *Aids* 16.17
- Henderson DA (1998) 'Bioterrorism as a public health threat' *Emerging Infectious Diseases* 4.3
- Horton R (2001) 'Violence and Medicine: The necessary politics of public health' *Lancet* 358
- Institute of Medicine (US) (1998) *The Future of Public Health* Committee for the Study of the Future of Public Health, National Academy Press
- Joseph DG (2003) MSJAMA 'Uses of Jacobson vs Massachusetts in the age of bioterror' *Journal of the American Medical Association* 290
- Kirkhorn SR and Schenker MB (2002) 'Current health effects of agricultural work: respiratory disease, cancer, reproductive effects, musculoskeletal injuries, and pesticide-related illnesses' *Journal of Agricultural Safety and Health* 8.2

- The Lancet* (2003) Comment: 'Mexico, 2004: research for global health and security' 362
- Lederberg J (1996) 'Infectious Disease: A threat to global health and security' *Journal of the American Medical Association* 276
- Lederberg J, Shope RE and Oaks SC (1992) *Emerging Infections: Microbial threats to health in the United States* Committee on Emerging Microbial Threats to Health, Institute of Medicine (US) National Academy Press
- Mitka M (2003) 'Bioterror exercise tests agencies' mettle' *Journal of the American Medical Association* 289
- Morbidity and Mortality Weekly Report (2003) 'Elevated Mortality Associated with Armed Conflict: Democratic Republic of Congo' 52.20
- Olson KB (1999) Aum Shinrikyo: Once and future threat? *Emerging Infectious Diseases* 5.4
- Rosegrant MW and Cline SA (2003) 'Global Food Security: Challenges and policies' *Science* 302
- Sachs J (2001) *Macroeconomics and health: investing in health for economic development* Commission on Macroeconomics and Health, World Health Organisation.
- Salama P, Spiegel P and Brennan R (2001) 'No Less Vulnerable: The internally displaced in humanitarian emergencies' *Lancet* 357
- Schoeman JC (2000) 'Disease and Security: The effect of emerging and re-emerging diseases' *Medicine, Conflict and Survival* 16.3
- Thompson B, Coronado GD and Grossman JE (2003) 'Pesticide Take-home Pathway among Children of Agricultural Workers: Study design, methods, and baseline findings' *Journal of Occupational and Environmental Medicine* 45.1
- UNAIDS (2000) 'AIDS Becoming Africa's Top Human Security Issue, UN warns' Press Release
- UNAIDS (2003) Statement to the United Nations Security Council by Dr Peter Piot, Executive Director and Under Secretary-General 17.11.03
- Vastag B (2003) 'Openness in biomedical research collides with heightened security concerns' *Journal of the American Medical Association* 289.6
- Whiting J (2004) 'Politics in medical journals' *Lancet* 363
- WHO (2001) 'Global Health Security – Epidemic alert and response' Executive Board, 107th Session EB107/INF.DOC./7 16.1.01
- WHO (1946) *Constitution*

3.2 Health and Foreign Policy*

Colin McInnes

The focus of this paper is on health in the declaratory foreign policy of the UK, US, Canada and Australia. These four have been chosen for two reasons. First, they are of particular interest to The Nuffield Trust and the Trust has engaged with the policy communities in all four as part of its work on health and foreign and security policy. Second, all four are major developed Western powers none of whom currently suffer from major health crises but all of whom may be affected by international health developments directly (for example from bio-terrorism or from the spread of infectious diseases) or indirectly (through poor health slowing the global economy, or from instabilities in the international system).

It should be emphasised from the outset that the focus is on *declaratory* policy. There may be differences, for political or presentational reasons, between what is said and what is done. Rhetoric may at times be divorced from reality and important questions also need to be asked about policy implementation. But this focus on declaratory policy rather than policy implementation is deliberate for three reasons. First, major statements on foreign policy are more likely to reveal conceptual underpinnings than policy outcomes. They reveal the thinking behind policy, the rationale for policy, key aims, and the strategies for accomplishing those aims. Although conceptual thinking may be inferred from policy outcomes, a more direct route is the statements which accompany policy. Second, the manner in which foreign policy is articulated both reveals the manner in which it is considered by the policy elite and in turn helps to construct the social reality in which policymakers operate. In other words, what is said cannot be readily divorced from what is thought and what is done. Rather they are mutually constitutive. Further, in modern mature democracies such as the UK, US, Canada and Australia, with freedom of speech and relatively open access to information, disjunctions between declaratory statements and policy outcomes can often be revealed (albeit that such disjunctions might be partially obscured by 'spin'). This places pressure upon policymakers to ensure that what is said is also done. And finally, policy implementation is, to a certain extent, the focus of the next stage of the UK Global Health Programme. This paper therefore sets out what is *said* as a benchmark for subsequent studies regarding what has been done.

Although the focus is on *foreign policy*, the notion of a foreign policy operating without reference to other policy communities (particularly trade, security and international development) no longer holds in the four countries being considered. All make reference to the need for interagency cooperation – indeed in the case of Canada and Australia foreign affairs and trade are formally linked into one department. Furthermore, modern foreign policy is often a major activity for the premierships. Foreign policy therefore is no longer the preserve of King Charles Street or Foggy Bottom, but also Downing Street and the White House. Therefore the focus is not exclusively on statements emanating from foreign ministries, but also includes a number of key statements and documents from elsewhere within government.

* I would like to thank Alan Ingram for his comments on an earlier draft of this paper.

This paper is structured into five sections. The first examines how policy elites consider the contemporary world. Most statements on foreign policy include sections on ‘the nature of the contemporary world’ or similar. This is essential for understanding the context in which policy elites believe they are operating. Second, the paper examines key issues on the foreign policy agenda and where (or if) health fits into that agenda. The paper then moves on to address three questions which broadly structure other papers in this series. Whom or what is the focus of foreign policy? Which health issues are legitimate foreign policy issues and which are not, and how do we decide? How should foreign interrelate with other elements of government over global health?

The contemporary world

‘diplomacy’ has a new definition in the post-Cold War era (State Department 2004)

In the UK, US, Australia and Canada there is a recognition that the world has changed. Often linked to the end of the Cold War, it is not clear that these changes are all a direct consequence of the end of the Cold War. Three major themes can be detected: the emergence of a global agenda, spurred on by globalisation, and including the emergence of transborder and transnational risks; the blurring of the traditional domestic and international divide; and the importance of values.

The global agenda

A number of points recur on a regular basis in major statements on international policy in all four countries concerning what might be termed ‘the global agenda’. Although details may differ, the general thrust is similar, particularly:

- a shared recognition of a global agenda affecting all countries (Straw in FCO 2003; Romanow 2002).
- a common acceptance of the emergence of global problems usually cited as the environment, population and disease (for example, State Department 2004; DFAT 2003).
- a demand for coordinated international attention – in President George W Bush’s words ‘no nation can build a safer, better world alone’ (US National Security Strategy (White House 2002); see also FCO 2003).¹
- an explicit understanding, by all bar the US, that globalisation can work for good and ill; globalisation is identified with exacerbating transborder risks while for the UK’s DfID ‘making globalisation work for the poor’ is a major theme, reflecting concern over its potentially harmful impact upon the poorer nations of the world (FCO 2003; DfID 2000; DFAT 2003; DFAIT 2003b).

*Blurring the domestic/international divide*²

1 For the US in particular this international action should be on their terms, reflecting US values (White House 2002). This perspective is more implicit but identifiable in statements from the other case studies

2 As Derrida has noted (Derrida 1981), a hallmark of Western thought has been the binary divide (such as good/evil, right/wrong) and that this has been one of the underpinnings of modernity. The breakdown of binary divides may therefore be seen as symptomatic of the post-modern condition. In foreign policy, the key divide has been between the domestic and international and the *recognition* of the blurring of this divide has therefore been seen as being of fundamental significance.

All four case studies accept that the traditional distinction between foreign and domestic issues has blurred and on some issues almost disappeared (FCO 2003; DFAT 2003; DFAIT 2003a). Thus Jack Straw, in his introduction to the Foreign Office's 2003 strategy paper, states 'foreign affairs are no longer really foreign. What happens elsewhere increasingly affects us at home'. Similarly the 2002 US National Security Strategy states 'the distinction between domestic and foreign affairs is diminishing. In a globalised world, events beyond America's borders have a greater impact inside them'. This view is not unique to the Bush administration. In its 1999 Strategic Plan, the State Department argued:

that a major paradigm shift has occurred in global, diplomatic and economic affairs since the end of the Cold War. This has rendered the distinction between domestic and foreign affairs one of convenience rather than of fact. As the proliferation of US Government agencies with overseas responsibilities illustrates, almost every facet of national life, from crime, to travel, to the environment and the economy, is related, intimately and directly, to the conduct of global policy. (State Department 1999)

The significance of this ought not to be underestimated. Borders are permeable and foreign ministries are among an increasing number of government departments with an international perspective.

Three further points ought to be noted:

- The emphasis in this blurring of distinctions is on how events 'out there' have an impact upon domestic policy, not on how Western policy might affect the domestic policy of other states.
- Although a number of issues are regularly mentioned as examples of this phenomenon, it is very rare for health to be one of these, and when it is, it is usually disease.
- Almost universally, integration into the global economy is seen as the major reason for this blurring of distinctions.

Values

All four case studies exhibit a strong and explicit commitment to promoting values. Indeed, in 1995 Canada adopted the promotion of values as one of the three pillars of its foreign policy (DFAIT 2003a), while the Blair administration included an ethical dimension in the Foreign Office's 1997 mission statement. This is in stark contrast to the traditional notion of foreign policy as the realm of *realpolitik* inhabited by statesmen such as Chatham, Bismarck and Kissinger³ and where President Carter could be chastised as 'naïve' for attempting to incorporate a normative element to his foreign policy.⁴

Note that the divide may have been artificial, but it had nevertheless been constructed as being crucial and the breakdown of this construct is what is significant.

³ This is not to say that values were absent in the foreign policy of Bismarck, Kissinger and others, but merely that they were less explicit and not always grounded in moral concerns for the improvement of others.

⁴ A criticism not levelled at Reagan for his advocacy of human rights, albeit framed in a different context (namely as part of a critique of the Soviet Union and its allies).

For the US, these values can be summed up simply as ‘freedom’, with President Bush committing the US to ‘extend[ing] the benefits of freedom across the globe’ (White House 2002). For the US, even free trade is a ‘moral principle’ (National Security Strategy 2002). But the US, like the others examined here, also demonstrates humanitarian concerns and appears to accept a degree of responsibility to act when a natural or man-made disaster leads to suffering elsewhere (State Department 2004). In particular this is seen in the US in the case of HIV/AIDS. There is also a widespread acceptance of the importance of promoting good governance as a value (for example, FCO 2003; DFAT 2003). All bar the US explicitly raise the promotion of human rights as being part of their foreign policy,⁵ with Robin Cook being perhaps the most articulate and outspoken advocate; but it is rare to see health mentioned in this context (FCO 2003, 2004; Cook 1997; DFAT 2003; DFAIT 2003b).

Here, more than anywhere else, the difference between what is said and what is done has received attention, and usually criticism. US statements on human dignity being ‘non-negotiable’ for example appear at odds with the treatment of prisoners at Guantanamo Bay. Nor are values above criticism – again US policy regarding reproductive health and abortion have been the focus of considerable criticism.

Health and the foreign policy agenda

Aside from health, four groups of issues broadly constitute the foreign policy agenda as stated in policy documents. Health is generally grouped with other ‘global issues’ such as the environment and population, well down the agenda. Disease is more often mentioned than ‘health’ itself and, in particular, HIV/AIDS is the agenda item.

Terrorism and WMD

Although defence against attack remains, in President Bush’s words, the ‘fundamental commitment of the Federal Government’ (White House 2002), only Australia argues that ‘traditional security concerns remain’ (DFAT 2003). And although the 2002 US National Security Strategy argues for the ‘essential role of American military strength’, there is no sense that aggression from other states is a key concern for foreign policy. Rather the emphasis has shifted to threats from terrorism and WMD, and in particular the potential of terrorists armed with WMD. This is the top agenda item for the US, UK and Australia (for example FCO 2003; DFAT; Downer 2003) and even though Canada ‘has not been a direct target of terrorism on the massive scale of the 11 September 2001 attacks, Canadians understand that the threat of terrorism is real and its impact extensive’ (DFAIT 2003b). This priority is new to the post-9/11 world – in 1999 the State Department’s Strategic Plan placed ‘counterterrorism’ low down its list of strategic goals, although WMD was second on the list (State Department 1999). It would however seem foolish to think that the ‘war on terror’ will not continue to dominate foreign policy agendas for the foreseeable future.

Economic interests

⁵ Although the Bush administration emphasises the promotion of ‘human dignity’ as part of its foreign and security policy, there is a noticeable reluctance to use the term ‘human rights’.

The promotion of economic interests and market liberalisation figures prominently as a foreign policy priority (for example, FCO 2003; State Department 1999; DFAT 2003, possible exception is Canada). Key to this is a liberal free trade economic agenda focusing on securing markets for further economic growth. This policy priority is usually couched in terms of promoting the national interest and national growth, but the global interest in further economic growth is also apparent, sometimes explicit but often implicit. The US links economic growth with security (National Security Strategy 2002), but this is unusual in being so explicit. More often it is couched as an ‘interest’ rather than a security issue.

Failing states

During the 1990s, failing states were a preoccupation of Western foreign policy, with crises in places such as the former Yugoslavia, Somalia, Sierra Leone and East Timor figuring prominently. Post-11 September 2001, this agenda appears to have moved from a humanitarian concern for such states to a fear that they may prove breeding grounds for international terror. Thus the 2002 US National Security Strategy begins with ‘America is now threatened less by conquering states than we are by failing ones’. This is not to say that humanitarian concerns and development assistance have disappeared – far from it – but they are less prominent and concerns over international terror have coloured Western perspectives on failing states.

Global issues

There is widespread recognition of the emergence of a range of ‘global issues’, or what are sometimes referred to as ‘transborder threats’, which require international cooperation to deal with and are part of foreign policy. Lists of such issues cited in policy statements may include crime, illegal trafficking in goods and people (particularly drugs), migration and the environment (for example, State Department 1999; DFAT 2003). Although health is often included in such lists, it is dealt with separately in this paper. Australia is explicit in linking this to globalisation, but this is implicit in other statements (DFAT 2003). These issues are not always prominent and invariably not at the top of the foreign policy agenda, but they are present and attention is paid to them.

Health

In the United States, a number of high profile foreign policy speeches have either focused on, or included, health issues (for example Bush 2003; Dobriansky 2001; Powell 2003). HIV/AIDS has by far and away been the most important of these issues, with disease in general also frequently mentioned and occasionally TB and malaria. More general health issues are rarely raised. In its 1999 Strategic Plan, the State Department includes protecting human health in its mission statement – but as the last of 16 strategic goals, and as one of the global issues which together form the last of seven national interests (State Department 1999). Later on it discusses this goal in more detail, its focus being largely on disease but also on investing in basic health in developing nations. Post-11 September 2001, in the introduction to the 2002 National Security Strategy, President Bush explicitly commits the US to reducing

the toll of disease, especially HIV/AIDS, while in the document itself ‘secur[ing] public health’ is raised, as is backing for the global fund.⁶

In the UK, the FCO strategy paper (FCO 2003) has little mention of health. It is not present in the eight broad policy priorities, although disease is mentioned as an ill-effect of globalisation and a risk to peace and development, and strengthening international action on disease is briefly mentioned in the discussion on the sixth policy priority, sustainable development. Nor does health figure on the FCO’s home page on its website, even as a ‘global issue’ (www.fco.gov.uk). Despite health being seen by some as a human right, and despite the emphasis given to human rights by Blair’s first foreign secretary, Robin Cook, when Cook summarised the six core human rights of the Universal Declaration in a major speech on human rights and British foreign policy, health was absent; and when he set out ‘12 policies that put into effect our commitment to human rights’, health was similarly absent (Cook 1997). According to the FCO website, his successor Jack Straw has given no major speech on human rights. Health however receives considerably more attention in the 2000 White Paper on International Development (DfID 2000). The focus of the White Paper is very much on poverty reduction and health is largely seen in this light. In particular it argues that ‘To succeed in the new global economy, poor countries need healthy and educated people’. The paper therefore identifies the promotion of better health and education for poor people as one of 11 key policy commitments. The White Paper acknowledges that ‘poor people suffer disproportionately from poor health and malnutrition’ and argues that ‘better health is essential if poor people and countries are to benefit from globalisation’. It also acknowledges that globalisation has had a detrimental effect on health and in particular on the transmission of disease; it further notes that migrants and displaced peoples are more susceptible to communicable diseases. Unusually for a policy statement, it even raises the problem of non-communicable diseases and how changing consumption patterns (particularly tobacco) are affecting health in poor countries (DfID 2000).

Australia’s 2003 White Paper on foreign and trade policy (DFAT 2003) briefly mentions communicable disease (and especially HIV/AIDS) as a global challenge, and HIV/AIDS figures in a sentence on Africa. But health is not discussed in the chapter on global threats to security, the focus instead being on terrorism. Indeed the White Paper devotes more space to the need for quarantine measures to protect Australian agriculture than to human health. In a speech to a conference on global health in 2003, Foreign Minister Downer acknowledged that ‘disease and global health issues certainly add to the uncertainty we face in the conduct of our foreign policy’, but began the speech by outlining a foreign policy focusing on terrorism, WMD and relations in Asia (Downer 2003).

The 2002 Final Report of the Commission on the Future of Health Care in Canada argued that, although health in Canada could not be divorced from health elsewhere, health care to date had ‘been focused on what happens in our own country’. It continued in critical vein to argue that ‘the broader area of health promotion is very much an afterthought in Canada’s

⁶ The US National Security Strategy has however been criticised because, in its attempt to coordinate all elements of US policy into the war on terror, foreign policy has been militarised and development securitised. This is discussed in the background paper on development.

foreign policy' (Romanow 2002). However it went on to argue that 'we have an opportunity to ensure that access to health care is not only part of our own domestic policy but also a prime objective of our foreign policy as well'. The Commission argued that 'Canada's health care system is not immune to international developments' and that Canada should use its international good standing to take a leadership role 'to help improve health and health care around the world'. This forceful statement with its broader view of health was not however reflected in the Canadian government's opening statement in its 'dialogue' on foreign policy. In this, health is barely mentioned aside from the potential for HIV/AIDS to destabilise states as one of a series of 'worrying developments' (DFAIT 2003a). In the subsequent document summarising the views of respondents, health figures more prominently as a humanitarian concern and that (following similar sentiments to the Romanow Commission) leadership in this area would be playing to a Canadian strength (DFAIT 2003b).

Whom or what is the focus of health in foreign policy?

Foreign policy has traditionally been characterised as the promotion of the national interest on the international stage. As Robin Cook stated when Foreign Secretary, the purpose of foreign policy is 'to pursue our national interest' (Cook 2000). In this context, the focus would be the state and global health policy would be subsumed into calculations of the national interest. But in an interdependent or globalised world, calculating the national interest requires broader considerations than merely narrow self-interest, such that 'national interest will more and more coincide with global interest' (Cook 2000). Further, normative concerns may appear not only in policy outcomes – what some have seen as a tension between the promotion of humanitarian values and the national interest – but also in determining what the national interest is. Explicitly or implicitly, the national interest often contains a normative element. Current US foreign policy for example explicitly talks of 'human dignity' as being 'nonnegotiable' not simply out of a sense of justice but also because it is in their perceived national interest to promote a world of particular values (National Security Strategy 2002; Powell 2003). Thus the national interest is a complex concept not always to be confused with narrow self-interest. This section therefore examines the role of global health in the context of the national interest and particularly the extent to which it is subsumed into the national interest, whether it contributes to the determination of the national interest, or whether it is set up as separate to, and potentially in opposition to, the national interest.

Significantly, the key US post-9/11 statement on international policy was entitled *The National Security Strategy* (2002, emphasis added).⁷ In similar vein, Australia's 2003 White Paper was entitled *Advancing the National Interest* (DFAT 2003, emphasis added), though neither the UK nor Canada are quite so explicit in foregrounding the national interest. For most of *The National Security Strategy* the focus is explicitly on the national interest and when cooperation is discussed it is cooperation on America's terms. For this it has been extensively criticised. But the vision contained within the document is rather more complex and multifaceted than some of the criticism might lead us to believe. In particular there is a

⁷ The State Department's 2004 Strategic Plan for FY 2004-9 (State Department 2004), produced in conjunction with the US Agency for International Development, was almost ignored compared to the public interest in and administration attention to *The National Security Strategy*.

normative agenda a work, albeit one which promotes US values rather than a more cosmopolitan view:

The US national security strategy will be based on a distinctly American internationalism that reflects the union of our values and our national interests. The aim of this strategy is to help make the world not just safer but better. (White House 2002)

Similarly in the UK, although Robin Cook talked of the global community needing ‘universal values’, one of the four objectives in the Foreign Office’s Mission Statement was ‘building respect for *our* values’ (Cook 2000, emphasis added). His successor, Jack Straw, begins the FCO’s 2003 strategy paper by talking of promoting ‘our national interests and values’ (FCO 2003). The US State Department’s 2004 Strategic Plan may initially be seen to be promoting a relatively narrow self-interest. Its mission statement defines its purpose as ‘[to] create a more secure, prosperous, and democratic world for the benefit of the American people...[and to] advance the interests of the nation and the American people’ (US State Department 2004). Later on, AIDS is presented as a *national* security challenge and global issues are discussed because they have an impact on the US. But there is also a sense of promoting the global good, particularly with regard to health matters. Thus:

The United States has a direct interest in safeguarding the health of Americans and in preventing the threats posed by diseases worldwide. Epidemic and endemic diseases can undermine economic growth and stability, and threaten the political security of nations, regions and the international community...emerging infectious diseases of epidemic or pandemic proportions...pose a serious threat to American citizens and the international community. (US State Department 2004)

There is also evidence of a strong humanitarian impulse with regard to global health issues which transcends the national interest. In the US, this is particularly the case with HIV/AIDS.⁸ Paula Dobriansky, Under Secretary for Global Affairs in the State Department, stated that HIV/AIDS was a global problem and that ‘from both a security and a humanitarian standpoint, we cannot sit idly by’ (Dobriansky 2001). This perspective remained in the US after 11 September 2001. The State Department’s 2004 Strategic Plan argued that ‘the American people believe that they and their government should be leaders in helping those suffering from natural or manmade disasters – even when there may be no threat to US security interests’ (US State Department 2004), while President George W Bush said in a major speech on HIV/AIDS that ‘if you value life and say every life is equal, that includes a suffering child on the continent of Africa’ (Bush 2003). In a similar vein Secretary of State Powell commented on the need to ‘promote human dignity [by transforming] the inadequate system of global public health’ (Powell 2003) while Robin Cook stated that ‘human rights are

8 Indeed not only has HIV/AIDS received more attention in the US foreign policy discourse than any other global health issue, it has almost certainly received more than all other health issues put together. In this respect it has become *sui generis*. There is therefore an argument that too much should not be inferred from the manner in which it has been treated for the argument on global health more generally.

indeed of little value without freedom from hunger, from want and from disease' (Cook 1997).

Canada expresses this slightly differently with its explicit human security approach to foreign policy. This approach 'recognises that the security of states is essential but not sufficient to ensure the safety of their citizens' (DFAIT 2003a). In its dialogue on foreign policy:

respondents strongly urge that the security of individuals as well as states should be an ongoing priority of Canadian foreign policy... A broad conception of security as a human-centred protection of basic rights resonates strongly with Canadians, and respondents often urge Canada to act vigorously in the cause of international human rights and democratic freedoms. (DFAIT 2003b)

This complex mix of the national interest, global interests, values and humanitarian obligation is not as effectively mirrored in Australia's 2003 White Paper, nor the major speech given by Foreign Minister Alexander Downer on global health policy. Rather global health is presented by Downer as largely being of importance because of its ability to impact upon security and prosperity. As Australia is part of a globalised world it cannot remain unaffected by such developments even if they occur elsewhere (Downer 2004). The White Paper for example reflects a similar sentiment when discussing development aid:

The single objective for Australia's aid program is...to advance our national interests by assisting developing countries to reduce poverty and achieve sustainable development. Greater economic growth and improved stability in Australia's region will contribute to the security and prosperity of Australians. (DFAT 2003)

Only briefly and somewhat reluctantly does the White Paper '[recognise] the moral obligation for a wealthy country like Australia to help reduce poverty' (DFAT 2003).

To conclude, the state remains very much the focus for foreign policy and the promotion of the national interest remains its primary objective. But there is general acknowledgment that the national interest is linked to the global interest and that (implicitly or explicitly) promoting global health is in both the national and global interest; that values play a role in defining the national interest, and promoting values (such as human rights, human dignity and freedom) is explicitly seen by three of the four as a key foreign policy task; and the security of the individual is also highlighted, whether through Canada's human security approach or the humanitarian impulse in the UK and US.

Which health issues are legitimate foreign policy issues and which are not, and how do we decide?

The first of these questions is relatively easy to answer in terms of declaratory policy, since such issues are outlined in public documents. In the four case studies, the following health issues are identifiable as foreign policy concerns:

- HIV/AIDS is not only regularly mentioned but is by far the most prominent health issue in public documents (for example, Dobriansky 2001; DfID 2000; DFAT 2003). This is particularly so in the US where it is regularly identified as a top priority for foreign policy, even after 9/11 (Bush in National Security Strategy 2002; Dobriansky 2001). This emphasis appears to be prompted in part by the sheer scale of the humanitarian problem (often termed a ‘catastrophe’) but also by the manner in which HIV/AIDS touches on a variety of foreign policy concerns including the fear of destabilising political effects, concern for regional stability and for economic growth.
- Other infectious diseases in general are also mentioned, but less frequently (for example, DfID 2000; Downer 2003). If specific diseases are mentioned they are usually TB and malaria, although only the US has linked this to the Millennium Fund in key documents.
- The relationship between health and international trade is often raised, particularly in the context of TRIPS and securing access to key pharmaceuticals (National Security Strategy 2002; State Department 2003a; Powell 2003; DfID 2000). The connection between trade and economic development (and by implication health) is also occasionally made, as are vague references to the public health crisis in developing countries impeding their growth and development (for example, National Security Strategy 2002). The international market for health professionals is mentioned as a concern only by DfID in the UK, pleading for sensitivity to its impact elsewhere (DfID 2000). Canada is alone in raising concerns over free trade rules threatening public health services, and then they were only raised by the Romanow Commission rather than the foreign and trade policy community (Romanow 2002).
- Although bio-terrorism features prominently as part of the War on Terror, this fact is not reflected in discussions of global health policy. Wittingly or not, the two are treated as separate issues in public documents. The exception to this pattern is the US, where the National Security Strategy explicitly links the US medical system with homeland defence ‘to manage not just bioterror, but all infectious diseases and mass-casualty dangers’.

Identifying what makes a global health issue a foreign policy issue is not easy from the major policy statements. It appears as though the process is pragmatic and ad hoc – that when an issue arises of sufficient seriousness it is addressed by the foreign policy community, but without any conceptual underpinning. Nevertheless the list above does suggest some criteria, principally:

- when a global health issue becomes a humanitarian catastrophe, or when one is threatened. (At present however only HIV/AIDS falls into this category, despite the large number of tobacco-related deaths and deaths from TB and malaria. A humanitarian catastrophe may not on its own be sufficient.);
- when economic development is threatened;
- when regional stability is at risk; and
- when health issues are part of trade negotiations.

Interestingly, the threat of disease spreading to citizens in the West does not appear to be a criterion for a foreign policy issue. No attention is given in major foreign policy statements to the possible requirement to close borders to prevent disease entering. Nor is health explicitly linked in such documents to homeland security in the War on Terror, excepting the US.

Global health and inter-departmental cooperation

Identifying a clear and consistent relationship between foreign ministries and other government departments over global public health is complicated by different governmental practices, traditions and structures across the UK, US, Australia and Canada. Nevertheless a number of points are worth making.

First, there is a shared sense that modern foreign policy is by its nature an interagency affair, not something which can be left solely to foreign ministries. To a certain extent this is a product of the blurring of the domestic and international, but it is also probably a function of the complexity of modern policymaking and execution. US global health policy for example flows partly through the State Department (principally USAID), partly through the Department of Health and Human Services and partly through the White House (not least with regard to TRIPS). Further, as the State Department's 1999 Strategic Plan commented, 'Because so many new dimensions of international affairs are no longer exclusive to government, but are in the public realm, public diplomacy is moving to the core of foreign policy.' So foreign policy is open to a variety of other actors and influences. But the reverse is also true. As Alexander Downer commented, 'global health can no longer be the preserve of national health ministries. It also must be the concern of foreign ministries', though he also commented that 'less evident is a willingness on the part of governments around the world to accept that international health issues are legitimate foreign policy concerns' (Downer 2003).

Second, there is a strong sentiment that health crises demand political leadership (State Department 2003b; DfID 2000; Dobriansky 2003). This is usually expressed in terms of domestic leadership, but by inference it also applies internationally. What this suggests is not only that global health is more than an issue of technical cooperation, but also that the involvement of premiers may be required for successful policy, not just officials from foreign ministries or even Foreign Ministers.

Third, the link between health and development is stronger than that between health and foreign policy. In foreign policy statements, health is often linked with development; in the UK, where there are separate departments for development and foreign policy, DfID pays much greater attention in its policy documents to global health than does the FCO. But health is seen as more than a development issue, and there is a general recognition that global health impacts upon traditional foreign policy concerns such as security and trade. In particular, health figures in discussions on international trade, particularly TRIPS, and in questions of economic growth.

Fourth, health is often referred to as a security issue, primarily because of its ability to destabilise regions of the world but also because of possible links with bio-terror. Health therefore features in the US National Security Strategy, but interestingly not in the UK

Ministry of Defence's most recent White Paper on defence (MoD 2003). As an international security issue, a tentative judgment might therefore be that health falls more naturally within the remit of foreign ministries than ministries of defence.

Is health a foreign policy issue? The US has made by far the most statements linking health and foreign policy, but these are largely in terms of infectious disease and particularly the humanitarian catastrophe of HIV/AIDS; in the FCO, there is only slight attention to health as an issue and instead DfID is the lead agency for global public health; in Australia, the Downer statement in 2003 was minor watershed in placing health on the foreign policy agenda, but the agenda was dominated by other issues and global public health figured because of its potential impact on regional stability and (Australian) prosperity; and in Canada, despite the Romanow Commission's explicit linkage of health (domestic and global) and foreign policy, the government's initial document commencing the dialogue on foreign policy failed to pick this up in any significant manner.

Conclusion

Through the eyes of Western foreign policy, the word has changed. A global agenda is emerging requiring international cooperation, the traditional divide between the domestic and international is blurred and the promotion of values is an explicit policy aim.

All of this suggests that global public health should be a foreign policy item. But health does not appear high on the foreign policy agendas of the UK, US, Australia and Canada. It is seen as one of a set of global issues ranking some way below the current focus on terrorism and WMD, and even below other agenda items such as economics and trade and failing states. This is not to say that health is not recognised as an issue in foreign policy – increasingly that is the case – but its position on the agenda remains lowly, and although there are potential health dimensions to other agenda items this has done little to promote health as a global issue in its own right.

Two notable exceptions to this are the attention paid to HIV/AIDS, principally but not exclusively in the US and to a large extent couched in terms of a humanitarian catastrophe; and the manner in which concern over access to pharmaceuticals by poor countries subverted the free trade agenda and in particular TRIPS. It is interesting that the economic consequences of rapidly transmitted diseases receive comparatively little attention in the top level policy documents, although of some of these pre-date SARS (but not all – eg FCO 2003). It will be interesting to monitor developments in this respect, particularly with advent of avian flu.

Within foreign policy, the national interest still remains key, but tempered by a recognition that it cannot be divorced from global interests and that values (including humanitarian concerns) also play a part. Therefore although the focus remains the state, the global and the individual also figure in foreign policy concerns.

There is no explicit thinking on what makes a health issue a foreign policy issue. The process is pragmatic and ad hoc but a number of items recur: HIV/AIDS; other infectious diseases; health and trade; and to a lesser extent, the role of health in the War on Terror. (Interestingly

it is ‘disease’ rather than ‘health’ that dominates discussion; rather it is ‘disease’.) The strongest links between health and foreign policy are in the fields of development and trade. Sometimes these fall within the remit of foreign ministries sometimes they do not. When they do not, the foreign ministry may not be the lead department in relating to health departments on global public health issues – in the UK for example, DfID pays much greater attention to global public health in its 2000 White Paper than does the FCO in its 2003 strategy paper.

References

- Bush GW (2003), ‘President speaks on fighting global and domestic HIV/AIDS’ 31.1.03 www.state.gov
- Cook R (1997), ‘Human rights into a new century’ Speech delivered at FCO, London 17.7.97 www.fco.gov.uk
- Cook R (2000), ‘Foreign policy and national interest’ Speech delivered to the Royal Institute of International Affairs, London 28.1.00 www.fco.gov.uk
- Derrida J (1981) *Positions* Bass A (tr)
- DFAIT (2003a) *A Dialogue on Foreign Policy* Department of Foreign Affairs and International Trade, Canada www.foreign-policy-dialogue.ca
- DFAIT (2003b) *A Dialogue on Foreign Policy: Report to Canadians*. Department of Foreign Affairs and International Trade, Canada www.foreign-policy-dialogue.ca
- DFAT (2003), *Advancing the National Interest: Australia’s Foreign and Trade White Paper*. Department of Foreign Affairs and Trade, Australia www.dfat.gov.au
- DfID (2000) *Eliminating World Poverty: Making globalisation work for the poor* Department for International Development, The Stationery Office
- Dobriansky PJ (2001) ‘The fight against HIV/AIDS’ www.state.gov
- Downer A (2003) ‘Why health matters in foreign policy’ Speech to the UK-Australia seminar: Health and Foreign Policy, Canberra, 16.9.03 www.foreignminister.gov.au
- FCO (2004) ‘Global Issues, Human Rights: The place of human rights in UK foreign policy’ Foreign and Commonwealth Office www/fco.gov.uk
- FCO (2003) *UK International Priorities: A strategy for the FCO* Foreign and Commonwealth Office, The Stationery Office
- MoD (2003) *Delivering Security in a Changing World: Defence White Paper* Ministry of Defence, The Stationery Office
- Powell CL (2003) Presentation at HIV/AIDS plenary, 22.9.03 www.state.gov
- Romanow RJ (2002) *Building on Values: The future of health care in Canada* Final Report of Commission on the Future of Health Care in Canada (the Romanow Commission) www.healthcarecommissoin.ca

State Department (2004) *Strategic Plan Fiscal Years 2004-2009: Security, democracy, prosperity* US Department of State and US Agency for International Development

State Department (2003a) 'The President's plan for AIDS relief' 29.1.03 www.state.gov

State Department (2003b) 'The United States emergency plan for HIV/AIDS relief' 10.6.03 www.state.gov

State Department (1999) *US Department of State Strategic Plan* Office of Management and Policy Planning

The White House (2002) *The National Security Strategy of the United States of America*

3.3 Health and Security Studies*

Colin McInnes

The aim of this paper is to offer a preliminary understanding of the relationship between health and international security – or ‘global health security’ – from the perspective of security studies. Within the academic discipline of International Relations, and its sub-discipline security studies, there is no consensus on the definition of security. In particular, there is no accepted understanding of whose security is to be protected (what is termed below the ‘referent object’). This was not always so. Prior to the 1980s there was little theoretical work on the nature of security. There was an implicit understanding that security was about protecting the state and the source of threat and of protection was military. Theoretical work concentrated on promoting state security against military threats, and in particular deterring nuclear (and later non-nuclear) attack. This narrow understanding still exists in some of the literature (for example, Gray 2000), but is more often termed ‘strategic studies’ than ‘security studies’.

The key change came in 1983 with the publication of Barry Buzan’s *People, States and Fear* (Buzan 1983). Buzan made two crucial moves. First he widened the agenda of security to include a more disparate range of issues than simply military threats. Second, he identified three different ‘levels’ at which security resides: the global, the state and the individual. This set the scene for two decades of scholarship on the meaning of security, not least by demonstrating that security as a concept had been under-theorised (Buzan 2000).

This paper therefore begins with a ‘mapping exercise’ which identifies key schools of thought and approaches to security. In the US the key debate remains between the neo-realists and neo-liberals, but within Europe the divide is more complex with the neo-neo’s often being seen as one camp with more uniting them than dividing them. One influential divide is between what Robert Cox (1981) termed ‘problem solving’ theory (which accepts the nature of the social world and identifies best means for promoting security within that world) and ‘critical’ theory which attempts to move beyond the current social world to one which is more structurally secure. Another is Smith’s rationalist vs reflectivist divide (Smith 1996, 2000). For Smith, rationalists attempt to explain what happens while reflectivists are more interested in understanding the nature of the problem.

This mapping exercise takes as its key organising principle the referent object for security. It begins with those approaches which are essentially state-centric (what may be considered as the traditional or more orthodox accounts), and then moves onto schools and approaches which focus on different referent objects (here termed critical accounts). Following a survey of the field, the paper proceeds to a more detailed appraisal of the work of the Copenhagen School, and in particular their 1998 framework for analysis (Buzan, Waever and de Wilde 1998). Drawing on this, the final section then constructs an understanding of global health security. It addresses three questions underpinning the wider UK Global Health Programme project of developing a conceptual framework:

* I would like to thank Harley Feldbaum, Alan Ingram and Kelley Lee for their comments on earlier drafts of this paper.

- Whom or what is to be protected through the practice of global health security?
- Which health issues are legitimate security issues and which are not, and how do we decide?
- How should health, foreign and security policy interrelate?

Traditional/Orthodox accounts of security

The dominant accounts of security share a focus on the state as the referent object of security, and are ‘scientific’ in attempting to use a positivist methodology. As theories they are, to use Robert Cox’s term, ‘problem solving’: they accept the nature of the social world as a given and work within those structures and processes to deal with issues as they arise. Aside from the English School, there is little explicit normative content and order is prioritised over other social concerns. There are two main schools here – neo-realism (derived particularly from Waltz’s 1979 structural account of the state system) and neo-liberalism (or neo-liberal institutionalism). The debate between them is frequently referred to as the ‘neo-neo’ debate. The English School shares some of the concerns of the neo-libs, but with a more normative content, a greater concern for social justice, and an emphasis upon states constituting a social order – what Hedley Bull famously termed an ‘anarchical society’ (Bull 1997). Buzan was (and probably remains, despite his work with the Copenhagen School) a neo-realist but has modified neo-realism to include domestic and global factors.

A number of Europeans (for example, Smith 1996; Waever 1996) have commented that there is more consensus between the neo-neos than there is difference – at the epistemological, methodological and ontological levels there are striking similarities; but as regards security there are key differences. Although all of these schools may be used to adopt an International Relations (IR) approach to global health, (with the exception of the English School) none share the humanitarian concerns of public health and none offer the ability to work usefully with health policy. Their priority lies with foreign and security policy, and health would only be accommodated when it could usefully support these.

Neo-Realism

(eg Betts 1997; Freedman 1998; Mearsheimer 1990)

This is probably the most explicitly state-centric model of the international system. Although other actors are sometimes acknowledged, the neo-realist account places the state as the dominant actor. It offers a structural account of the state system where the key feature is anarchy (by which is meant a lack of central authority). For neo-realists security is military and obtained through self-help and the balance of power. Health is therefore a security issue only when it affects military considerations.

Barry Buzan is probably the single most important security theorist of the past 25 years. Ken Booth (in)famously argued that after the 1983 publication of *People, States and Fear* the rest ‘have been writing footnotes to it’. In this, Buzan made two key moves. The first was to address the ‘levels of analysis’ problem. Buzan argued that security could be examined at three levels: the individual, the state and the global. Although individuals are the ‘irreducible

basis' of security, the state remains the referent object as the key provider of security at both the international and sub-state level. Buzan's second key move was to broaden the range of security issues from a narrow focus on military, to include four other issues (political, societal, economic and ecological). Buzan has been criticised by other neo-realists (for example Freedman 1998) because he risked losing focus by widening the agenda. Few now would hold to this position and many would accept the distinction between strategic studies (military security) and security studies (Buzan's wider agenda).

Buzan was also criticised by non-realists because of his state-centrism – despite calling his key book *People, States and Fear*, he consciously turns away from security at the individual level. In reply Buzan argues that the state guarantees the security of individuals and therefore the security of the state is paramount (but see Booth's argument that the state is sometimes the threat to individuals not the guarantor of their security). Buzan also argues that the state is the proper focus for *international* security and that the security of individuals is a separate matter. This became increasingly problematic as the internal/international divide broke down in the 1990s with issues such as migration and refugees, and led to Buzan's move into collaborating with Waever to develop notions of societal security, discussed below.

Neither in his guise as a neo-realist in the 1980s expanding the security agenda, nor in his later discussions of societal security, does Buzan address health as a security issue. This may be because he considers it a secondary issue, contributing to the five key areas. But it may simply have been an omission.

Neo-Liberalism

(eg Jervis 1982)

Neo-liberalism shares neo-realism's state-centric focus, but argues that the effects of anarchy can be mitigated by international cooperation. Neo-liberals see co-operation as both possible and desirable. Some would even argue that the hallmark of the international system is co-operation not conflict. In contrast to neo-realism's focus on relative gains (that what is to one state's advantage is to another's disadvantage), neo-liberals point to the possibility of absolute gains through cooperation on issues such as trade and security.

Neo-liberal economics has had a major impact upon world trade and neo-liberalism underpins many of the arguments for international institutions. Though health is rarely if ever explicitly addressed in this literature, it has also had a huge indirect impact on global health security though its emphasis upon free trade (eg TRIPS) and institutions (eg WHO). There is therefore greater scope in neo-liberalism for health as an international issue (promoting global health as an absolute gain, emphasising cooperative regimes), but more limited as a security issue given the focus on the state and a narrow understanding of security.

The English School

(eg Bull 1977; Wheeler 2000)

For the English School, the effects of anarchy are mitigated by norms and patterns of behaviour, including international law. Rules of acceptable behaviour exist and may be

further developed. Space therefore opens up for progress on issues such as human rights (and by inference global health). The international system is classically portrayed by Hedley Bull as a society, albeit an anarchical one, and the English School have tended to demonstrate a much greater concern with normative issues (following on from emphasis upon international norms), including justice and humanitarianism. This opens up the possibility of health being seen not only as an international issue but as a security issue, but no attention has been paid to this to date.

Critical accounts

This section is concerned with critical (ie non-state centric) *theories*, though it should also be noted that there are a number of critical *approaches* which are issue-based and only loosely aligned with a particular theoretical basis. The most notable of these is Peace Studies. The taxonomy is loosely based upon Smith's (2000), but as Smith points out many of these are united more by what they disagree on than what they agree with. Further some schools, such as feminist security studies, are so broad and wide ranging that they could equally be divided into a variety of schools or approaches rather than a single voice. For our purposes, however, it is convenient to consider them together.

The Copenhagen School

In the 1990s, principally in collaboration with Ole Waever at the Copenhagen Peace Research Institute, Barry Buzan began to move on significantly from his earlier (1983) work taking into account both theoretical developments and the events following the collapse of communism. Amongst a number of signature publications, perhaps the most useful here is the 1998 collaboration *Security: A new framework for analysis* (Buzan, Waever and de Wilde 1998). This work explicitly engages with the questions of the referent object and what defines a security issue to provide a compelling theoretical account, which is discussed in more detail below. Much of the critical attention this work has received focuses on the perceived shift in focus from the state to society. Buzan appears to argue that the changed security issues of 1990s makes his previous state-centric focus on security untenable. 'Societal security' is concerned with preserving the identity of social groups against a variety of threats.

Like Buzan's work of the 1980s, this has proved extremely significant but also very controversial. McSweeney (1996, 1998) and Smith (2000) both detect unresolved tension between Buzan's residual state-centrism and neo-realism and Waever's post-modernism. Perhaps more important are McSweeney's (1996) criticisms over society as a referent object. McSweeney provides two key arguments: that society is diffuse rather than coherent, and therefore difficult to focus on; and that society is being objectified in 'societal security' as a social fact when it is merely a construction. Although the idea of societal security was an important, if controversial development, in the early conceptual chapters of Buzan *et al's* work, it actually reveals a rather more complex picture of security emerges.

Making Security: Social constructivism

(eg Adler and Barnett 1998; Katzenstein 1996) and strategic culture (eg Gray 1986; Jacobsen 1990; Johnston 1995; McInnes 1996)

Although these are usually considered as different approaches – and at least one major strategic cultural theorist (Gray) is more properly seen as closer to realism than social constructivism – they do share one important feature which differentiates them from orthodox accounts concerning how the world is understood. Neo-neos in particular assume that events in the ‘real world’ can be understood in a uniform or common manner. Not everyone will share this common interpretation, but that represents a failure of understanding on the part of those decision makers. Some responses are objectively better than others. A good decision maker will maximise benefits and minimise costs and risks. There is, in short, a real world out there and common sense should be used to inform rational decision-making.

By contrast, strategic culture argues that the world is interpreted through a cultural lens, which may be influenced by a variety of factors including geography, history, political beliefs and institutions, which are specific to each social group. Thus the social world is constructed differently by each actor and security means different things to different actors because of their individual strategic cultures. Responses to security threats moreover are not determined by a rational cost/benefit analysis where there is one ‘best’ solution, but are influenced by past experiences, belief systems and so on which may be specific to that particular actor. Although change is possible, most strategic cultural theorists see general approaches to security as relatively immutable. Issues may come and go, but they will be seen and decisions made on them through a deep-seated series of assumptions about the nature of the world and appropriate responses. Thus health may arise as a security issue, but how it is viewed and how decisions are made will be affected by an actor’s strategic culture.

Although much of the analysis within strategic culture focuses upon the state, it also recognises that there are other actors with their own cultures and concerned with their own self-preservation (for example, McInnes 1996). Thus although strategic culture may be criticised for state-centrism, this is more by the choice of those engaged in the analysis than because of any specific orientation of the approach.

Although strategic culture has entered the mainstream of security thinking, problems over defining and identifying culture persist. For the purposes of this paper, however, there are two main obstacles to using strategic culture as a basis for conceptual thinking. First, culture is a poor explanatory tool because of difficulties in identifying what culture is and how it affects policy. Second, strategic culture does not provide the sort of conceptual tools required to answer the questions identified above. Its main use is in explaining policy outcomes rather than in identifying the nature of the problem.

Social constructivist approaches to security draw upon wider theories of social constructivism – that the social world does not exist independent of the actors within it but is constructed by them inter-subjectively. Although actors are influenced by past understandings, the social world is not immutable and progress is possible. For social constructivists, state-centrism is a construct which can be changed, as can those issues which are on the agenda. Nevertheless Smith (2000) points out that social constructivists are essentially state-centric in their analysis, and that their empiricism makes them ‘explainers’ rather than ‘understanders’ of the

social world. In sum, social constructivism (and by the same token strategic culture) is not critical in a Coxian sense.

Critical Security Studies

(eg Krause and Williams 1997; Booth 1991)

Critical Security Studies (CSS) derives its name from Cox's distinction between 'problem solving' and 'critical' theories. It is therefore explicitly concerned with offering a sustained critique of existing social structures (not only the state system but the theoretical approaches and epistemologies which underpin and justify it). It is sceptical of Buzan's attempt to widen the security agenda, seeing it as an example of problem solving theory which does not address underlying structural problems. Without addressing these underlying issues security cannot be achieved. The work of Booth and Wyn Jones (1999) in particular shifts the focus firmly to the individual and they argue that security rests in human emancipation. It draws inspiration from the work of Gramsci and the Frankfurt School and is explicitly normative in approach.

Health would fit nicely into the CSS agenda through the focus of Booth *et al* on the security of the individual (although CSS has yet to satisfactorily provide a link between human security and the state as an actor and provider). Less helpful for our purposes is the focus on and critique of social structures.

Feminist Security Studies

(eg Enloe 1988, 1990; Elshtain 1987; Cohn 1987)

Although there is a very broad range of ideas within this general approach, they are united in a dissatisfaction with orthodox security studies' pretence of being gender neutral. Cohn for example examines the language and symbols used, identifying a masculine construction of the weapons and terminology of war, while in perhaps the best known of feminist writings on security Cynthia Enloe (1990) asks the simple question of 'where are the women?' and identifies the hidden role of women in security. For most feminist writers, security (and especially the military) is deeply patriarchal and reinforces a power relationship in which women are subjugated to a masculinised agenda. As Smith (2000) writes on Enloe, 'Only by showing where women fit into international relations can we see how power really operates.' Feminist security writings are useful here because they remind us that gender is a key issue and warn us of the dangers in thinking we are being gender neutral when in fact we are being gender blind. But they offer little help in answering the three questions.

Post-modern/post-structural accounts

(eg Campbell 1992, 1998; Klein 1994; Dillon 1996)

Like feminist security studies, post-modern (or post-structural) accounts are united more by what they disagree with than what they agree on. Whereas feminists disagree with orthodox accounts for presenting a gender-blind, masculinised view of security, post-structuralist security studies critiques the epistemological basis of traditional accounts. In particular they argue that there is no one truth which can be arrived at through empirical testing. There are only competing knowledge claims which are expressed through the speech act and which reflect power relations. Language is not a transparent conduit for meaning, but a political act

which interprets and constructs the social world. Large parts of post-structural security studies therefore draw on Derrida and examine how speech acts (including written material) are used to create a particular form of security, defining what is and what is not a security issue and how they should be treated (eg Campbell 1992). Further, discourse analysis is used to demonstrate how 'security' is used to defend the *idea* of the state (Klein 1994) and how writing about security is used to construct the identity of the state (Campbell 1992). For post-structuralists, issues are not security issues because they can be empirically matched against some objective criteria. Instead issues are made security issues through speech acts. Health *per se* neither is nor is not a security issue; it is only made a security issue when powerful constituencies make it so through the speech act.

A framework for analysis: the Copenhagen School

Buzan, Waever and de Wilde (1998) explicitly attempted to produce a new framework for security in what had by then become a fragmented discipline. Their analysis however was not a synthesis of the various schools which had emerged over the previous 15 years, but a move forward from Buzan's own 1983 work in two important respects. First, it explicitly acknowledged that the world had changed with the end of the Cold War. In particular it demonstrated much greater scepticism over the role of the state and introduced the idea of societal security (defending the identity of a social group as a security issue). Second, it attempted to blend Buzan's neo-realism with Waever's post-structuralism. Both moves have been criticised: for example, McSweeney (1996) over societal security, Smith (2000) and McSweeney (1996) over the latent tension between blending neo-realism and post-structuralism (though Smith in particular fails to elaborate convincingly on this).

Despite these criticisms, Buzan, Waever and de Wilde offer a compelling argument which is used as the basis here for developing an understanding of the relationship between health and security. This is not meant to imply that the approach of the Copenhagen School is beyond criticism, or that other schools or approaches do not offer valid insights. But Buzan *et al* offer a way of answering the three questions which is both intellectually compelling and has a degree of support in the academic world.

Buzan *et al* begin by raising the problem of defining security issues once analysis has moved beyond a narrow military definition. They acknowledge that this problem has led some to argue against expanding the agenda away from its narrow focus – that broadening the realm of security leads to a loss of definition (for example, Freedman 1998). To misquote the arch neo-realist Kenneth Waltz, security is in danger of being applied to everything and therefore meaning nothing. But Buzan *et al* defend their broadening agenda, arguing that what is needed is a new means of defining issues as security issues. Their project is to 'explore the logic of security itself to find out what differentiates security...from that which is merely political'. They do admit, however, to two problems with the widening agenda. First, that applying the security label to a wide range of issues risks state involvement where that might prove 'undesirable and counter-productive'; and, second, that security is in danger of being '[elevated] into a kind of universal good thing – the desired condition toward which all relations should move...this is a dangerously narrow view. At best, security is a kind of stabilisation of conflictual or threatening relations, often through the emergency mobilisation of the state.'

Buzan *et al* then identify a number of conceptual tools which are used in their framework. Of specific importance to our enterprise are:

- *Levels of analysis* This is of fundamental concern to us since much of their subsequent thinking is concerned with referent objects at different levels. For our purposes the fundamental problem is the relationship between unit level actors (states, but also multi-nationals) and individuals (the referent object for human security approaches). Buzan *et al* admit that levels interact and that system-wide phenomena may have sub-unit or individual effects and vice versa. Crucially they argue that ‘the criterion for answering the levels question is essentially political: what constellation of actors forms on the issue’.
- *Sectors* This is a tool for disaggregating security into groups of issues – eg environmental security, military security. Each sector is defined by a specific pattern of interaction, but is part of a complex whole. Health is not identified as a sector by Buzan *et al*, but meets the necessary criteria. But note that from this analysis, health is *part* of a complex whole and that the relationship between health and other sectors/security issues ought not to be ignored.
- *Security complexes* Although security is global, most interactions are regionally based. Thus local security complexes arise where interdependencies are greater and security cannot be understood without reference to this. Because these form subsystems, distinctive operational norms may arise within security complexes. Classically, security complexes are identified with states and military security. Can such complexes exist outside the realm of military threats and states? Buzan *et al* identify two means of opening up security complex theory to a wider variety of sectors and actors: homogenous complexes and heterogeneous complexes.
 - *Homogenous complexes* This complex is sector-specific, that is security complexes emerge grouped around a sector. This complex may consist of a variety of actors and may result in distinctive patterns of behaviour because of the requirement for emergency action.
 - *Heterogeneous complexes* This assumes that the driver for security complexes is a regional logic which may embrace a variety of sectors and actors.

Note that this is a tool for analysis and that we may choose which best fits our needs. Health may be both a homogenous complex – with specific patterns of interests, issues and concerns – or a heterogeneous complex, such as sub-Saharan Africa, where health is one of a number of inter-related issues. Security complexes are defined by referent objects and may represent a ‘constellation’ of security concerns.

- *Securitisation* Here the hand of Wæver’s post-structuralism is most apparent. Buzan *et al* argue that labelling an issue as a ‘security’ issue takes it beyond the realm of normal political discourse and allows exceptional actions to be undertaken. As Buzan *et al* state

'[in] depicting a threat the securitising agent often says something cannot be dealt with in the normal way'. Security becomes a 'self-referential practice...[an] issue becomes a security issue...not necessarily because a real existential threat exists but because the issue is presented as a threat'. This process is securitisation.

For Buzan *et al*, the character of security in an international relations context is different from the 'everyday' meaning of security. Security is about survival. It is 'when an issue is presented as posing an existential threat to a designated referent object'. There is no satisfactory objective measurement of what is or is not a security issue, nor can we usefully differentiate between 'real' and 'imagined' security issues. What may seem imagined to one state may nevertheless be very real to another. An 'imagined' security issue might also lead to 'real' actions which then make it a real issue for other states. But Buzan *et al* do not wander into the trap of arguing that security is simply subjective. Rather they present a more complex argument:

The label *subjective*...is not fully adequate. Whether an issue is a security issue is not something individuals decide alone. Securitisation is intersubjective and socially constructed: Does a referent object hold general legitimacy as something that *should* survive, which entails that actors can make reference to it, point to something as a threat, *and* thereby get others to follow or at least tolerate actions not otherwise legitimate? This quality is not held in subjective and isolated minds; it is a social quality, a part of the discursive, socially-constituted, intersubjective realm.

A key element of this is that the special nature of international security warrants extraordinary measures to handle them. Gaining acceptance for such measures requires approval and therefore a consensus that this is a legitimate security issue warranting extreme measures. Hence security is intersubjective.

The idea that security is intersubjective and that issues are created as security issues through speech acts raises a problem: who are the actors who, through their speech acts, can create security issues? Clearly this power is not universal but biased towards certain actors who are 'generally accepted voices of security'. Three facilitating conditions are necessary for a speech act to be successful in the process of securitisation:

- it must follow the accepted grammar of security (that is, use accepted terminology and concepts);
- it must come from an actor in a position of authority to pronounce on security (eg a state); and
- it helps (but may not be necessary) if the object can be generally held to be threatening.

The securitisation argument is a crucial move for us in terms of defining which issues are security issues. As Buzan *et al* argue, the 'definition and criteria for securitisation is constituted by the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects'. So, in defining health issues as security issues,

they do not need to meet external criteria but rather be agreed upon intersubjectively as constituting an existential threat which cannot be dealt with in the normal way, and which has a political impact. Thus HIV/AIDS infection has been agreed upon and has political effect and is therefore a security issue, but obesity has not (yet).

Finally for the purposes here, Buzan *et al* discuss actors and referent objects: the question of 'whose security?' They usefully distinguish three types of actor:

- Referent objects: defined as 'things that are seen to be existentially threatened and that have a legitimate claim to survival'. In principle any actor can be a referent object; in practice referent objects are limited by the three facilitating conditions above. Buzan *et al* argue that size is important here. Too large and the referent object loses focus and therefore finds difficulty in attracting legitimacy (eg 'humankind', 'the working class'). Too small (individuals) can seldom establish a 'wider security legitimacy in their own right'. Although this latter argument is presented in a somewhat flimsy manner, if the analysis is correct then it offers a solution to the problem of health's focus on individual security and foreign and security policy's on the state. In other words, individuals would have to establish intersubjectively a legitimate claim as referent objects against specific threats. Or as Buzan *et al* put it: 'referent objects must establish security legitimacy in terms of a claim to survival'. Buzan *et al* therefore accept the argument that human security may be a legitimate security concern and that the individual may be a referent object (by this they mean individuals, not a named person), but only if they meet the facilitating conditions.
- Securitising actors: actors who have the necessary level of accepted authority to declare a referent object threatened. Although a complicated category to pin down, Buzan *et al* argue that this is usually government officials, pressure groups and lobbyists, political leaders etc. They do not mention academics, but they might be considered securitising actors as might NGOs and charitable trusts in certain circumstances.
- Functional actors: neither of the above, but who may nevertheless have an ability to influence decisions in the relevant sector. The example given is that of a polluting company in environmental security. Pharmaceutical companies would be an obvious analogue in the health sector. But this is a difficult category since a company might also become a securitising actor or a referent object under different circumstances (or even in the same situation).

Global health security

This section attempts to build on the insights of the discussion on security above to develop our own conceptual basis for health as a security issue. In particular it explicitly addresses the three questions identified above:

- Whom or what is to be protected through the practice of global health security?
- Which health issues are legitimate security issues and which are not, and how do we decide?

- How should health, foreign and security policy interrelate?

Whom or what is to be protected through the practice of global healthy security?

This paper began by identifying a problem in terms of the level of analysis: that whereas foreign and security policy focused upon the state as the referent object, public health policy focused upon the community with a tendency towards the individual. However the analysis above has suggested that within the academic sub-discipline of security studies the picture is somewhat less clear. Two decades ago Barry Buzan identified security at three distinct levels of analysis; 15 years later, together with Waever and de Wilde, he identified five distinct levels of analysis and had begun to move away from the state as the referent object for international security. In the interim, a host of different approaches to security have emerged, few of which see the state unproblematically as the referent object of security. Nevertheless the dominant approaches to security – particularly in North American academic circles and within the policy community – are still focused upon the state as the primary referent object, and the problem therefore remains.

What this outpouring of scholarship offers us, however, is an opportunity to find a way through this problem. Buzan *et al* suggest that ‘the criterion for answering the levels question is essentially political: what constellation of actors forms on the issue’ (Buzan, Waever and de Wilde 1998). In this instance the ‘constellation of actors’ is the two policy communities, and by implication the designated referent object would be the result of agreement or struggle between the two communities. Indeed to a certain extent this struggle can already be seen with some of the work on global health security being framed in terms of threats to states (eg Elbe 2002, 2003; Shine 2002) and others adopting a more human security approach (Commission on Human Security 2003). Deciding global health security’s referent object through a struggle between two policy communities is, however, less than ideal: if a ‘winner’ emerges, then so will a ‘loser’.

Although Buzan (1983) argued that the individual remained the ‘irreducible basis’ for security, it is usually only when issues have broader implications for the community that they have political legitimacy as security issues. Thus the referent object is not the individual but the community. Though the state may form a community, communities with distinct health security issues may exist within a state. Thus the state is not necessarily the referent object, rather it is the community, which may or may not be a state. In this sense, ‘community’ is used in the public health sense rather than Buzan *et al*’s ‘societal security’. What makes a health issue a global issue is agreement that it cannot be resolved at the national level and/or that it has implications beyond national borders. Thus the referent object is the community, but issues are only global issues if there is agreement that they have implications beyond or cannot be resolved by an individual state.

One area of departure from Buzan *et al* is in the level of risk required for an issue to be considered a security issue. Buzan *et al* place the bar at a high level – that of an existential threat – in order to differentiate security issues from the normal political discourse. In so doing they perhaps betray the origins of international security theory as military threats to state survival. Certainly the issue of survival fits firmly within more traditional discourses on

security, but does not necessarily reflect the wider agenda Buzan himself has been so instrumental in promoting. Issues do not need to pose existential threats for them to be considered security issues. Threats to lifestyle and livelihood have also been widely seen as security issues in that they have the capacity for extreme negative effects on individual and social well being, even though they may not directly threaten the existence of a social group. Security is not simply about existence, it is about social well-being and a certain level of stability and predictability (as Buzan *et al* themselves recognise). Thus the level of risk may be expanded from that of an existential threat to extreme threats to life, lifestyle and livelihood.

Which health issues are legitimate security issues and which are not, and how do we decide?

There is no objective, scientific set of criteria which can be used to determine whether an issue is a global health security issue or not – nor is it purely a subjective matter. Instead such issues are determined intersubjectively through what Buzan *et al* term a securitising process. The securitising process begins with a claim that an issue is outside the ordinary political process because of the level of risk involved and that it can only be dealt with by emergency action. As Buzan *et al* make clear, the risk need not be real for a claim to be made and its success does not depend upon it meeting a set of objective criteria but on how the claim is made and by whom. For a claim to be successful, a number of criteria (facilitating conditions) have to be met concerning who makes the claim, how the claim is made if the object can be generally held to be threatening. These are however only facilitating conditions – meeting them does not guarantee that a claim will be successful. What is critical is gaining a consensus on the legitimacy of the claim.

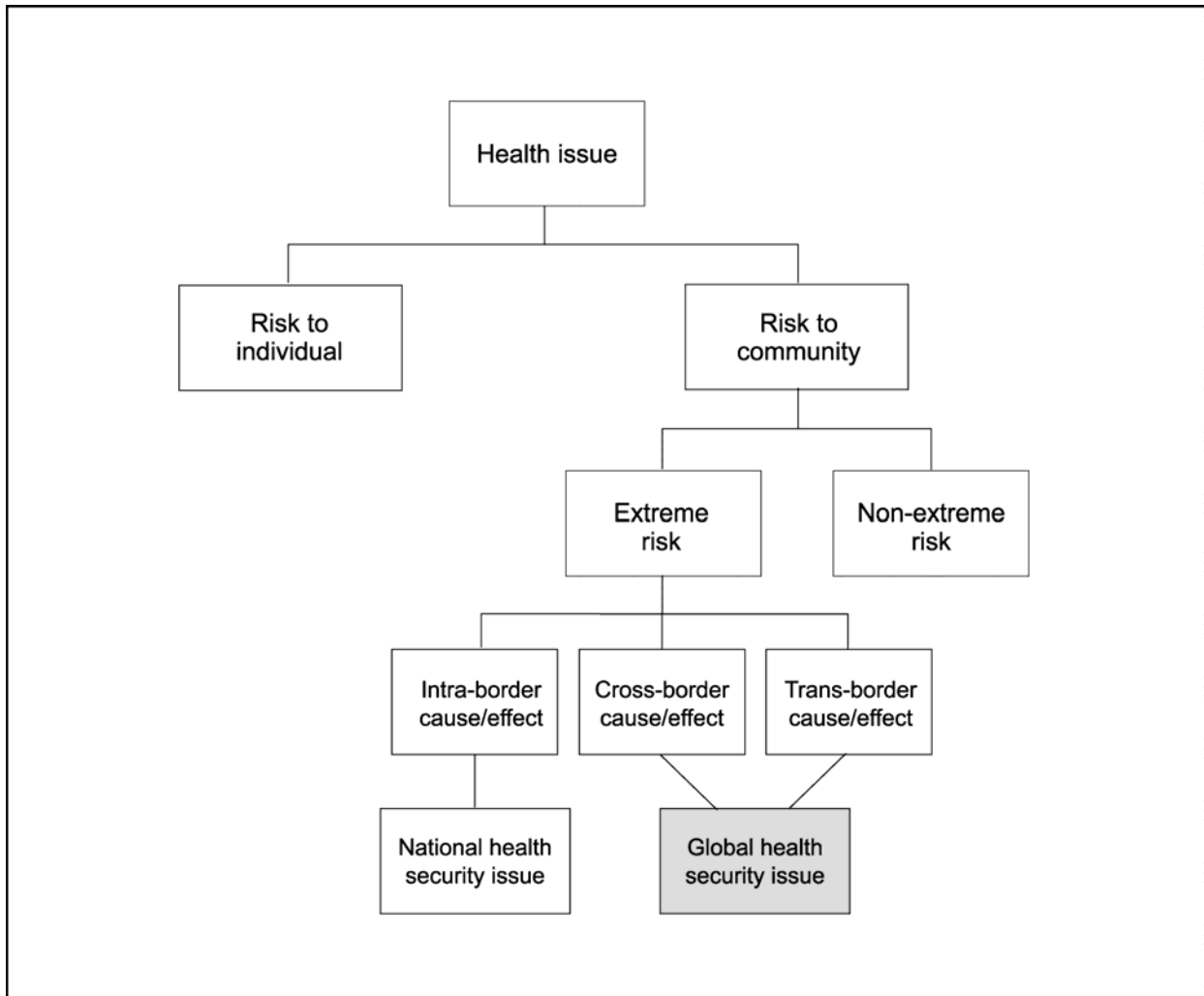
Using the idea of a securitising process, the suggestion here is that what raises an issue to the level of a global health security issue is its credibility – in other words that there is intersubjective agreement that this is so. To gain this credibility a number of criteria have to be generally agreed to have been met. Three criteria appear to be critical:

- An issue must be perceived as an extreme threat to life, lifestyle or livelihood, with substantial political effect and that these effects go beyond individuals into the community.
- That the issue cannot be dealt with nationally, or that it has implications beyond national borders.
- That the issue has legitimacy as a security issue. This requires that the claim is made either by a recognised actor, or that it can be phrased in the grammar of security and that the issue can be presented as a threat. For Buzan *et al*, the claim has to be made by a recognised security actor. But given that issues may arise outside the traditional realm of security specialists, this seems an overly narrow criterion. In these instances, a claim may originate outside the arena of security specialists but, provided that it uses the grammar of security, may then be recognised by the security community. Thus public health professionals may use the grammar of security to alert the security community to an issue.

But it is also important to note that the claim itself is insufficient to give the issue credibility.

Thus if intersubjective agreement can be reached that a health issue is a legitimate security issue, that it cannot be dealt with nationally and that it poses an extreme threat to a community, then it may be considered a global health security issue.

Figure 2: Current thinking within security studies on global health security⁹



How should health, foreign and security policy interrelate?

Global health security may be seen as a homogenous security complex. That is, it resembles a security complex where local interactions produce a distinctive sub-system. But whereas security complexes are usually thought of in regional terms, a homogenous security complex is not regionally based but sector specific. The complex is only part of security in a broader sense and may rub up against other security complexes (eg the environment, military); but

⁹ This chart was formulated by Kelley Lee.

global health security can be disaggregated from the whole because of the distinctive issues involved (what Buzan *et al* term a ‘constellation’ of security concerns). It should be noted that this does not imply ghettoisation, rather that there are an identifiable set of interactions. Nor does health only fit into a homogenous complex – sub-Saharan Africa for example may be seen as a heterogeneous complex where health is a key issue.

Within the complex a variety of actors may be involved. Crucially, relationships within security complexes are unique to each sector. Each complex may demonstrate its own particular forms of interaction and operational norms. These in turn are not set, but are evolving. Thus the relationship between health and foreign and security policy in global health security will not mirror relationships in other security complexes (that is, it will not be structurally determined), rather distinct patterns of behaviour will emerge. Although these patterns are prompted by emergency concerns (otherwise these would not be security issues, merely political) security complexes are nevertheless likely to form their own operational norms and will demonstrate the potential to evolve.

Given that health may be seen as a complex in its own right, questions then arise as to what the pattern of interactions have been and how successful the securitisation process has been. In other words, there is scope for empirical studies of how this complex has developed and of how health figures within regional (or heterogeneous) complexes. Some of these questions will be addressed in the subsequent research of the UK Global Health Programme.

References

- Adler E and Barnett M (eds) (1998) *Security Communities* Cambridge University Press
- Betts R (1997) ‘Should strategic studies survive?’ *World Politics* 50
- Booth K (1991) ‘Security and emancipation’ *Review of International Studies* 17
- Bull H (1977) *The Anarchical Society* Macmillan
- Buzan B (2000) ‘“Change and insecurity” reconsidered’ in Croft S and Terri T (eds) *Critical Reflections on Security and Change* Frank Cass
- Buzan B (1983) *People, States and Fear: The national security problem in international relations* Harvester/Wheatsheaf
- Buzan B, Waever O and de Wilde J (1998) *Security: A new framework for analysis* Lynne Rienner
- Campbell D (1998), *National Deconstruction: Violence, identity and justice in Bosnia* University of Minnesota Press
- Campbell D (1992) *Writing Security: United States foreign policy and the politics of identity* Manchester University Press

- Cohn C (1987) 'Sex and death in the rational world of defense intellectuals' *Signs: Journal of women in culture and society* 12.4
- Cox R (1981) 'Social Forces, States and World Orders: Beyond international relations theory' *Millennium* 10
- Dillon M (1996) *Politics of Security* Routledge
- Elbe S (2003) *Strategic Implications of HIV/AIDS* Adelphi Paper 357 OUP/IISS
- Elbe S (2002) 'HIV/AIDS and the changing landscape of war in Africa' *International Security* 27
- Elshtain J (1987) *Women and War* Basic
- Enloe C (1990), *Banana, Beaches and Bombs: Making feminist sense of international politics* University of California Press
- Enloe C (1988) *Does Khaki Become You? The militarisation of women's lives* Pandora
- Freedman L (1998) 'International Security: Changing targets' *Foreign Policy* 110
- Gray CS (2000) *Modern Strategy* Oxford University Press
- Gray CS (1986) *Nuclear Strategy and National Style* Hamish Hamilton
- Jacobsen CG (ed) (1990) *Strategic Power: USA/USSR* Macmillan
- Jervis R (1982) 'Security Regimes' *International Organisation* 36
- Johnston AI (1995) 'Thinking about strategic culture' *International Security* 19
- Katzenstein P (ed) (1996) *The Culture of National Security: Norms and identity in world politics* Columbia University Press
- Klein BS (1994) *Strategic Studies and World Order: The global politics of deterrence* Cambridge University Press
- Krause K and Williams M (eds) (1997) *Critical Security Studies* University of Minnesota Press
- McInnes C (1996) *Hot War, Cold War: The British army's way in warfare 1945-90* Brassey's
- McSweeney B (1998) 'Durkheim and the Copenhagen School: A response to Buzan and Waever' *Review of International Studies* 24
- McSweeney B (1996) 'Identity and Security: Buzan and the Copenhagen School' *Review of International Studies* 22
- Mearshiemer JJ (1990) 'Back to the Future: Instability in Europe after the cold war' *International Security* 15
- Shine K (2002) *Bioterrorism: From panic to preparedness* RAND Corporation
- Smith S (2000) 'The Increasing Insecurity of Security Studies: Conceptualising security in the last 20 years' *Critical Reflections on Security and Change* Frank Cass

- Smith S (1996) 'Positivism and Beyond' in Booth K, Smith S and Zalewski M (eds) *International Theory: Positivism and beyond* Cambridge University Press
- Waever O (1996) 'The Rise and Fall of the Inter-paradigm Debate' in Booth K, Smith S and Zalewski M (eds) *International Theory: Positivism and beyond* Cambridge University Press
- Waltz KN (1979) *Theory of International Politics* Addison-Wesley
- Wheeler NJ (2000) *Saving Strangers* Oxford University Press
- Wyn Jones R (1999) *Strategy, Security and Critical Theory* Lynne Rienner

3.4 Health, development and security

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The purpose of this paper is to shed light on the increasing engagement between the public health, foreign and security policy communities in terms of development and human security. The paper argues that recent attempts to problematise the relationship between development and security offer a compelling lens for viewing how major international health issues are being framed in terms of a security agenda. The paper examines a corpus of work that has been highly critical of the apparent merging of the development and security agenda. Authors such as Joanna Macrae and Mark Duffield have questioned the legitimacy of linking development with security, viewing the ‘securitisation’ of development as an expression of power and interests in the international system. The security-driven development agenda contrasts with recent policy approaches to development that are based on the concept of human security.

A similar polarisation of viewpoints is increasingly apparent over a range of international health issues. Close association of development assistance with military intervention and western security interests, as well the merging of security agenda and international health issues, are both processes that have gained momentum after the Cold War and the events of 11 September 2001. While it is acknowledged here that there are legitimate security issues at play with respect to international health, we argue that the co-option of the international health agenda threatens to marginalise human security approaches to health, and constrain the manner in which global health issues are articulated in future.

In particular, the paper will answer the following questions from a development perspective:

- Whom or what is to be protected through the practice of global health security?
- Which health issues are legitimate security issues and which are not, and how do we decide?
- How should health, foreign and security policy interrelate?

Towards a merging of the development and security agendas?

The relationship between development and security has been among the most controversial in international relations. Since the end of the Cold War, and particularly in the last decade, there have been high-profile calls for providing development assistance within the policy framework of military and humanitarian intervention (OECD 2003). A central debate within the surrounding discourse is whether states have a justifiable right to intervene in other sovereign entities, as well as how and when such a right might be exercised, and under whose authority (Evans and Sahnoun 2001). Other approaches have emphasised the positive role that development aid can play in creating and maintaining security. For example, a 2003 policy report published by the World Bank cites development assistance as an effective instrument for conflict prevention (World Bank 2003).

Since the events of 11 September 2001, and the subsequent launch of the War on Terror, many development organisations have voiced concerns that a new era of political polarisation is being ushered in, largely at the expense of the needs of the poor and human rights. From 1993 until around 2001, levels in development aid have declined (Lee *et al* 2004). As they rise once again, there is concern that donor countries are moving to redefine 'development cooperation', under the rules of the Organisation for Economic Cooperation and Development (OECD),¹ to allow the diversion of aid to enhance international security (OECD 2004; Carter 2004). In the aftermath of the Madrid bombings of March 2004, for example, the European Union (EU), the world's largest donor bloc which provides around £19 billion in aid per year, has hinted at proposals to link development aid explicitly to the War on Terror (Christian Aid 2004). If this proves the case, the development community believes that there is real cause for concern that development goals based on humanitarian principles (eg poverty reduction, Millennium Development Goals) will become increasingly subordinated to foreign and security policy objectives (BOND 2003). This is particularly evident where countries rated negatively in terms of governance, corruption, repression and abuse of human rights, are offered aid to take a supportive position on the War on Terror.² Former British Foreign Secretary Robin Cook has echoed these concerns: 'I find it particularly depressing that any of our aid effort should be diverted to fund the occupation of Iraq... regardless of what any of us may think about the invasion of Iraq, we surely can all agree that the poor around the world should not pay for the consequences.' (BBC News 2004)

Within the scholarly community, despite the fact that the disciplines of International Relations (IR) and Development Studies have generally remained separate spheres of inquiry (Lee and McInnes 2003), there has been increasingly vigorous debate over efforts to link the development and security agendas. Writers such as Duffield (Duffield 2001a), Macrae (Macrae 2001), Slim (Slim 1997) and Goodhand (Goodhand 2002) have sought to bridge the two disciplines, mostly from the perspective of development studies. Their core argument has been that development concerns should not be subordinated to international security issues, and that securitisation of aid threatens the chances for achieving genuine human security.

Duffield and others identify the securitisation of development with the post-Cold War period. However, the links between development and security have long been recognised and can arguably be traced to ideas of 'development' from the mid-19th century. The concept of

1 The OECD Development Assistance Committee (DAC) defines official development assistance (ODA) as: (a) grants, long-term (ie over one year maturity) capital transactions and specific development-related internal transactions made by governments or the official sector of DAC countries; (b) private long-term capital transactions made by residents of DAC countries; and (c) grants by private non-governmental organisations (NGOs) based in DAC countries. See OECD (2000).

2 For instance, financial aid from the UK, EU and US to Pakistan, a country that had been subject to sanctions and international diplomatic pressures because of its nuclear testing policy, human rights abuse and military coup in 1999, increased substantially directly after 11 September 2001. In October 2001, DFID pledged £105 million to support Pakistan's Poverty Reduction Strategy. The EU announcement on increased assistance to Pakistan (including additional development aid and a preferential trade package) specifically referred to the country's decision to support the international coalition against terrorism. See www.dfid.gov.uk and <http://europa.eu.int>. Another example is the shift in US foreign policy towards Kenya. The Bush administration has become more sensitive toward the country's politics in order to advance its counter-terrorist agenda in the region. See Barkan (2004) and Lyman and Morrison (2004).

development during this period was articulated with respect to efforts to reconcile the rapid changes brought about by industrialisation with the need to maintain social order (Duffield 2001b). Development, in this context, was imbued with the ability to bring stability to the instability of rapid urbanisation, employment restructuring and widespread impoverishment. Similar ideas characterised policy thinking during the mid-20th century after the Second World War and amidst post-war reconstruction and decolonisation.

However, the provision of development aid soon became entangled in Cold War politics, with aid flows becoming delineated between either pro-NATO or pro-Warsaw Pact countries. In essence, development concerns became inextricably linked with the geopolitical power struggles of the US and Soviet Union. The initial post-colonial development regime was mainly concerned with promoting economic growth based on capital investment and the transfer of expertise and know-how (Duffield 2001a). Dominant development theories, notably the 'stages of growth' model, assumed that all countries could follow the same trajectory of development given the appropriate inputs. By the late 1960s, however, the failure of many newly-independent countries to make such advances, amidst severe poverty and inequality, led to new critiques of prevailing models. Dependency theory, for example, argues that developing countries are trapped in a position of disadvantage by the existing structure of the international political economy. Within a neo-colonial system, poor countries of the South remained dependent on the dominant North for capital, knowledge and markets (Frank 1967). Underdevelopment was a direct consequence of the manner in which wealth was produced and distributed.

Until the late 1970s, development discourse on Asia, Africa, and Latin America focused on the nature of development. From the economic development theories of the 1950s, to the 'basic human needs' approach of the 1970s, the main preoccupation of theorists and politicians was the kinds of development needed to solve the social and economic problems of these parts of the world. The need for development had achieved a status of certainty in social imagination, as Escobar writes, and concepts such as 'another development', 'participatory development', and 'socialist development' have been widely proposed (Escobar 1995). He argues that the history of development is closely associated with prevailing power relations in the global political economy, and the manner in which the paradigm is articulated is also constructed by the ideologies which characterise these relations.

In this sense we can view the ending of the Cold War during the late 1980s, and the ensuing reconfiguration of strategic interests, as precipitating a reassessment of the relationship between development and security. This was a process which, for a number of authors, has involved a further major repackaging of the development paradigm, and a shift in the ideology surrounding aid. Today, economic prosperity and growth are not only viewed as co-dependent upon security, but expressly linked as policy issue areas by many western governments. Indeed, underdevelopment is now problematised more in terms of the threat it potentially poses to the security of powerful countries, than to the well-being of affected populations.

Duffield's framework for analysis

Duffield provides an unusual framework for viewing the contemporary aid and security nexus in terms of the limits of global governance. He suggests that powerful states could be referred to as 'metropolitan', while weaker states (eg rogue states, states prone to conflict, low-income countries) as 'borderlands'. Metropolitan states are described as abusing power by, at best advocating certain forms of globalisation in order to control borderlands, and, at worst, excluding such countries from any participation in a system of global governance. During the 1990s, western governments began to view such borderlands as posing a potential threat to western interests. The most striking aspect of Duffield's analysis is his explanation of how underdevelopment itself is perceived as posing a security threat to metropolitan states. In short, this reconfiguration of the security agenda places development at the heart of global security concerns (Curtis 2001). Duffield describes this contemporary 'merging of development and security' in the following way:

[T]he commitment to conflict resolution and the reconstruction of societies in such a way as to avoid future wars represents a marked radicalisation of the politics of development. Societies must be changed so that past problems do not arise, as happened with development in the past; moreover, this process of transformation cannot be left to chance but requires direct and concerted action. With most policy statements, there is a noticeable convergence between the notions of development and security. Through a circular form of reinforcement and mutuality, achieving one is now regarded as essential for securing the other. Development is ultimately impossible without stability and, at the same time, security is not sustainable without development. This convergence is not simply a policy matter. It has profound political and structural implications (Duffield 2001a).

In this context, underdevelopment is seen as a threat to national and global security by, for example, fuelling illicit drug-trafficking, supporting the transnational spread of terrorism, and increasing uncontrolled population mobility. The World Bank report, *Breaking the Conflict Trap*, for example, describes conflict and its associated security problems as a failure of development (World Bank 2003). This 'repackaging' of development as a security concern has led to efforts to influence domestic conditions such as economic policy, governance and poverty (Curtis *et al* 2001). In other words, it is argued that the social concerns of many bilateral aid agencies have begun to overlap with the concerns of the foreign policy and security communities.

This perceived convergence, which remains highly contestable, is seen as an indictment of the current policies and activities of certain aid agencies. In describing the use of aid as a political and operational tool by western governments, Duffield highlights the hidden agendas of some developing countries as they attempt to disguise security fears as pressing developmental concerns. He argues that development has undergone its own rejuvenation in terms of being rediscovered as a strategic tool of conflict resolution and social reconstruction. Thus the role of development actors as agents of security has been rediscovered (Duffield 2002).

Yet Duffield and others express concern with this type of securitisation of the development agenda arguing that it will not address the real development concerns of the Third World. They consider the changing nature of conflict, and the increasingly influential role of 'high politics' on humanitarian and development policy. Duffield examines the extent to which foreign policy objectives determine the delivery and conditionality of aid, in turn raising ethical issues surrounding traditional humanitarian principles. The interventions in Afghanistan and Iraq reflect the concern that humanitarian aid practices are determined by western foreign policy goals, rather than humanitarian principles.³ The question ultimately remains who should hold responsibility for, and the capacity to, intervene in conflict and non-conflict situations, and to what ends.

The distinction between security and human security⁴ is fundamental to understanding concerns about this policy convergence. The term 'security' is traditionally equated with protection from physical harm. The concept of 'human security' concerns the need to provide for the basic needs of daily life by ordinary people. According to the Commission on Human Security:

human security means protecting vital freedoms. It means protecting people from critical and pervasive threats and situations, building on their strengths and aspirations. It also means creating systems that give people the building blocks of survival, dignity and livelihood. Human security connects different types of freedoms – freedom from want, freedom from fear and freedom to take action on one's own behalf. To do this, it offers two general strategies: *protection* and *empowerment*. Protection shields people from dangers. It requires concerted effort to develop norms, processes and institutions that systematically address insecurities. Empowerment enables people to develop their potential and become full participants in decision-making...human security complements state security, furthers human development and enhances human rights...respecting human rights is at the core of protecting human security. (Commission on Human Security 2003)

The United Nations Development Programme (UNDP)'s *Human Development Report 1994* proposes that human security complement the concept of 'human development' since, without human security, exercising freedom of choice in human development would not be possible (Commission on Human Security 2000). Contemporary debates about investment in social

³The traditional principles of neutrality, impartiality, independence and universality, as embodied by the International Committee of the Red Cross, are seen as under attack by the new coherence agenda. Universality implies that humanitarian action should reach all conflict victims. With the merging of politics and humanitarian action, however, the provision of assistance can be restricted to individuals and countries seen as following favoured policies. Non-conforming countries may be excluded, amounting to conditionality for humanitarian assistance. Impartiality means that humanitarian response should be guided by need alone, and that there should be no distinction between 'good' and 'bad' beneficiaries. Subordinating humanitarian objectives to political and strategic ones, makes some victims more deserving than others. The principle of independence contradicts the coherence agenda, as many humanitarian agencies remain dependent on money from donor states. A lack of independence makes impartial action more difficult. The loss of perceived neutrality under the coherence agenda compromises humanitarian immunity and threatens access to victims. It may also jeopardise the security and independence of aid personnel. As a consequence aid personnel may be exposed to security risks and may sometimes even be deliberately targeted (eg Iraq and DRC). See Curtis *et al* (2001) and Pasquier (2001).

⁴ For a detailed discussion see Background Paper 3.3 above.

development reflect this tension between human and national security.⁵ However, and despite the ideological contrast between human security and traditional approaches, there has been some blurring of the two agendas. For example, since the late 1980s, humanitarian action has been seen increasingly as integral to the strategy by some western governments to transform conflict, reduce armed and civil violence, and set the stage for development (Curtis *et al* 2001). Macrae and Leader argue that the end of the Cold War resulted in the political disengagement of major powers from the geopolitical periphery, in many cases leaving development and humanitarian organisations to fill this diplomatic space. Development aid and humanitarian action have been increasingly relied upon to fulfil political and strategic objectives for both ideological and pragmatic reasons. The push to downgrade superpower rivalry in the developing world, growing pressures on aid and defence budgets and, in many settings, an absence of viable governance mechanisms have all contributed to an increasingly close association between the security, development and humanitarian assistance communities (Macrae and Leader 2001).

Limitations to Duffield's analysis

Although Duffield provides a powerful account of the contemporary securitisation of aid, his underlying assumptions need further consideration. First, it may be argued that his paradigm is not exactly new. Realists and neo-realist theories of power politics in international relations, for example, would argue that Duffield's analysis of the convergence of aid, security and foreign policy is business as usual. Western governments have always linked their aid policies to their strategic needs, relatively neglecting those countries perceived to be of lesser economic and political interest to them (Macrae 2001). Those deemed of direct interest (eg Sierra Leone, Afghanistan, Iraq, Kosovo, East Timor, Israel), in turn, receive ongoing consideration. While the specific countries given attention change as the geopolitical map is reconfigured, the basic principle of 'great powers' putting national interest at the forefront of foreign policy (including aid policy) has been at the heart of the classical realist paradigm in international relations.

Second, Duffield's argument that western countries are disengaging from 'basket case' borderland countries, leaving NGOs and other development organisations to act as sole aid providers, pays insufficient attention to changes in the type and intensity of political and economic engagement in today's global world. Duffield's model of globalisation (borderlands versus metropolitan) is remarkably similar to the work of André Gunder Frank (Frank 1969) and Immanuel Wallerstein (Wallerstein 1974) who wrote during the 1960s and 1970s about the core-periphery structure of the international political economy. In using the terms 'borderlands' (periphery) and metropolitan (core), it is unclear what 'new' relationships

⁵ Hugo Slim usefully analyses development and humanitarian activities. Responding to the Rwandan genocide with relief aid to civilians, and with advocacy to support the indictment and trial of *genocidaires*, NGO actions are labelled 'humanitarian'. Working with pastoralists on matters of land rights and livelihood, their activities are characterised as 'developmental'. This distinction is an old one. It is also an essentially unhelpful one because it implies that these two types of activities represent different professions with distinct values. For too long, use of these terms has implied that humanitarianism and development are radically different moral pursuits. The ethic of the humanitarian has been stereotyped as a sort of temporary, morally myopic project which limits itself to meeting urgent physical needs before hurriedly abdicating in favour of development workers and their much grander ethic of social empowerment and transformation. See Slim (2000).

between aid and security are being described by Duffield in his analysis. He seems to argue that the end of the Cold War is simply intensifying previous dependency relationships, allowing western governments to apply aid policy as a disciplinary tool more effectively. While self-interest continues to influence which countries are engaged with, processes of globalisation, notably economic globalisation, are leading to an emerging global political economy with unprecedented levels of integration. Hence, the types and scale of engagement within and between countries are far more intense today than ever before in terms of forms of international cooperation and emerging governance mechanisms.

Third, the reconfiguration of social relations within and across countries by globalisation is not taken into account by Duffield's rather state-centric analysis of the links between development and security. While he argues that the securitisation of aid is being driven by processes of globalisation, he gives no account of what he means by this. There is little discussion of the agents of global change: who are they and who, in the context of this paper, is securitising aid? Is aid being securitised to ensure that powerful western governments can continue to define the globalisation project and, in doing so, continue to prosper and remain secure? Or is globalisation restructuring power relations in such ways that new relationships between security and aid are needed? A fuller exploration of the way in which globalisation is impacting on contemporary development and security challenges is clearly needed (Lee 2003).

In summary, the relationship between development, foreign policy and security has been a long contested one. The provision of development aid, and perhaps to a lesser extent, humanitarian action, has never been untainted by the interests of donor governments. However, there is a sense that there has been a trend towards the more overt and instrumental use of aid. This has raised intense concerns within the development community about the extent to which this is taking place, and the appropriateness of this trend. How will it impact on the core goals of development aid based on humanitarianism and social justice? As a discussion paper published by BOND⁶ asks, 'who will benefit: the populations of developing countries or of donor countries?' (BOND 2003). Health sector aid, and health-related humanitarian action, have traditionally been seen as relatively neutral forms of aid. Whether or not this is indeed the case, there are now similar concerns being raised within the international health community.

Global health security

Whom or what is to be protected through the practice of global health security?

Development discourse has evolved, in some ways, alongside colonialism in its reflection of the hegemony of dominant powers (Escobar 1995). The field is a rich and contested one, with schools of thought too wide-ranging to cover here. In broad terms, development theory and policy in many donor countries over the past decade has strongly focused on untying aid from national interests, encouraging the targeting of the poor within and across countries. This greater emphasis on poverty alleviation, basic needs (eg basic health care packages), debt

⁶ BOND, which stands for British Overseas NGOs for Development, is an umbrella organisation representing more than 280 charities and aid organisations.

relief and redirecting of aid budgets to the 'poorest of the poor' reflect this shift. The referent object, in this context, is vulnerable individuals and populations demonstrating the greatest need (for example, one billion living on less than US\$1 per day).

Since 11 September 2001 this type of development discourse is no longer limited to low-income countries but to so-called failed states or 'rogue-states' (Chomsky 2000). After the attacks on the World Trade Centre and Pentagon, the Bush Administration created a 'National Security Strategy' uniting diplomacy, defence and development policy. Aid, in this context, was officially tied to the War on Terror (Mekay 2003). This holds important implications regarding which countries qualify for development assistance and the criteria for aid.

From the perspective of the development community, closer linking of aid with security policy shifts the referent object away from the most vulnerable (whoever and wherever they may be), to those individuals and populations that pose the greatest perceived threat to the strategic interests of selected donor countries. This is seen as a return to forms of aid more closely tied to geopolitical interests. In this sense, efforts to 'securitise' aid, both development aid and humanitarian assistance, may be unwelcome. Despite efforts since the end of the Cold War by the security community to redefine the concept of 'strategic interest' to take into account transborder (non-state) factors, national interest remains the starting point. This is in sharp conflict with the principle held by the development community that aid should be provided to those in greatest need.

Despite persuasive attempts by some G8 leaders to argue the moral and altruistic imperatives for committing themselves to the development of poor nations, there are many particularly within global civil society (particularly humanitarian and developmental NGOs) who doubt those grounds. A recent Christian Aid report argues that 'aid is viewed increasingly as a means of promoting and safeguarding the donors' own interests, particularly their security, rather than addressing the real needs of poor people. Aid, in other words, is seen as co-opted to serve the War on Terror' (Christian Aid 2004).

There is ongoing debate within the global health community on the macro-economic question of where health investment should be targeted on sector-wide reform (trying to improve the entire health system) or on specific (vertical) programs aimed at producing improvement in particular areas (perhaps AIDS, malaria, non-communicable diseases etc). This can make it difficult to pinpoint the referent object in policy discussions on development, human security and health.

Which health issues are legitimate security issues and which are not, and how do we decide?

The high-level attention to global health since the mid-1990s is due to a significant extent to a recognition that there is a strong relationship between health and development. Poor people suffer greater ill health and shorter life expectancy as a consequence of, for example, higher than average child and maternal mortality, and inequitable access to healthcare and social protection. Conversely, health is seen as a crucial determinant of economic development. Healthier individuals are less likely to be poor and healthy populations are more likely to contribute to economic growth and prosperity.

For example, the World Health Organisation's Commission on Macroeconomics and Health (CMH) suggested that an investment of US\$119 billion (£158 billion) in health each year by 2015 will produce a return of US\$360 billion a year. It would do this by saving lives, allowing people to be economically productive, and by spurring economic growth through a variety of mechanisms including faster demographic transition to lower fertility rates, higher investments in human capital, increased household saving, increased foreign investment, and greater social and macroeconomic stability (World Health Organisation 2001). Similarly, the Millennium Development Goals (MDGs) were agreed in 2000 by 189 countries of the United Nations, with the support of the World Bank, International Monetary Fund (IMF), OECD and G7 and G8 countries.⁷ Three of the eight Millennium Development Goals call for specific health improvements by 2015: reducing child deaths, reducing maternal mortality, and slowing the spread of HIV/AIDS, malaria and tuberculosis. Indeed, health is increasingly viewed as fundamental to the first MDG, eradicating poverty and extreme hunger (OECD 2003). Under the aegis of the CMH, the link between health and economic development was empirically established. In 2002, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria was created to fulfil commitments by G8 countries to improve the health of populations in low-income countries. Along with initiatives by governments, private individuals (such as the Gates Foundation) and corporations (public-private partnerships, corporate social responsibility initiatives) have become more active in health development.

More recently, health has come to be linked more closely to the security agenda, both in the traditional sense⁸ and, in line with development thinking, human security. Indeed, the focus on health by the former, primarily driven by the US government, might be seen as a reflection of efforts to reconcile fundamental conflicts in perspective between the development and security communities. This renewed interest among world leaders in health is being driven by increasing recognition that global health and global security are inextricably intertwined (Smith 2002). In March 2002, President George W Bush proposed establishing a Millennium Challenge Account (MCA), beginning in fiscal year 2004, that would provide substantial new foreign assistance to low-income countries that are 'ruling justly, investing in their people and encouraging economic freedom' (see Radelet 2003). Part of the original plan was to invest in health but the funding allocation has since been scaled down (Becker 2004). In July 2004, President Bush signed the Project Bioshield Act which 'authorises \$5.6 billion over 10 years for the [American] government to purchase and stockpile vaccines and drugs to fight anthrax, smallpox and other potential agents of bioterror' (White House 2004).

Some within the development community wholly reject such efforts as inappropriate and potentially damaging to the humanitarian and rights-based principles underpinning aid. Or perhaps more worryingly for the development community, some see the health sector as a potential 'tool' or 'instrument' of foreign and security policy. Within the security community,

7 The Millennium Development Goals commit the international community to achieving the following by 2015: 1. Eradicate extreme poverty and hunger, 2. Achieve universal primary education, 3. Promote gender equality and empower women, 4. Reduce child mortality, 5. Improve maternal health, 6. Combat HIV/AIDS, malaria, and other diseases, 7. Ensure environmental sustainability, 8. Develop a global partnership for development.

8 For example see US National Intelligence Council (2002) and White House (2002)

there are fears that broadening the definition of security will mean wandering into territory best left to social policy.

The concept of human security offers a potential way forward. A number of scholars of International Relations have begun to address human security needs, bringing them into the development field. Health development figures in some of these writings, but has rarely been addressed as a core issue in its own right and debate over health security is still at an embryonic stage (Lee and McInnes 2003). While health is often encompassed as part of a range of factors that contribute to human security, or that represent 'new' threats to national security, health has never been the central focus of analysis. Health has had a more prominent place within development studies and approaches to human rights. Within these contexts, it is treated as a core goal of socioeconomic development efforts, mostly focused on the national and local levels. At the global level, health security becomes framed more narrowly within traditional foreign and security policy concerns (eg SARS, HIV/AIDS). These debates are discussed more fully in the accompanying background paper 3.2 and 3.3.

How should health, foreign and security policy interrelate?

Efforts to reconcile the health and security agendas at the national and subnational levels, within the development community, have been largely through the concept of human security. Extension of such thinking to the global level has so far, however, been limited. The development community remains wary of efforts to achieve a closer convergence of the development and security agendas, and closer links between health, foreign policy and security are seen as a reflection of this. A rights-based approach to development sets the achievement of human rights as an objective of development. Human rights are the scaffolding of development policy (ODI 1999), and underpin international development targets such as the UN Millennium Declaration and Millennium Development Goals (MDGs).⁹

Within this context, the emerging global health agenda currently stands at a crossroads. On the one hand, a human security approach to health development offers a broadened and, arguably, therefore a more meaningful conception of security itself. It is a characteristic assumption of the approach, as stated as a guiding principle in the Commission of Human Security Report (2003), that genuine security is unattainable without achieving overall health and well-being. In this sense, a human security approach may even offer an opportunity for the global health community to influence the security agenda progressively. On the other hand, there is a risk that health development may become linked to a narrower security agenda with its traditional and narrower focus on the national interests of the powerful, and on military intervention. This policy dilemma is central to the scholarly works on development and security reviewed in this paper, and to the issues raised by this paper. This is, in itself, a potential problem with taking a human security approach to either health or development,

⁹ Many other questions also arise. Are rights really indivisible, in the sense that economic, social and cultural (ESC) rights are equally as important as consumer protection rights? If ESC rights are legitimate, how can they be made operational? And who has the responsibility to protect and fulfil those rights? Is it the state in which the right-holder lives, or do others (other states, non-state actors) carry a share of the burden? There are challenges here to theory and to law, but more important to the policy and practice of many different actors in the international community. See ODI (1999).

namely that basic human needs and rights can only be articulated in reference to some form of security agenda.

Whether this relationship evolves may be influenced by trends in aid funding. Levels of development aid began to recover in the early 2000s from an historic low. Development assistance from high-income countries, as a percentage of Gross National Income (GNI), declined during the 1990s, with only four countries (Denmark, the Netherlands, Norway, and Sweden) achieving the UN's target of 0.7 per cent (United Nations Development Programme 2003). The prompt, however, has in large part been the concern since 11 September 2001 among wealthier countries about global security as a component of economic development. Richard Smith, editor of the *British Medical Journal*, argues that the US, which gives a much lower proportion of its GNI on aid than any other rich country, may well be persuaded, in this context, to increase aid (Smith 2002). Yet if security is the key prompt, funding may go not to those most in need but rather to those who present the biggest perceived threat. The development community will need to engage in this emerging dilemma in future. The role of the health sector may be central to these debates.

Conclusion

In summary, there are clear parallels between the perceived convergence of the development and security agendas over recent decades, and the more recent closer association between certain global health issues and security policy. The debates surrounding both links are strikingly similar in terms of the concerns raised by both the development and health policy communities. Of particular note is the recognition that closer engagement can bring clear benefits in terms of political influence and priority. At the same time, there are clear risks in engaging such a powerful policy community. Rather than furthering policy objectives based on human rights and other humanitarian principles (human security), which the development and health communities share, there is a risk of becoming co-opted into traditional security objectives driven by narrower national interests.

The dilemma facing the development community over the past decade, during a period of declining aid budgets, has been intensely debated by the development studies community. Efforts to understand and critique the increased convergence between development and security policy by scholars such as Duffield and Macrae offer important insights for similar trends between the health and security policy communities. The global health community could thus draw more readily on this existing literature to think through its own policy challenges. Can the policy objectives of these very different policy communities be reconciled?

Finally, in grappling with the double-edged sword of security policy, the development community has yet to fully explore the challenges posed by processes of globalisation. The work of Duffield and others is focused exclusively or primarily on the state, giving insufficient attention to the plethora of transnational actors and forces at play. The growth of global civil society, private sector and other non-state actors, along with emerging forms of governance in which they increasingly participate at a multitude of levels (global, regional, subnational), make the policy environment a far more complex one. Furthermore, worldwide

flows of populations, goods and services, capital and knowledge make analyses of development and security policy focused on the state increasingly outdated. Within public health, globalisation is now recognised as having potentially important impacts on the broad determinants of health. Similarly, globalisation must be understood as impacting on the determinants of development and security. Are there common lessons to be learned? Will globalisation require even closer convergence of different policy communities and their agendas?

References

- McSweeney B (1998) 'Durkheim and the Copenhagen School: A response to Buzan and Waever' *Review of International Studies* 24
- Barkan JD (2004) 'Kenya After Moi' *Foreign Affairs* January/February
- BBC News (2004) 'Poor paying for war on terror' BBC News Online (world edition) 10.5.04 <http://news.bbc.co.uk>
- Becker E (2004) 'Bush scaling back dollars for Third World' *New York Times* 29.1.04
- BOND (2003) Global Security and Development *Discussion Paper*, July 2003 (updated October 2003) www.bond.org.uk
- Carter N (2004) "'War on terror'" threatens aid priorities' *Reuters AlertNet* 10.5.04 www.alertnet.org
- Chomsky N (2000) *Rogue States: The rule of force in world affairs* Pluto Press
- Christian Aid (2004) *The Politics of Poverty: Aid in the new Cold War* www.christianaid.org.uk
- Commission on Human Security (2003) Outline of the Report of the Commission on Human Security www.humansecurity-chs.org
- Commission on Human Security (2000) *Better Health for Human Security* www.humansecurity-chs.org
- Curtis D (2001) *Politics and Humanitarian Aid: Debates, dilemmas and dissension* HPG Report 10 Overseas Development Institute
- Curtis D, Macrae J and Duffield M (2001) Editorial 'Politics and Humanitarian Aid' *Disasters* 25.4
- Duffield M (2002) 'War as a Network Enterprise: The new security terrain and its implications' *Cultural Values* 6.1/2
- Duffield M (2001a) *Global Governance and the New Wars: The merging of development and security* Zed Books
- Duffield M (2001b) 'Governing the Borderlands: Decoding the power of aid' *Disasters* 25.4

- Escobar A (1995) *Encountering Development: The making and unmaking of the third world* Princeton University Press
- Evans G and Sahnoun M (2001) Foreword in *The Responsibility to Protect: Report of the International Commission on Intervention and State Sovereignty* International Development Research Centre
- Frank AG (1969) *Capitalism and Underdevelopment in Latin America: Historical studies of Chile and Brazil* Monthly Review Press
- Frank AG (1967) 'Sociology of Development and the Underdevelopment of Sociology' *Catalyst* 3
- Goodhand J (2002) 'Aiding violence or building peace? The role of international aid in Afghanistan' *Third World Quarterly* 23.5
- Lee K (2003) *Globalisation and Health: An introduction* Palgrave Macmillan
- Lee K and McInnes C (2003) *Health, Foreign Policy and Security: A discussion paper* UK Global Health Programme Working Paper 1, The Nuffield Trust
- Lee K, Walt G and Haines A (2004) 'The Challenge to Improve Global Health: Financing the Millennium Development Goals' *JAMA*, Special Issue on Global Health
- Macrae J (2001) *Aiding Recovery? The crisis of aid in chronic political emergencies* Zed Books
- Macrae J and Leader N (2001) 'Apples, Pears and Porridge: The origins and impact of the search for "coherence" between humanitarian and political responses to chronic political emergencies' *Disasters* 25.4
- Mekay E (2003) 'Development: US urged to reduce foreign aid focus on security' *Inter Press Service* 31.10.03 www.aegis.com
- ODI (1999) What can we do with a rights-based approach to development? *ODI Briefing Paper*
- OECD (2004) 'OECD extends development assistance criteria' *Development and Cooperation*
- OECD (2003) 'Policy Coherence: Vital for global development' *OECD Policy Brief*, July
- OECD (2003) Poverty and Health in Developing Countries: Key actions *OECD Policy Brief*
- OECD (2000) Development Co-operation Directorate *DAC Statistic Reporting Directives* 10.5.00 DCD/DAC
- Lyman PM and Morrison JS (2004) 'The Terrorist Threat in Africa' *Foreign Affairs* January/February
- Pasquier A (2001) 'Constructing Legitimacy' Seminar on Politics and Humanitarian Aid: Debates, dilemmas and dissension, Commonwealth Institute, London 1.2.01
- Radelet S (2003) 'Will the Millennium Challenge Account be Different?' *Washington Quarterly* Spring

- Slim H (2000) 'Dissolving the Difference between Humanitarianism and Development: The mixing of a rights-based solution' *Development in Practice* 10.3/4
- Slim H (1997) 'Relief Agencies and Moral Standing in War: Principles of humanity, neutrality, impartiality, and solidarity' *Development in Practice* 7.
- Smith R (2002) Editorial 'A time for global health' *British Medical Journal* 325 13.7.02
- The White House (2004) 'President Bush signs Project Bioshield Act of 2004' Press Release 21.7.04
- The White House (2002) *The National Security Strategy of the United States*
- United Nations Development Programme (2003) *Human Development Report 2003: Millennium Development Goals: A compact among nations to end poverty* Oxford University Press
- US National Intelligence Council (2002) *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China* Central Intelligence Agency
- Wallerstein I (1974) *The Modern World System: Capitalist agriculture and the origins of the European world economy in the sixteenth century* Academic Press
- World Bank (2003) *Breaking the Conflict Trap: Civil war and development policy* A World Bank Research Report <http://econ.worldbank.org>
- World Health Organisation (2001) *Macroeconomics and Health: Investing in health for economic development* Report of the Commission on Macroeconomics and Health

3.5 The WTO, Trade Rules and Global Health Security *

Owain Williams

This paper examines how the institutional dimensions of globalised trade impact upon public health, and considers this relationship with reference to global health security. National health systems and public health provision are affected by the rules that govern globalised trade, as embodied in World Trade Organisation (WTO) agreements. These agreements have the potential to change the architecture of global health governance significantly, and have direct implications for various public health communities and national health systems. In more general terms, the WTO is limiting the ability of its member states to regulate important aspects of trade and production that have health security implications for their populations (Koivusalo 1999). An overriding preoccupation with the need for free trade and open markets has subordinated what were traditionally sovereign powers over public health, leading to what has been described as a ‘rolling back’ of state authority in this area (Raghavan 1990; Held *et al* 1999). This paper argues that the WTO also threatens to open up publicly-provided national health systems to private firms and market disciplines. For these reasons the WTO should be considered as instrumental in promoting a new political economy of global health that carries significant risks for global health security (Hong 2000; Field *et al* 2000; Labonte 2000).

While the paper focuses on the WTO, other far-reaching relationships between trade and health security are also considered. For example, cross-border flows of certain goods, such as tobacco and asbestos, have major health security implications, as do changing patterns of consumption and production. These relationships have received increasing attention (for example, Lee and Collin 2003), with globalisation intensifying the health risks that cross-border trade has always presented. WTO agreements are the focus of this paper because they have curtailed the ability of governments to regulate important aspects of global trade as it affects health, and have placed limits on domestic health policy-making which impedes free trade or access to markets. This is representative of a new system of global health governance and regulation that links global health security inextricably with trade rules.

The paper is structured around three principal sections that examine the WTO and health security nexus. The first establishes what principal referent objects are important. The second discusses why the WTO-inspired system of global health and trade governance should properly be viewed as an indirect yet legitimate threat to global health security. The third section explores the policy and regulatory changes demanded by four of the WTO’s constituent agreements.¹

* Alan Ingram made a number of useful comments on an earlier draft of this article.

¹ In total there are 12 legally-binding agreements that encompass the WTO. The four agreements of the WTO that have specific implications for health are: The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS); The Agreement on Technical Barriers to Trade (TBT); and The General Agreement on Trade in Services (GATS).

Whom or what is to be protected through the practice of global health security?

The first Working Paper of the UK Global Health Programme suggested the global public health security paradigm as a lens for viewing the relationship between health, foreign and security policies (Lee and McInnes 2003). The approach is similar to the emerging paradigm of global health security put forward by the World Health Assembly in 2001. These frameworks share some important theoretical and normative starting points, most notably that health and security are interdependent variables, and that health is an important consideration in terms of both human and traditional security.

There are also striking commonalities with human security approaches in International Relations, which have challenged traditional security studies' concern with military threats to the security of the state (Buzan 1991). Whilst traditional security approaches have identified the state as the sole or unit of analysis, early work on human security viewed the individual as the 'irreducible basis' for assessing security (Buzan 1991). More recently, Buzan and others have offered societies and communities as the principal referent objects for work on human security, with the nature, definition and geographical scope of community changing according to different security threats and political contexts (Buzan *et al* 1998; Thomas 2000). Global health security also leads to a similar exploration of referent objects when the relationships between health and major challenges to health are considered (Lee and McInnes 2003; Ogata and Sen 2003).

A focus on public health, trade and the WTO highlights an asymmetric relationship between communities, states and institutions of global governance. Indeed, most critical analyses of the trade regime and health have principally focused either on the level of its effects on public and national health systems, or upon the WTO's role with respect to the wider level of global health governance (Hong 2000; Koivusalo 1999). Because the WTO is primarily about promoting free trade rather than ensuring public health its role may clash with the different objective of global health security whether the referent objects are states or communities. In fact, the WTO can be seen as representing a collection of interests that cuts across these fields, with transnational corporations playing highly influential roles (Kim *et al* 2000; Hong 2000; Labonte 2000).

WTO agreements have significantly reduced the range of policy measures and regulations available to governments to restrict elements of international trade in pursuing national health goals (ICTSD/IISD 2003). The WTO rules also embody a strong impetus toward health sector liberalisation, largely based on 'back door' requirements for states to allow the WTO authority over seemingly insignificant areas of public health regulation (Pollock and Price 2000, 2003; Raghavan 1998; WDM 2002a). Such changes in the WTO rules have required some political will on the part of WTO members, or at least the agreement of the more powerful developed country members. Unfortunately, these countries have conferred health governance powers on the WTO that may be difficult to claw back in future.

The WTO and global health security

WTO rules have major implications for global health security on at least two important levels. As the above sections have intimated, the WTO has gained considerable governance powers with respect to public and national health. This transfer of power and authority over public health matters raises profound questions about democratic accountability, not least when health outcomes at the levels of populations are concerned. The regulatory and policy consequences of WTO agreements also mean that states have less legal and political control over externally or globally-generated health threats (Lee 2003). Where such measures are currently available to states they can be challenged if they are held to be in breach of specific WTO obligations. The section below briefly explores the WTO's new health governance powers, and the mechanisms that have been used to rein in the regulatory and health policy flexibility of member governments.

The WTO and global health governance

Besides its influence on trade and production, the WTO also increasingly cooperates with other international institutions such as the IMF and World Bank in shaping national welfare and public service policies (Dembele 2003; Kim *et al* 2000). However, because the WTO applies rules consistently across its member states, its effects on health service liberalisation and deregulation are significantly wider than these other organisations. With respect to the privatisation of national health systems the trade regime is achieving what the IMF and World Bank have only managed to promote in a comparatively piecemeal fashion. Whilst ostensibly designed to govern trade relations between states, the WTO has extended the reach of so-called 'trade-related' issues into the powers that states have on firms and markets (Raghavan 1990; Ruggie 1995). Indeed the WTO has systematically brought a range of different policy areas under its governance, including: rules on technology transfer; environmental safeguards; intellectual property; and food safety standards. These previously discrete areas of public life have been subordinated to the imperative of free and open markets. Where WTO agreements touch on welfare and health policies, they act to homogenise the policy space that governs the relations between its member states and private economic agencies, thereby skewing policies in favour of open markets and private economic agencies rather than the wider public good.

These WTO rules will produce a profound realignment of the state's role as the principal provider of public health, and as its guarantor via regulation and standard setting. This is a realignment that is principally intended to liberalise the political and regulatory space that has traditionally stymied the more widespread private provision of healthcare internationally. It might also lead to profound and long-term changes to the manner in which individuals and communities see the state as the ultimate guardian of public health. The idea that public health might be a restriction on trade rather than aid to human well-being may constitute the biggest ideological shift since its emergence as an area of government responsibility in the Victorian era (Koivusalo 1999; Koivusalo 2003).

The WTO maintains that it does not promote free trade over social and welfare goals, and has published a benchmark document with WHO that claimed that all of the WTO's health-

related agreements allow scope for regulations that erect barriers to certain goods or trade practices on public health grounds (WHO/WTO 2002). This document states that countries have the right to take measures to restrict imports or exports of products when necessary to protect the health of human beings, animals or plants, and that when liberalising services, they retain the right to regulate in order to meet national policy objectives, in areas such as health. Eight specific health issues were covered – infectious disease control, food safety, tobacco, environment, access to drugs, health services, food security, as well as some emerging issues, such as biotechnology. Launching the document, a WTO representative stressed that ‘WTO Agreements are sensitive to health issues. In fact, health concerns can take precedence over trade issues. If necessary, governments may put aside WTO commitments in order to protect human life. And, according to WTO jurisprudence, human health has been recognised as being “important in the highest degree” (WHO 2002)’.

While a cursory understanding of WTO rules might suggest that this is the case, it is likely that public health regulations or standards that are anti-free trade, might ultimately be judged by the WTO Dispute Settlement Body. Corporate challenges to government policy along these lines have achieved notable successes (Shaffer 2003). Public health policies and regulations will almost certainly not be challenged on the basis of the general principle that open trade has primacy over public health goals, but will be undertaken within the terms of specific obligations found within individual WTO agreements. So while no country or international organisation would be prepared to suggest that free trade is more important than public health, WTO agreements in effect ultimately lead to exactly that position. To this end, the Dispute Body supplies a form of autonomous and supra-national juridical system that can enforce compliance to the overriding free trade imperative found in all WTO agreements. This body has in a number of cases subordinated health security to the uninhibited flow of certain goods and services across borders (WTO 1997; 1998; 2000).

The Dispute Body also holds ultimate authority over the manner in which states choose to implement and shape their domestic policy in the widening range of areas that are deemed as being ‘trade-related’. For example, in instances where welfare or economic policies are found to have a detrimental or discriminatory effect on free trade, the dispute machinery allows for the imposition of punitive tariffs on specific economic sectors or exports of the offending party (Martin and Winters 1996; Shaffer 2003). This has already been the case in at least one high profile WTO dispute surrounding beef cattle fed with growth hormones (see below). The dispute settlement machinery therefore has profound implications for social and economic policy-making (Gould 2004).

For these reasons the WTO is becoming the single most important international institution in the architecture of global health governance. Despite the often highly-technical and opaque nature of the agreements that relate to health, it is clear that they collectively serve to limit state authority over public health (Hong 2000; ICTSD/IISD 2003; Koivusalo 1999). The WTO is also formalising commitments to liberalise health services and health markets across its constituent member states, providing a legal framework under which health service provision becomes subject to competition (Joint Submission 2003; Mashayekhi 2000; Raghavan 1998). Simply put, because the WTO has assumed health governance powers in so

many areas traditionally associated with state authority, the WTO cannot any longer be construed as simply supplying rules for trade. Global trade rules now offer a form of international jurisprudence by which other areas of global and domestic policy can be judged in terms of their impact on free trade.

Trade challenges to global health security

Four WTO agreements have direct global health security implications. They include: The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS); The Agreement on Technical Barriers to Trade (TBT); and The General Agreement on Trade in Services (GATS). Because of the extremely detailed nature of each agreement, and the nuanced and technical character of most legal interpretation to date, no more than an overview of their health security implications can be provided here. However, whilst each separate agreement relates to some discrete activity or component of global trade as it pertains to health, they can be characterised by two broad categories of obligations on WTO member states.

First, many of the agreements' rules require either deregulation in terms of public health constraints on trade, or, more specifically, give detailed grounds by which national level health regulations can be adjusted to meet with some form of internationally-inspired standard. This reduces diversity and sovereign choice as to how public health goals are pursued. For example the FAO's Codex Alimentarius, which provides scientific and voluntary standards for food safety which states can adopt, is used under the SPS agreement as a yardstick by which to judge the legitimacy of national food standards and sanitary measures. Similar standard and regulatory yardsticks are offered in the TBT and TRIPS agreements (Correa 1994).

The second category of obligations relates to the promotion of private rights over knowledge systems or products which are essential to human health (as is the case with TRIPS), or give an impetus toward the privatisation of publicly-funded national health systems (as is the case with GATS). In the case of the TRIPS agreement, medical knowledge, biological resources and medicines are made subject to a wholly new balance of rights between patent holders and the interests of the wider public. The promotion of private rights over products such as essential drugs has profound health security implications. Likewise, GATS views essential services such as health as areas for competition rather than as public goods. Whilst the WTO's health-related rules are detailed and highly complex, when taken together they suggest a new and emerging global political economy of health which is privately orientated.

General Agreement on Trade in Services (GATS)

GATS rules govern a broad range of some 160 service sectors and the agreement is broadly committed to the progressive liberalisation of global trade in services. Critics of GATS therefore see the agreement as holding potentially disastrous consequences for public health and other essential services, if indeed these types of essential service fall within the agreement's ambit (Pollock and Price 2000a; Sexton 2003; Woodward *et al* 2002). The question of whether or not GATS requires the privatisation or liberalisation of health and

other public service sectors has been the subject of intense debate, and has driven the WTO to issue a major rebuttal of the ‘privatisation fictions’ about the agreement (WTO 2001b). Other areas of concern regarding health security here include the GATS rules covering domestic regulations; the need for countries to specify what types of service they wish to open up to competition; the limitations to be placed on competition within such sectors; and rules covering modes of supply of services. Each of these areas have been the subject of extensive debate, given their obvious importance to the future viability of publicly-funded national health systems, and to the wider treatment of health as a public or private service within the wider global political economy. A critical reading of GATS and these debates suggests that the agreement is playing a role in what has been described as a ‘collapse in global public health’ (Garrett 2002).

Dispute has centred on whether or not GATS actually requires health and other essential services to be liberalised or privatised. Although Article 1 states that services provided in the exercise of government authority can be excluded from coverage, and is adamant that public services are only subject to competition and liberalisation if member states choose to make them so, substantial grounds have been identified for questioning states’ ability to exercise these powers (Drager and Fidler 2004; Pollock and Price 2000; 2003; Raghavan 1998; 2000; Thompson and Loewenson 2004; WDM 2002a; 2003; WTO 1994; 2004).

Trade-Related Aspects of Intellectual Property Rights (TRIPS)

TRIPS effectively supersedes previous national and international intellectual property rights (IPR) conventions that existed before the WTO, and strengthens the levels of IPR protection that were previously available to right holders (Braga 1996). The agreement imposes ‘minimum’ standards of protection of IPRs that apply across all member countries of the WTO and for the first time, therefore, certain categories of IPRs are now available globally (Correa 1994). The agreement also extends IPR rules to new and existing technologies that were previously excluded from many nationally-based IPR systems (Braga 1996; Correa 1992). With regard to the health dimensions of the agreement, the most notable of these technologies and products are pharmaceuticals, gene sequences, and biotechnological products and processes (covered in Article 27). It is therefore in the agreement’s patent rules that the most serious potential consequences for global health security can be found. Patents are also the area of TRIPS that have produced significant public debate in this respect, mainly as a consequence of the price-distorting effect of patents on drugs and therapies with potentially life saving uses (Bond 1999; Deardorff 1990; Subramanian 1995). The TRIPS agreement has therefore been identified as a substantial threat to global health security, most notably in terms of how the agreement is exacerbating worldwide inequalities in terms of access to essential drugs (Thomas 2003).

A number of negative effects of TRIPS have been identified:

- impeding responses to the HIV/AIDS pandemic by keeping prices of antiretroviral drugs above affordable levels (Thomas 2003);
- obstructing access to generic versions of patented drugs by limiting parallel importation;

- curtailing the manner in which governments can exempt products such as drugs from national patent systems on the grounds of public health needs (see, for example, Correa 1994; Thomas 2003);
- raising prices for a range of drugs (Braga 1996; Hong 2000), with knock-on negative effects for individuals and health systems, but positive effects on corporate profits (Bond 1999; Deardorff 1990; Subramanian 1990; 1995; Subramanian 1990); and
- potentially limiting the ability of countries to produce patented drugs in future.

Where states such as India and Brazil have continued to produce these drugs after TRIPS came into force, they have done so largely on the grounds that they are necessary for reasons of national interest, emergency or public health. However, these drugs are essentially copies of patented drugs which are mainly on-patent in other countries and produced by Northern firms. When other third countries try to import the cheaper generic versions of the drugs, the WTO patent rules have been brandished (Thomas 2003). As described below, companies have also used TRIPS to try and justify the extension of their patent rights across global markets, irrespective of the relative wealth of public health communities or the inelasticity of demand for their product.

TRIPS lists a number of reasons or instances in which patents (and indeed all areas of intellectual property covered by TRIPS) can be excluded from protection (see especially Article 27 (WTO 1994)). These include reasons of public order, morality, and human, animal and plant health. Also under Article 8:

Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.

TRIPS would therefore seem to maintain what could be described as a ‘balance of rights’ approach to intellectual property, wherein the need to protect the fruits of private invention is measured against the wider public good (Williams 1998). Yet TRIPS places substantial limits on the ability of states to act in this way, and imposes burdens should they choose to do so (Braga 1996). This again amounts to an asymmetric set of rules that effectively leaves public health subordinate and exposed to intellectual property rights that some are more able to exercise than others.

This has been especially important in the case of patent rights being exercised over certain drugs involved in the treatment of HIV/AIDS, where the majority of those affected live in developing countries (Thomas 2003). The conflict between public health needs and patent rights crystallised around South Africa being threatened by US trade sanctions over its 1997 Medicines and Related Substances Control Act (Bombach 2001). The act allowed South Africa to invoke compulsory licenses or authorise the parallel importation of drugs from countries where the medicine could be found at cheaper prices. This became a test case for the

assertion of national public health needs over stringent interpretation of TRIPS patent rules (Thomas 2003).

The US was actually asking South Africa for what amounted to a TRIPS-plus change to its national laws, that is, a level of protection beyond the tough standards of patent protection required even by the WTO rules. The United States Trade Representative (USTR) and a range of US-based corporations (alongside the EU) challenged the South African patent law within the South African High Court. South Africa was also subjected to pressure from the USTR via the Special 301 Watch List that allowed for suspension from the US General System of Preferences. This was in itself a unilateral trade sanction, illegal under WTO rules, and affected South African exports to the US worth some three billion US dollars. The TRIPS case was never brought before the WTO Dispute Body, but caused an unprecedented furore amongst NGOs, civil society and health groups concerned with the ascendancy of the WTO/TRIPS over national health measures and the injustice of patenting with respect to access to essential medicines. The legal case was dropped in 2000 as a result of President Clinton's last Executive Order in office.

While the issue has not as yet been assessed by the WTO Dispute Body, which might yet have the final say on parallel importing, compulsory licensing and other anti-patent health measures, in 2004 the USTR has launched a fresh bilateral attack on South Africa's stance on pharmaceutical licensing and parallel importation, and it is likely that the WTO Dispute Body will be called into the area of drug pricing and patent enforcement. It is also unclear what the long-term application of TRIPS will be for these issues, given the lack of jurisprudence in this area. Nonetheless, it appears that the TRIPS agreement is already having a substantial impact on global health security. In the case of South Africa, only concerted action by a handful of developing countries and civil society groups offset even more serious consequences.

Technical Barriers to Trade (TBT) and Sanitary and Phytosanitary Standards (SPS)

The TBT and SPS affect health security at the national and global levels in similar ways. They set out the grounds upon which governments can limit various types of trade by the imposition of certain standards and public health regulations. Each agreement requires that domestic technical regulations and standards governing products should not become barriers to trade, demands that countries are able to scientifically justify such standards to the WTO and encourages diverse domestic product standard rules to converge on international norms or agreements where they exist.

In the case of the SPS, the standards relate to food safety (for animals, plants and humans) and the processes used to produce food (WTO 1994). The SPS allows governments to take measures to protect public health, whilst committing members to adapt these measures to international standards and scientific and risk assessment procedures (WHO/WTO 2002). The SPS ostensibly allows countries to enact public health measures when they are unable to determine the level of risk, but requires them to garner sufficient evidence to that effect within a reasonable period of time. Likewise, the TBT applies to technical standards as they relate to all tradable products, and places limits on the uses of national regulations and product

standards to protect (for example) human, animal or plant health, in order that they are not used as discriminatory barriers.

In the case of both agreements, there are important issues at play regarding global and national public health security. The first of these pertains to the degree of scientific evidence that is necessary to justify a ban on the production and importation of a given product or foodstuff. In the case of the SPS agreement, this has involved a running battle in the WTO and FAO Codex Commission on the use of the precautionary principle by the EU (Koivusalo 2003). The EU has applied the precautionary principle to justify the ban on importation of GM seed and beef cattle fed with hormones. The latter led to what is possibly the most important WTO dispute with regards to the interaction of health and global trade to date (WTO 1997; WTO 1998). In this dispute the precautionary principle, and thereby public health security, came a poor second to trade. The SPS agreement actually insists that its members seek *sufficient* scientific evidence to justify such bans (Article 5), and this is widely held as meaning that the use of the precautionary principle with respect to public health and food safety (as well as other products) will not be tolerated by the WTO Dispute Body (ICTSD/IISD 2003). Ultimately, this body will be expected to judge whether or not domestic regulations covering elements of food safety have been enacted on the basis of sufficient scientific evidence.

Similar concerns persist with the TBT agreement, where the questions of what are acceptable standards to impose on products and processes, and the level of scientific proof necessary to justify banning their importation, also dominate debate. The TBT rules imply that product and process bans are permissible on the grounds of human health, and the agreement grants governments the right to regulate trade and importation of specific products in order to protect plant and animal life, and preserve public health and the environment (WTO 1994). The imposition of mandatory regulations on products is therefore permitted at the national, regional and international level. However, the ability of governments to impose regulations is limited by Article III of GATT, whereby members are instructed not to discriminate between 'like products', whatever their country of origin (WTO 1994).

The 'like product' doctrine has formed the basis of an important test case of the TBT rules with regard to public health. In March 2001 the Appellate Body of the WTO made a ruling on a French ban on the importation of products containing asbestos. France had been challenged by Canada on the basis that the substitute product (PCB) in use in that country was a 'like product', and thereby the ban unfairly discriminated against Canadian asbestos exports (WTO 2000). The right to ban asbestos on health grounds was eventually upheld in 2001, but the very fact that this case came to the Dispute Body at all should be viewed as indicative of how the WTO has gained governance powers in another area that is central to health security as it relates to trade.

Whilst the asbestos dispute ruled in favour of France on the grounds of public health there are a number of important principles at play. First, the WTO Dispute Body has established authority in another regulatory area with regard to health (product safety and standards).

Although this decision upheld the general principle of public health safety over free cross border trade in certain dangerous products, it nonetheless made public health bans subject to the lexicon of trade law. Thus issues such as the 'likeness' of competing products came into play. In the future the issues at play in a dispute may be less clear cut (the health effects of asbestos are, after all, both horrific and well established) and subject to challenge. Even in the asbestos ruling France's ban was only supported by two of the total three members of an appellate body composed of trade lawyers.

A second key health-related issue that the agreements have generated pertains to which bodies are appropriate for determining either public health regulation, technical standards, or for establishing scientific judgements on the safety of given foodstuffs or products. The SPS refers authority in these respects to the FAO Codex Alimentarius Commission, as it is the major international forum within which diverse domestic food safety standards have been harmonised. Unfortunately, the Codex is also a body which has been increasingly criticised because its standards and agenda have been so heavily skewed in the interests of the international food industry, and often at the expense of global public health security and nutrition (Avery 1995).

Codex-inspired food safety standards have already influenced the outcome of a WTO dispute regarding an EU ban on imports of US and Canadian meat containing growth hormones. The now infamous trade dispute has its origins in a 1988 EU challenge to a Codex sub-committee ruling on the safety and human health impact of growth hormones in meat. The challenge was rejected by the Codex, with the EU independently moving to ban imports under its own food safety regulations in 1988. The ban was eventually to become the subject of a major challenge to the EU's position under the Dispute body of the WTO in 1996.² The US and Canada held that the EU ban was based on insufficient scientific evidence, and that the EU was therefore in contravention of its SPS obligations in seeking to apply food safety standards to growth hormones deemed safe by the Codex (see WTO 1997; 1998).

The EU eventually lost its case at the final Appellate Body stage of the dispute (WTO 1998), and was judged to have acted without an adequate risk assessment of the growth hormones involved. More recently, a perceived failure to provide sufficient scientific evidence formed the grounds for the US's formal complaint to the WTO (in January 2003) against the EU's continued ban on certain GM foodstuffs on public health grounds (WTO 2003). The dispute has so far not reached a conclusion, but the decision will dictate future national choices with regard to the spread of the GM foods globally. It will also largely determine how governments are able to react to uncertain health risks involved in biotechnology by limiting the use of the precautionary principle. It was largely because of US pressure through the WTO that the EU parliament voted to lift the ban in 2003, with the EU Commission continuing to debate licensing GM foodstuffs and GM planting in 2004.

The TBT suggests that the International Standards Organisation (ISO) might be used as the appropriate product standard-setting body. However, and whatever the merits of the ISO, it is

² For a basic chronology of the EU beef hormone dispute, see, for example, FASonline (www.fas.usda.gov).

no more than a voluntary international industry association, and as such has little or no democratic credentials. The TBT also provides scope for international standards to be set by industry organisations on a voluntary and self-regulating basis. Given the use of Codex standards by the WTO Dispute Body, it is likely that at some point a country will use these 'voluntary' industry product standards as a basis for challenging another member's domestic regulations in a test case dispute.

It is also clear that the WTO has neither the capacity nor authority to establish food and product standards, or to act as an arbiter of technical regulations. However, the lack of any scientific credibility, medical or public health expertise in the WTO has not stopped it from making critically important rulings in these areas (Koivusalo 2003). In the case of both agreements considered here, internationally-derived standards that may themselves be open to question are providing an effective legal and scientific yardstick by which national product regulations can be judged in WTO disputes. The disputes that have arisen so far under the two agreements rely heavily on scientific evidence and risk assessments, and established international standards have been preferred over the exercise of the precautionary principle by governments and regional bodies such as the EU. However, the precautionary principle can be seen as a vital tool by which public health can be protected and an essential component in achieving health security at the domestic and global level (Raffensperger and Tickner 1999).

The SPS and TBT represent important areas of health governance where the WTO is assuming authority in an incremental fashion. It is worth noting that Appellate Body decisions in these vitally important disputes over the public health impact of trade in certain products are made by just three people. The decision to uphold the French government's ban on imported asbestos was carried by only two votes to one. In these cases global health security may ultimately rest on decisions which are made in an undemocratic fashion, by non-experts in a given field, on technicalities which defy a common sense approach to health regulation.

Conclusions

This paper has explored the increasing power of the WTO in global health governance, and traced how four of its agreements can be expected to impact negatively on global health security. The WTO could have a major structuring role on the manner in which public health is provided and regulated. It will have an impact on people's access to healthcare and medicines and supply a legal framework by which global trade will interact with health. In terms of economic policy as it relates to health, the WTO is promoting a neo-liberal agenda that is both more coherent and far-reaching than policies promoted by the IMF and World Bank in the 1980s and 1990s. The WTO health-related agreements are based on a series of liberal assumptions about the relationship between trade, growth, wealth and health, and these assumptions are being used to justify the global roll-out of policies. This involves the deregulation of public health; the liberalisation and creation of 'health markets'; and a significant alteration of the balance between public health goals and private interests.

The WTO has rapidly established itself as one of the most powerful international fora for generating international health policies and standards. However, the WTO secretariat,

associated trade missions, and lobby groups, are largely populated by economists and international trade lawyers. This has led to questions about its competency to make decisions with massive implications for global health security (Koivusalo 1999).

The Dispute Settlement Body is an important indicator of the WTO's new powers over domestic health policy-making. While they have not yet been fully exercised, they are real and present dangers to health security. It is likely that the Dispute Settlement Body will be the final arbiter of whether policies are either *necessary* or *too burdensome* with respect to free trade. The overwhelming majority of WTO members simply cannot afford to follow the example of the EU in the beef hormone dispute. Failure to comply with a dispute decision on the grounds of public health costs the EU a great deal of money each year, and would be a drain that many developing countries simply cannot afford. Dispute decisions in instances where health policies and trade agreements are in conflict will be incremental, and their effects on global health policy and governance will therefore be cumulative and hard to quantify.

This paper has argued that because WTO agreements undermine key pillars of public health policy and constrain the ability of states to make decisions designed to protect the public health of their communities, they constitute legitimate global health security issues. They affect the security of those communities whose states are least able or willing to assert themselves in the arena of global governance. Sustained advocacy has enhanced the health security for many, but continuing inequalities, the dynamism of the global economy and the uneven playing field of global governance mean that much more action is required to achieve anything approaching global health security in the positive sense of health for all.

While WTO documents recognise that public health constitutes a special case, public health policies are always to be judged by neo-liberal standards, backed up by a punitive sanctions regime. This asymmetry presents challenges in constructing relationships between health policy and trade policy that do not privilege trade. While there may be some common ground between the two, there are also numerous areas of tension. It is not always possible to reconcile the tenets of global health security with the imperatives of free trade. Where conflicts arise, open policy processes and democratic accountability are essential to achieving legitimate outcomes.

References

- Lee K and McInnes C (2003) *Health, Foreign Policy and Security: A discussion paper* UK Global Health Programme Working Paper 1, The Nuffield Trust
- Avery N (1995) 'How TNCs Influence Global Food Standards' *Third World Network Features* 24.10.95 www.hartford-hwp.com

- Bombach KM (2001) 'Can South Africa Fight Aids? Reconciling the South African Medicines and Related Substances Act with the TRIPs Agreement' *Boston University International Law Journal* 19
- Bond P (1999) 'Globalisation, Pharmaceutical Pricing, and South African Health Policy: Managing confrontation with US firms and politicians' *International Journal of Health Services* 29.4
- Braga CP (1996) 'Trade-related Intellectual Property Issues: the Uruguay Round and its economic implications' in Martin W and Winters LA (eds) *The Uruguay Round and Developing Countries* Cambridge University Press
- Buzan B (1991) *People, States and Fear* Harvester Wheatsheaf
- Buzan B, Waever O and de Wilde J (eds) (1998) *Security: A new framework for analysis* Lynne Rienner
- Correa CM (1994) 'The GATT Agreement on Trade-related Aspects of Intellectual Property Rights: New Standards for Patent Protection' *EIPR* 16.8
- Correa CM (1992) 'Biological Resources and Intellectual Property Rights' *EIPR* 14.5
- Deardorff A (1990) 'Patent Protection and Developing Countries' *The World Economy* 13.4
- Dembele DM (2003) 'The myths and dangers of PRSPs' Bretton Woods Project www.brettonwoodsproject.org
- Drager N and Fidler DP (2004) 'Managing Liberalisation of Trade in Services from a Health Policy Perspective' World Health Organisation www.who.int
- Field M.G, Kotz DM and Bukhman G (2000) 'Neoliberal Economic Policy, "State Desertion" and the Russian Health Crisis' in Kim JY *et al* (eds) *Dying for Growth: Global inequality and the health of the poor* Common Courage Press
- Garrett L (2002) 'The collapse of global public health' *Health Matters* 47 www.healthmatters.org.uk
- Gould E (2004) 'Panel Strips WTO of Another Fig Leaf' Polaris Institute www.polarisinstitute.org
- Held D, McGrew A, Goldblatt D and Perraton J (1999) *Global Transformations: Politics, economics and culture* Polity
- Hong E (2000) 'Globalisation and the Impact on Health: A third world view' Paper for the People's Health Assembly, December 2000, Savar, Bangladesh. www.phmovement.org
- ICTSD/IISD (2003) 'Trade in Services' *ICTS/IISD Doha Round Briefing Series 2.3* International Centre for Trade and Sustainable Development/International Institute for Sustainable Development www.iisd.org
- Joint Submission to the World Health Assembly (2003) 'The GATS Threat to Public Health: A joint submission to the World Health Assembly' www.wdm.org.uk

- Kim JY, Irwin A, Millen J and Gershman J (eds) (2000) *Dying for Growth: Global inequality and the health of the poor* Common Courage Press
- Koivusalo M (2003) 'Assessing the Health Policy Implications of WTO Trade and Investment Agreements' in Lee K (ed) *Health Impacts of Globalisation: Towards global governance* Palgrave Macmillan
- Koivusalo M (1999) 'World Trade Organisation and Trade-Creep in Health and Social Policies' *GASPP Occasional Papers* 4 www.gaspp.org
- Labonte R (2000) 'Economic Globalisation, Trade Liberalisation, Governance and Health' Canadian Society for International Health www.csih.org
- Lee K (2003) 'Introduction' in Lee K (ed) *Health Impacts of Globalisation: Towards global governance* Palgrave Macmillan
- Lee K and Collin J (2003) *Globalisation and Transborder Health Risk in the UK: Case studies in population mobility and tobacco control* Nuffield Trust
- Lee K and McInnes C (2003) 'Health, Foreign Policy and Security' *UK Global Health Programme Working Paper 1* Nuffield Trust
- Martin W and Winters LA (eds) (1996) *The Uruguay Round and Developing Countries* Cambridge University Press
- Mashayekhi M (2000) 'GATS 2000 Negotiations: Options for developing countries' *Trade-Related Agenda, Development and Equity (TRADE) Working Papers* 9 www.southcentre.org
- Pollock AM and Price D (2000a) 'Globalisation? Privatisation!' *Health Matters* 41 www.healthmatters.org.uk
- Pollock AM and Price D (2000b) 'Rewriting the Regulations: How the World Trade Organisation could accelerate privatisation in health care systems' *Lancet* 356
- Pollock AM and Price D (2003) 'The public health implications of world trade negotiations on the general agreement on trade in services and public services' *Lancet* 362
- Raffensperger C and Tickner J (eds) (1999) *Protecting Public Health and the Environment: Implementing the precautionary principle* Island Press
- Raghavan C (1990) *Recolonisation: GATT, the Uruguay round and the Third World* Zed Books
- Raghavan C (1998) 'Clear North-South divide on services negotiations' Third World Network www.twinside.org.sg
- Ruggie JG (1995) 'At Home Abroad, Abroad at Home: International liberalisation and domestic security in the new world economy' *Millennium* 24.3
- Sexton S (2003) 'GATS, Privatisation and Health' Presentation at 'Service without Borders? Privatisation, GATS and the consequences for women', Cologne 9-11 May 2003 www.thecornerhouse.org.uk

- Shaffer GC (2003) *Defending Interests: Public-Private Partnerships in WTO litigation* Brookings Institution Press
- Subramanian A (1990) ‘TRIPs and the Paradigm of the GATT: A tropical, temperate view’ *The World Economy* 13.14
- Subramanian A (1995) ‘Putting Some Numbers on the TRIPs Pharmaceutical Debate’ *International Journal of Technology Management* (Special Issue on the Management of International Intellectual Property) 10.2/3
- Thomas C (2000) *Global Governance, Development and Human Security* Pluto Press
- Thomas C (2003) ‘Trade Policy, the Politics of Access to Drugs and Global Governance for Health’ in Lee K (ed) *Health Impacts of Globalisation: Towards global governance* Palgrave Macmillan
- Thompson C and Loewenson R (2004) ‘The WTO Global Agreement on Trade in Services (GATS) and Health Equity in Southern Africa’ *SEATINI/Equinet Policy Paper* 12 www.equinet africa.org
- Williams O (1998) ‘Signposts to Sui Generis Rights 7 – Sui Generis Rights: A balance misplaced’ GRAIN www.grain.org
- Woodward D, Drager N, Beaglehole R and Lipson D (2002) in Vieira C (ed) *Trade in Health Services: Global, regional and country perspectives* Pan American Health Organisation, Program on Public Policy and Health, Division of Health and Human Development
- WDM (2003) ‘GATS: From Doha to Cancun’ World Development Movement www.wdm.org.uk
- WDM (2002a) ‘Trade in Services’ World Development Movement www.wdm.org.uk
- WDM (2002b) ‘Leaked European negotiating documents confirm WDM’s fears about GATS’ World Development Movement www.wdm.org.uk
- WHO (2002) ‘WTO agreements and Public Health – a joint study by the WHO and the WTO secretariat’ World Health Organisation Published at www.who.int
- WHO/WTO Secretariat (2002) *WTO Agreements and Public Health* World Health Organisation/World Trade Organisation
- WTO (2000) ‘WC Measures affecting asbestos and asbestos-containing products. Report of the Panel’ WT/DS135/R 18.9.00 World Trade Organisation
- WTO (1998) ‘EC Measures concerning meat and meat products (hormones). Report of the Appellate Body’ WT/DS26/AB/R, 16.1.98 World Trade Organisation
- WTO (1997) ‘EC measures concerning meat and meat products (hormones) complaint by the United States. Report of the Panel’ WT/DS26/R/USA 18.8.97 World Trade Organisation