How is health a security issue? Politics, responses and issues

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In the closing decade of the 20th century the myriad challenges posed by infectious disease in a globalized environment began to be re-conceptualized as threats to national and human security. The most widely applied model for identifying and responding to such threats is securitization theory, as proposed by the Copenhagen School. Although its analytical framework is generally accepted, its utility remains contested; especially in non-European and non-state settings. The papers in this special edition have several aims: (1) to analyse ways by which Asian states and international organizations have identified health challenges as security threats, (2) to draw upon the securitization model as a way of understanding the full extent to which these states and international organizations have responded to the health threat, and (3) to identify areas where the theory might be strengthened so as to provide greater analytical clarity in areas of health security. This paper acts as a broad introduction to a set of papers on ‘Unhealthy governance’ and explores some of the key findings from the subsequent papers.

Keywords Health security, pandemics, biohazards, zoonoses, securitization theory, Asia

KEY MESSAGES

- The identification of health challenges as threats to national security is weighted towards non-medical considerations.
- Domestic political agendas, economic aspirations, social and religious norms as well as international relations between states all serve to shape policy responses to health threats.
- An awareness of the impact that these non-medical considerations have is particularly important in Asia, where concerns of political legitimacy, economic and social resilience dominate policy processes, and in international organizations, where a multitude of domestic agendas compete with international responsibilities to shape the global health order.

Introduction

‘Whether naturally occurring or intentionally inflicted, microbial agents can cause illness, disability, and death in individuals while disrupting entire populations, economies, and governments. In the highly interconnected and readily traversed “global village” of our time, one nation’s problem soon becomes every nation’s problem as geographical and political boundaries offer trivial impediments to such threats.’ (Smolinski et al. 2003)

The end of the Cold War—and with it the demise of superpower conflict predicated on military might—opened an intellectual and policy space for the consideration of threats of a non-military nature. In 1994 the United Nations Development Programme released its annual report entitled New Dimensions of
Human Security. Although directed towards a development-studies audience, the report was quickly co-opted by security studies policy-makers and scholars as a landmark document that established the initial parameters of the then nascent field of non-traditional security research. Among the seven fields of human security identified in the report was that of health security.

The 1994 report identified health security as encompassing infectious diseases in the developing world as well as lifestyle diseases in the developed world. It suggested that common vulnerabilities in both worlds included an unequal distribution of resources to combat disease as well as an unequal access to health services. Where these insecurities overlapped were the sites of greatest health insecurity, with higher rates of infant mortality, the easier spread of infectious diseases and lower life expectancies. However, while the 1994 report created a set of baseline parameters for non-traditional security, in general, and health security, in particular, it only identified issues. A notable gap in the report is any understanding as to how these health challenges become to be identified as security threats. Put simply, in policy terms how is it possible to tell that ‘X’ is truly a threat? What are the indicators for a health challenge becoming a threat and, once it is identified as such, what are the appropriate responses?

Into this gap stepped the Copenhagen School (Buzan, Waever and de Wilde) who suggested that the course of threat identification—the process by which ‘X’ became ‘securitized’—could be broken down into several phases (Buzan et al. 1998). The first phase of securitization requires an actor to identify an existential threat to their existence. This identification is declaratory in nature (a speech act). This is followed by the acceptance of the issue by a target audience (usually civil society) who are convinced of its existential threat potential. With this acceptance comes a third phase shift whereby an emergency (extra-budgetary) reallocation of resources is made to combat the threat. Once the threat is successfully resolved, the issue is de-securitized to an extent that, if still present, it simply becomes part of the general policy environment with a reallocation of resources back to earlier priorities.

However, what the Copenhagen School does not address is the politics of a disease threat. In conceptualizing a rational-actor model—where policy-makers logically respond to threats because they threaten human existence—the securitization model ignores real-world situations where, for domestic reasons, securitizing actors can deliberately choose not to securitize an existential health threat or may securitize the threat via a speech act but choose not to allocate emergency resources to resolve it. The model—located within a state structure—is also vague as to how it can be applied in international organizations or across state borders. In identifying and resolving health threats, understanding the implications of these political distortions on emergency responses is critical. As the papers in this special edition demonstrate, the process of securitizing health threats (such as diseases) is frequently shaped by non-medical considerations; even where there is recognition of the threat facing the state or society.

As the country-focused papers on China and Vietnam illuminate (Herington 2010; Wishnick 2010), both chose not to securitize the threat posed by SARS and H5N1 (respectively) due to considerations of political legitimacy (for China) or the loss of economic opportunity (for Vietnam). The Indonesia-focused paper, meanwhile, demonstrates that it has chosen to preference its ‘viral sovereignty’ over co-operation with the international health community; in part playing to domestic political constituencies wary of international organizations and Western agencies (Elbe 2010). Beyond the countries covered in this special edition, it is also worth noting that the Thai government resisted securitizing the threat posed by H5N1 because of concerns of the resulting impact on the poultry export market; even as local poultry farmers were calling for the threat to be identified and emergency resources allocated.

Even within international organizations it is difficult to securitize a health threat due to political considerations. As the later paper on the Biological Weapons Convention demonstrates, states can resist the external securitization of health threats by international organizations by both insisting that they—rather than the United Nations—be the ones to identify and report on a potential biological weapons usage (Enemark 2010). In other words, that states hold the monopoly on the speech act and any acts by organizations seeking to articulate a threat are invalid. Further, states (especially developing states) use political arguments to cast aspersions on the independence of international biological weapons investigations; thereby rendering it problematic to effectively securitize a biological weapons threat from outside the state. Moreover, even when an international organization does successfully securitize a health threat (as the United Nations did with AIDS in 2000) state-based political considerations can shape the articulation and response processes. As the final paper in this special edition explores, not only can political agendas push the securitization of health threats but counter agendas can also work to de-securitize health issues by assigning different priorities and resources to the issue; regardless of the actual level of the threat (Rushion 2010).

Asia, in many aspects, is a complex testing site for the securitization of health. Politically, economically and socially, most societies in Asia evince different norms and practices from those found within the European milieu of the Copenhagen model. Further, the region is a unique geobiological environment; one where the infectious diseases from the developing world meet the lifestyle diseases from the developed world and where trade and transport hubs connect Asia to the global community. Internally Asia is also becoming an increasingly interconnected region. With this greater interconnectivity comes a compression of time and space that represents a fundamental challenge to those whose task it is to respond to health threats in a timely manner. As such, the policies and practices towards infectious disease outbreaks in the countries of the region, as well as the interplay between regional states and international organizations and institutions, are an important topic for study.

Method

For the last 10 years the Ford Foundation has been funding a research consortium on Non-Traditional Security in Asia. Across Northeast, Southeast and South Asia, scholars and activists have been working to understand how human security and securitization approaches could be applied to the many
challenges facing the region. In its third phase, one of the topics the consortium identified for further study was health security. It was the aim of this research topic to undertake a systemic review of threat-based responses to infectious diseases in Asia, in terms of both specific disease outbreaks and comparative responses between different disease outbreaks. These responses were focused at both the regional and international levels, with a series of country studies as well as reviews of international agreements and practices. By analysing these responses through the lens of securitization, an understanding of the priority different actors accord the threats posed by infectious diseases, as well as the interplay of different actors during the securitization process, could be developed. From this understanding, it was intended that the workshop would be able to evaluate how committed Asian states and the related regional/international organizations are to countering health insecurities, and to what extent other variables—political, economic, social or legal—alter the securitization of infectious diseases.

To that end, an international workshop was held in Hong Kong in May 2009 funded by the Ford Foundation. It drew together scholars from across Asia as well as the United States, the United Kingdom and Australia. A selection of those papers is presented in this special edition of Health Policy and Planning. Of the five papers included, three are country studies (China, Vietnam and Indonesia) and draw upon primary language and interview material not otherwise easily accessible to most health security scholars. The remaining two papers focus on health insecurities at the international level and combine cutting edge policy analysis with a detailed array of interdisciplinary source material. All these papers have been doubled reviewed: first, by a series of referees with backgrounds in non-traditional security, community health and international relations; second, by a group of public health and policy referees. The result is a set of interdisciplinary papers that sit at a nexus of security studies, health, and public policy; three disparate areas whose common core shapes responses to ongoing and new health threats—now and in the future.

Findings

Health and security

'It is time to close the book on infectious diseases, and declare the war against pestilence won.' (Stewart 1967)

All the papers in this special collection support the core assertion that health challenges—whether from infectious diseases or biohazards—represent a clear and distinct form of security threat; one that requires extraordinary measures or special organizations to properly address. This is a finding that has been recognized elsewhere by a range of other social and medical sciences scholars. Pirages and Runci (2000) commented that, ‘Viruses, bacteria, and various kinds of plants and animals have never respected national borders… Now there is growing concern over the impact of increasing globalisation on the potential development and spread of new and resurgent diseases across increasingly porous borders.’ Works by Garrett (1995) and Oldstone (1998) have charted the various types of diseases to which Pirages and Runci refer; those that have crossed national borders in the past and present as well as the types of state-society responses that have accompanied each outbreak. In the virology and bio-medical fields there is a large and rich literature on these diseases and their impact on the wellbeing of peoples (such as: Claas et al. 1994; Guan et al. 1996; Brown 2001; Tumpey et al. 2002; Vallat 2004; Choi et al. 2005).

Narrowing the field of research down to security studies, there are a smaller number of publications that link the threat of infectious diseases with national or human security and wellbeing. As Fidler noted, ‘Prior to the 1990s, infectious disease control, of whatever variety, was a neglected aspect of international relations’ (Fidler 2004: 800). Altman (2003) demonstrated how political and social structures inhibit responses to the threat of HIV/AIDS. A conclusion that was echoed by Whitman (2000), where the authors focused on the political factors that inhibit responses to infectious disease outbreaks; clearly showing how the modern international political system—with its preoccupation on sovereignty—inhibits transnational responses to such outbreaks. Without a more flexible system, virulent pathogens will be able to transcend national boundaries far more easily than could be the case. In Asia, where many societies have cultural reservations to deceased persons and where most states are loath to relinquish or pool their sovereignty to achieve common policy objectives, these conclusions have particular resonance.

McMurray and Smith (2001) sought to consider the impact globalization had on the health and wellbeing of societies as they move up the economic development ladder and become more enmeshed in global processes of trade and human interaction. Drawing on three case studies the authors showed how globalization is eroding state borders and thereby creating new transnational health challenges. As Price-Smith (2002) illustrated, these challenges can have a profound impact on the stability and prosperity of states. Brower and Chalk (2003) extended the work on the threats of infectious diseases, with specific reference to HIV/AIDS and public policy responses by United States government agencies. What these studies show is the need to develop strong linkages between sub-state, state and international agencies when addressing the security threat posed by infectious diseases and other bio-hazards.

This finding was backed up by Caballero-Anthony (2006) in her exploration of the link between securitization and public health goods in Asia. Caballero-Anthony suggested that by applying a securitization approach to preventing infectious disease outbreaks, securitizing actors would have a greater capacity both within and across countries to deal with pandemic consequences. Enemark in his study on natural plagues and biological weapons notes that ‘the health threats most suitable for securitization are outbreaks of infectious diseases – specifically those that inspire a level of dread disproportionate to their ability to cause illness and death – whether arising as a result of a natural process or human agency’ (Enemark 2007: 8). Looking at a similar period, Fidler (2003) concluded that, ‘The linking of public health and national security thus raises deeper theoretical issues and controversies about world politics in the global era’. The need to raise these ‘deeper theoretical issues’ in the context
of securitization theory is a gap in the securitization literature that these papers seek to address.

Globally, Chan, Støre and Kouchner have observed that ‘pandemics, emerging diseases and bioterrorism are readily understood as direct threats to national and global security’ (Chan et al. 2008: 498). Davies placed these responses particularly within the last two decades, noting that during the 1990s, ‘awareness of the threat that infectious disease outbreaks could pose to their citizens’ health and to their countries’ economic and political stability encouraged western governments to develop responses in national security terms’ (Davies 2008: 298). As a result, ‘health challenges now feature in national security strategies, appear regularly on the agenda of meetings of leading economic powers, affect the bilateral and regional political relationships between developed and developing countries, and influence strategies for United Nations reform. Although health has long been a foreign policy concern, such prominence is historically unprecedented’ (Fidler and Drager 2006: 687).

However, the question remains as to how best to address health challenges as security threats? As the papers in this special collection identify, the securitization model put forward by the Copenhagen School is a good starting tool but its applicability remains unclear. As all the papers suggest, there are contextual problems in applying securitization to issues of health insecurities in Asia and in international organizations. These findings revolve around a set of concerns: the identification of a health security threat, the governance of the response to the health threat and the desecuritization of the health threat, as well as the implications for the securitization of health threats across national borders. Each of these will now be explored in more detail.

Identifying a health threat

The first two steps in the securitization process require (1) an actor to identify an existential threat to their existence, and (2) a target audience to be convinced of the immediacy of the threat, so that a shift into an emergency mode to reallocate resources to successfully address the threat can be undertaken. These first two steps are inherently liberal-democratic in nature as they require supporting freedoms of information and expression. As Buzan et al. noted, a securitizing actor could be any ‘political leaders, bureaucracies, governments, lobbyists, and pressure groups’ (Buzan et al. 1998: 40). The problem that then emerges is what happens when the socio-political system is not liberal-democratic or when the securitization is initiated and/or carried out by an international body, itself the subject of capture by multiple (and possibly competing) state agendas.

Most of Asia is characterized by an absence of liberal-democratic systems with the types of plural authority structures identified by Buzan et al. Instead, most countries have authoritarian systems of governance with clear strictures on basic political freedoms (such as speech or assembly). Even where plural democratic political systems do exist, they are generally far weaker than their counterparts in Europe and can be distorted by powerful political figures (as the paper on Indonesia clearly demonstrates). Such authoritarian systems or political figures may prevent or corrupt the securitization process, subverting its urgency for their own political agendas.

As the article on China shows, the Chinese government frequently avoids securitizing threats as the need to move into emergency mode presents a legitimacy challenge to the government.

In the case of international organizations, the influence of state members can act to prevent or discourage the initial stages of the securitization process. As the case of the initial H5N1 outbreak in 2003 illustrated, member states will not necessarily share critical information where it is perceived to be against their national interest (Thomas 2006). Furthermore, states will react against the actions by international organizations where either their own national interests are jeopardized or where the organization is perceived as having exceeded its mandate and infringed on members’ sovereign rights. An example of this can be seen in Hong Kong’s push to have the World Health Organization’s travel advisory lifted in May 2003, on the grounds that the decline in tourist numbers were jeopardizing its economy. Within Asia, the Association of Southeast Asian Nations (ASEAN) is a regional organization that does not act beyond its member states interests. The ability of such an organization to initiate a securitization process over a health threat is minimal at best. The fact that the target audience for such regional or international organizations are the member states—whose interests are the ones being infringed—only further complicates the ‘acceptance’ stage of securitization.

Hence, applying securitization to non-liberal democratic countries, such as those found in most Asian countries, or to international organizations, which are heavily influenced by member states’ interests, is problematic. This is a finding that has been noted elsewhere (Caballero-Anthony 2006; Caballero-Anthony and Emmers 2006; Wilkinson 2007; Vuori 2008) and was alluded to by Wæver who stated that ‘the current quite absolutist concept of ‘securitised or not’, might be differentiated through empirical studies of mixed and partial situations’ (Wæver 2003: 26). However, as the country papers in this special edition establish, all the countries studied did securitize their responses to the health threat insofar as they identified an issue that required supra-normal efforts to address. In some instances, there is clear use of securitizing language once the situation became serious enough to potentially create a legitimacy challenge or once international pressure become strong enough (or a combination of both). In other cases, the health threat was addressed through the supra-normal provision of policies and resources from ‘public good and social order’ perspectives. This disaggregation of securitization’s initial phases argues for less emphasis to be placed on the actual speech act and acceptance, and more on the response phase and the roles of its different stakeholders than is currently the case.

Governing a health threat

To shift into emergency mode requires an array of stakeholders beyond the state. Business groups, civil society organizations and individuals all need to be mobilized to deal with health threats. The omission of any one cohort or the failure of any one cohort to reallocate resources and implement the emergency-mode policies jeopardizes the effective securitization of the health threat.
In Asia, the illiberal socio-political systems combined with strong state-market ties challenges the emergency mode phase of securitization by restricting information flows, actors and resources. Moreover, the centralized nature of these states' systems means that a more restrictive hierarchy is utilized rather than a more responsive heterarchical structure. Furthermore, the nature of the state systems politicizes the bureaucracy; subordinating it to the will of the ruling party and preventing it from delivering impartial advice. Beyond the iron triangle of the state-market-bureaucracy lies the civil society and its individual members. But, state-civil society relations in many Asian countries remains rudimentary, with the many regimes still wary of mobilizing their own populations; a problem of mistrust that flows in both directions. Yet as The Lancet noted: 'Transparency and continued communication between WHO, governments, health officials, the public, and the media' is critical in a health crisis (The Lancet 2009: 1495).

As the papers on Vietnam and China illustrate, there was a rational, political decision not to securitize existential health threats: in China in the case of SARS and in Vietnam in the case of H5N1. In both countries a decision was made that, for reasons of socio-political stability (China) or economic-political costs (Vietnam), it was preferable not to securitize a health threat (Herington 2010; Wishnick 2010). Overriding both countries strategies was a concern that securitizing a health threat was tantamount to acknowledging an inability to safeguard the well-being of their respective peoples. Such an acknowledgement could only call into question the legitimacy of the state in systems where there are no avenues for such questions to be raised. The internal tensions that such a contradiction would generate were considered a greater challenge than that posed by the health threat. This political rationale in illiberal regimes modifies the utility of securitization theory, requiring a greater understanding of the culture and norms of a country before applying a securitization yardstick.

Given this possible reticence, the issue of why a health threat is securitized must also be addressed. Fidler has argued that it is possible to identify a post-Cold War shift away from an international (Westphalian) order—characterized by the upholding of a state’s sovereignty where no other state or international organization can interfere in its domestic affairs—towards a post-Westphalian health order. This new order is characterized by the dissolution of the traditional domestic and international categories that was, in turn, an outcome of the clear policy recognition (led by the United States) that not only does the spread of infectious diseases not respect national boundaries but that their spread represents a clear challenge to all countries (Fidler 2004: 43–44). Under such a system there is a moral imperative towards human and health security irrespective of state borders which supersedes national (Westphalian) interests.

This ‘de-Westphalianization’ of health reached a peak between 2005 and 2007 with the revision and subsequent implementation of the new WHO International Health Regulations designed to more comprehensively prevent the spread of infectious diseases. Under the revised International Health Regulations, the ability of states to block information transfer was lessened, while the WHO was given greater scope to utilize non-state information in developing its official position. ‘Member states are now also required to respond to the WHO’s request for verification of information, irrespective of its source or origins’ (Bagchi 2007: 448). This allows civil society groups and private sector organizations to pass
information to the WHO, which it can then act upon—instead of waiting for states to provide formal notification. As a result, WHO members technically have far less scope for independent action than was previously the case; although many still return to expressing sovereign rights when it suits them to do so.

In Asia, however, it remains questionable as to what extent the de-Westphalianization of global health is adhered to by states. Numerous studies have shown that an abiding characteristic of the regional order is the retention of sovereignty, both as an intrinsic operating principle of a state’s foreign policy and as a reactive domestic policy against territorial incursions. Hence, even when a state is pre-disposed towards a de-Westphalian system—and even when it may engage at the global level in such processes—the realities of the regional order mean that a largely Westphalian orientation prevails domestically and in Asia. One good example of this can be seen in the Indonesian paper, where Health Minister Supari placed national sovereignty above the sharing of virus samples (Elbe 2010). Nonetheless, even in the case of Indonesia, there is a degree of co-operation proceeding; if not on a multilateral basis then on a bilateral basis. Thus, in considering why a state chooses to securitize health threats, it is necessary to balance its domestic constraints against its international obligations. When domestic costs clearly outweigh international benefits then a Westphalian response can be expected. When the potential costs and benefits are more mixed there is more scope for de-Westphalian actions, as suggested by Fidler.

Conclusions

In 2008 Aldis conducted a literature search on a range of topics related to ‘health security’, ‘global health security’ and other topics (Aldis 2008). This was a search developed through multiple online databases and websites as well as consultations. Aldis found approximately 300 publications that were relevant to his review. Two years later a second search on the single term of ‘health security’ using only a sole online database (Proquest) returned in excess of 1200 results. Although the two searches were different in scope and methodology, this simple exercise demonstrates just how rapidly the field of health security is expanding, but it is an expansion whose parameters and essential nature remain ill-defined and heavily contested.

The findings from these papers reinforce the utility of securitization theory in dealing with non-traditional security threats but suggest that care must be taken in its application. Cultural and religious agendas can and do have a significant impact on responses to health threats, with different social and political priorities altering the way in which a health challenge is securitized (or not). Moreover, the illiberal nature of many Asian states coupled with a politicized bureaucracy and close state-market relations limit the range of alternative advice that policy-makers can draw upon. This means that the securitization of health challenges in Asia is more easily subsumed to domestic political needs. What the country-focused papers in this collection do show is that health challenges are securitized in Asian states, although the purposes and scope of such actions can differ from the theoretical norm. Beyond the realm of the state, applying the securitization model to international organizations is made problematic by competing state norms and policy agendas. As the two papers on the securitization of health threats in international organizations demonstrate, non-Asian states also politicize health securitization for their own ends (Enemark 2010; Rushton 2010). At both levels, these conclusions argue for a deeper recognition of the policy drivers behind the securitization of health threats as well as a broader understanding of the response process than the model alone can provide.

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