

The Dangers of Securitizing Health

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HANNAH ROBERTS, DEC 4 2019

In this essay, I am going to argue that moving health into the security paradigm has primarily served to further secure those who are already safe, whilst putting those at greatest risk in more danger. To do this, I am first going to discuss securitization theory and how it has been used to selectively elevate specific health issues into the security realm. My argument will then revolve around the significance of who decides which disease or health issue will be elevated, who is considered the referent object, and why. I will then consider the consequences this has had for those on the receiving end of the subsequent policies implemented as a result. I intend to show that securitization can be a beneficial tool for policy makers in the global health struggle but that its highly Eurocentric nature creates a binary between the West and developing states. Given the current way security is framed, and the lack of representation for developing states in the decision-making process, the securitization of health has ultimately created more dangers than it has solved.

The threat from infectious diseases has been common throughout human history, yet it is only in the past twenty-five years that certain health issues have been propelled onto the security agenda through the process of 'securitization'.^[1] Securitization theory, advocated by the Copenhagen School, entails the shifting of typically non-traditional security issues, such as health, into the security paradigm through 'speech act'.^[2] By labelling something as a 'security' threat, it conveys a sense of urgency, giving an issue saliency and prioritization on the political agenda and therefore greater attention and resources from the international community.^[3] This seems like a positive shift towards human security given that the 'soft threats' of disease and poor sanitation are by far the leading causes of mortality compared to the traditional 'hard threats' of war and terrorism which have previously dominated the agenda.^[4]

However, as argued by Thierry Balzacq, securitization is better viewed as a 'strategic practice', used by political actors to achieve specific goals.^[5] Rather than using a 'positivist criterion-based assessment' to determine which issues ought to be securitized, securitizing actors choose the issues based on their own assessment of the threat.^[6] These securitizing actors are almost always political actors from Western, developed states in the form of organisations like the United Nations Security Council and World Health Organisation. The 'subaltern' cannot securitize because they are 'structurally excluded' from the bodies which have the power to determine which threats will reach the security agenda. Moreover, there is an inherent colonial dimension to securitization theory in which the subaltern are silenced and then spoken for.^[7] Consequently, the securitization of health can be viewed as an extremely politicized act in which predominantly Western powers have elevated only the specific health concerns that they believe threaten their own security- often at the expense of the issues most pertinent to developing states. Three issues have therefore come to dominate the agenda- HIV/AIDS, emerging infectious diseases such as SARS and Ebola, and bioterrorism.^[8]

Whilst there is no question that these can legitimately be considered global health concerns, particularly given how globalisation has made the spread of pathogens and disease far easier, this has led to an extremely narrow framing which overlooks the health issues that actually account for the highest morbidity rates in both developed and developing countries. For example, research by the Global Burden of Disease shows that emerging infections such as West Nile Virus, Ebola and Monkeypox have caused very few fatalities compared to, for instance, diarrhoeal diseases which cause 1.8 million deaths every year in the global South.^[9] However, because these previously contained diseases have started to spread to the West, they have been elevated by Western securitization actors at

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the expense of deeply problematic health concerns that affect millions of people in developing states such as malnutrition, malaria and diarrhoeal diseases, which are subsequently overlooked by the international community.[10]

This is extremely problematic in terms of resource allocation. Securitization is fundamentally a strategic tool used to push an issue to the top of the political agenda and thus set the priorities for health budgets and aid budgets. By only emphasising the diseases which the West are concerned will reach their borders, resources are diverted away from fundamental health infrastructure which could help provide greater sanitation, health education and thus prevent the spread of the diseases so feared by the West in the first place. For example, HIV/AIDS funding significantly increased from '6% of all global health aid in 1998 to roughly half of total health funding in 2007.'[11] This massively increased the number of people receiving treatment, helping abate the crisis, with an estimated 5.2 million people receiving antiviral treatment by 2008- a figure that would have been unthinkable in the late 1990s.[12] However, funding for health systems declined from 62% to 26% of total health aid as a result.[13] Indeed, this has been cited as one of the main reasons why the recent Ebola epidemic escalated to such an extent; the international community largely ignored early warning signs about a potential epidemic until cases were reported in the USA, clearly demonstrating that health securitization is about Western security rather than global health. Meanwhile, the West African states where it originated had abundant resources for treating HIV but had fundamentally ill-equipped healthcare systems to deal with such emergency situations.[14] This is arguably the most substantial danger of securitizing health; the inherent eurocentrism of securitization theory has led to the elevation of those diseases and infections which have the potential to cross the borders of developed states, but this is usually to the detriment of primary health care that could have prevented the cumulation of an epidemic in the first place.

The issue of skewed resource allocation is further exacerbated when one considers the state-centric nature of health securitization which has largely perpetuated as a result of who determines the security agenda. After the Cold War, there was an attempt by Critical Security Theorists from the Welsh School to extend the referent object down from the traditional focus on the state, towards the individual.[15] Whilst securitization theory seemed to allow for the expansion of the security agenda to previously non-securitized threats such as the environment and health, even Buzan argued that the individual remains subordinate to the state when it comes to the security agenda.[16] Any securitization that doesn't invoke 'statist concerns' has ultimately failed.[17] Accordingly, the health issues which have been successfully securitized have been framed in such a way that the referent object is the state- whether this be the securitizing actor's own state, or the state in which the health issue is most prominent. For example, HIV/AIDS has been securitized on the basis that it may indirectly cause state failure in high-prevalence countries through factors ranging from lost productivity and undermined confidence in the state to provide basic healthcare, to a weakened military and depleted security forces.[18] Indeed, the language of UN Resolution 1308 stressed the risk to military personnel and peacekeepers above all others as the key priority for UNSC intervention.[19] On the one hand, this leads to the disproportionate distribution of resources to militaries and security forces as the means of upholding state stability. On the other hand, this implies that only diseases which disproportionately affect men aged 15-24 (as the most likely demographic to form the army and security forces) will be securitized and thus receive the attention and resources this endows from the international community.[20] Consequently, health securitization could even be considered a gendered issue; diseases which affect women and children in developing countries are often overlooked by the security agenda because they do not make up the majority of the professionals and military personnel that are deemed essential for maintaining state stability. This is evidenced by the fact that more than 10 million children die every year from one of a small number of communicable diseases- 57% of which have been deemed preventable if money was instead invested in relatively simple healthcare infrastructure and early intervention.[21] Securitization of health inadvertently prioritizes the health of one person above that of another, whilst the underlying broader determinants of health are underplayed.

It is important to note that, even here, the securitizing actors in the West are less concerned about the people within the high-prevalence states than they are about the implications a developing state collapsing, as a result of a disease or epidemic, could have for their own state security in terms of migration, refugees and potential economic fallout.[22] There is a legitimate concern by people in the 'global South' that the people carrying the disease will be seen as the threat, rather than the disease itself. [23] Given that the concept of security is still firmly rooted in the traditional conception of states as the referent object, it follows that concept which is still highly militarized in terms of the

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solutions it offers. This is clearly indicated by the language of health security rhetoric such as when the World Bank President, James D. Wolfensohn, declared a 'war on AIDS'.^[24] There is an alarming paradox between health, as a challenge primarily affecting human security, and securitization as a response grounded in state-centrism and overt militarization.

This is a danger in two respects. McInnes observed this 'garrison mentality' following the outbreak of SARS when solutions involved stricter border control and attempts to regulate migration.^[25] Often solutions go even further involving the use of aggressive vaccination programmes, disease surveillance and quarantines that arguably violate civil liberties but are justified under the umbrella of 'emergency measures' that the securitization label brings.^[26] For example, Haitian refugees were seen as a high risk group for HIV and were therefore detained by the US in Guantánamo Bay between 1991 and 1994 to be subject to mandatory health inspections. The US then refused to allow anybody who tested positive into the country, even if they had asylum status.^[27] Likewise, in South Africa, the emergence of XDR-TB in 2006 led to the isolation of patients for a minimum of six months in a specialist facility, with some detained for as long as two years- often in sub-standard conditions- with no set framework for when someone should be released.^[28]

The second danger in seeing the carrier of the disease as the threat is that it massively increases the stigma associated with the disease and can perpetuate stereotypes about different groups of people. Public health measures have historically served as a means of racial exclusion and securitizing health only serves to legitimate this kind of behaviour under the guise of health security.^[29] For example in the US, public health has increasingly become entangled with border control. Increased medical screenings are being deployed at the border on the basis of discriminatory profiling, reinforcing the perception of migrants as a threat to both health and national security.^[30] States are more concerned about containment strategies to protect themselves than they are about the treatment and prevention of the disease within individuals, even when this is at the expense of fundamental human rights and civil liberties. It is unlikely that securitization can be used as an effective tool for the advancement of global health until it is de-militarized and grounded in notions of human security.

Throughout this essay, I have aimed to illustrate the dangers that arise in securitising health, primarily stemming from the inherent issues with securitization theory itself- namely that it is Eurocentric, state-centric and overtly militarized. This is not to say that securitizing health has not had some positive consequences; epidemics have been brought under control and the numbers being treated for HIV/AIDS has grown exponentially since the initial outbreak in the 1990s. However, it is difficult to say how much of this success can be attributed to securitization considering the simultaneous advancement of developmentization as another buzzword for political agenda setting.^[31] Meanwhile securitizing health has put those in developing states at high risk from militarized solutions, 'othering', and skewed resource distribution. Given that securitization is a very reactive tool, health would be better situated in the development paradigm so more attention can be devoted to primary healthcare infrastructure and policies which address the root causes of disease before they can become pandemics.

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