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Health, security and foreign policy

COLIN McINNES AND KELLEY LEE*

Abstract. Over the past decade, health has become an increasingly important international issue and one which has engaged the attention of the foreign and security policy community. This article examines the emerging relationship between foreign and security policy, and global public health. It argues that the agenda has been dominated by two issues – the spread of selected infectious diseases (including HIV/AIDS) and bio-terror. It argues that this is a narrow framing of the agenda which could be broadened to include a wider range of issues. We offer two examples: health and internal instability, including the role of health in failing states and in post-conflict reconstruction; and illicit activities. We also argue that the relationship between global public health, and foreign and security policy has prioritised the concerns of the latter over the former – how selected health issues may create risks for (inter)national security or economic growth. Moreover the interests of the West are prominent on this agenda, focusing (largely though not exclusively) on how health risks in the developing world might impact upon the West. It is less concerned with the promotion of global public health.

Health has risen markedly on the international agenda over the past decade. Key to this increased prominence have been two issues: the emergence and spread of infectious diseases such as HIV/AIDS, SARS and new drug-resistant strains of TB; and the risk from biological weapons, especially bio-terrorism.¹ There is of course nothing new about health as an international issue: infectious diseases have never recognised state boundaries and systems of international cooperation attempting to

* This article draws on discussions held at meetings in Australia, Canada, the UK and the US at which the authors were participant observers. These include a Conference on Health as a Foreign Policy Issue held at Ditchley Park, England in March 2002; Symposium on Global Health and Foreign Affairs held by The Nuffield Trust in London in March 2003; a Trilateral Meeting on Global Health and Security hosted by RAND in Washington in April 2003; UK-Australia Seminar on Health and Foreign Policy hosted by the Commonwealth Government of Australia in Canberra in September 2003; Workshop on Rapid Assessment of the Economic Impact of Public Health Emergencies of International Concern held at the University of Toronto in January 2004; and Meeting on HIV/AIDS and Other Infectious Diseases, Project on the G20 Architecture in 2020, Costa Rica, 12–13 November 2004. We are grateful to participants at these meetings although the authors remain wholly responsible for the material in this article. Research for this article was made possible from funding from The Nuffield Trust and The Nuffield Health and Social Services Fund. We would like to thank John Wyn Owen and Alan Ingram for their support and assistance in this work.

¹ Arguably a third important area where public health has impacted upon the international agenda has been tobacco control, not least the successful conclusion of the Framework Convention on Tobacco Control (FCTC). Tobacco-related diseases remain the single greatest cause of preventable deaths in the world. Tobacco sales have earned the industry record profits since the 1990s as companies have shifted their attention to the developing world, facilitated by trade liberalisation. The World Health Organisation under Gro Harlem Brundtland campaigned for comprehensive tobacco control measures worldwide, supported by the FCTC. Although the WHO presents this as

control their spread long pre-date the establishment of the World Health Organisation in 1948.² Moreover, there has long been humanitarian concern for international health development through the work of charitable foundations, nongovernmental organisations (NGOs), governments and multilateral organisations. What is different about recent attention to health issues is the apparently successful attempt to move health beyond the social policy and development agenda, into the realms of foreign and security policy.³ In the United States for example, health issues (and most particularly HIV/AIDS) have been the focus of, or figured prominently in, a variety of foreign policy speeches from key members of the administration.⁴ In 1999 the State Department cited the protection of human health as one of its strategic missions,⁵ and in its Strategic Plan for Financial Years 2004–9 stated:

a successful partnership between the public health and foreign policy communities, as Jeff Collin points out, this smacks somewhat of hagiography. The reality is that the public health community, particularly WHO, initiated and led this international effort. Working with the foreign policy community on tobacco control proved an uphill task at times. Working with them on infectious disease and bio-terror proved much easier. Jeff Collin, 'Tobacco Control', unpublished paper for The Nuffield Trust.

² The beginnings of sustained international cooperation on health were the International Sanitary Conferences held during the nineteenth century. These originated in concerns over the risk to European states from the transmission of acute and epidemic infectious diseases from outside the continent. Given the potential of such diseases to spread rapidly across national borders and cause high rates of morbidity and mortality, as well as disrupt burgeoning trade routes, international cooperation was pursued to mitigate the risks involved. Institutions such as the Organisation International d'Hygiène Publique (OIHP) were therefore created to build surveillance and reporting systems to support such cooperation.

³ For example, the Millennium Development Goals agreed in 2000 set three out of eight goals, eight of the 18 targets and 18 of the 48 indicators as related directly to health; the UN Security Council session of January 2000 was devoted to the threat in Africa from HIV/AIDS; UN Security Council Resolution 1308 of July 2000 addressed the need to combat the spread of HIV/AIDS during peacekeeping operations; United Nations Special Session on HIV/AIDS held in June 2001 declared the disease a security issue; World Health Assembly Resolution 54.14 adopted in May 2001 on 'Global health security: epidemic alert and response' focused on revision of the International Health Regulations; the G8 Summit held in Genoa in July 2001 agreed the creation of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; and WHO's adoption of the first international health treaty, the Framework Convention on Tobacco Control, in May 2003. The driving force behind this shift originated largely within the public health sector, motivated by a desire to secure greater political attention to global public health needs. Key players included WHO Director-General Gro Harlem Brundtland, President of the US Institute of Medicine Ken Shine, former World Bank economist Jeffrey Sachs, and former US Ambassador to the UN and President of the Global Business Coalition on HIV/AIDS, Richard Holbrooke. The target was both the foreign and security policy communities. From the perspective of public health advocates, differences between the two communities have so far not been deeply explored, and the two are broadly (though not always) seen in the same light. For the purposes of analysing public health engagement with these policy communities, this lack of distinction is taken as given.

⁴ See for example George W. Bush, 'President speaks on fighting global and domestic HIV/AIDS', 31 January 2003, available at: (<http://www.state.gov>), accessed on 16 January 2004; Paula J. Dobriansky, 'The fight against HIV/AIDS' and 'The emerging security threat of HIV/AIDS: Russia' both available at: (<http://www.state.gov>), accessed on 16 January 2004; Colin L. Powell, 'Presentation at HIV/AIDS plenary, September 22, 2003', available at: (<http://www.state.gov>), accessed on 16 January 2004. In addition, US President Clinton issued a Presidential Decision Directive in 1996 calling for a more focused US policy on infectious diseases; the US House International Relations Committee passed the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act in June 2001 authorising large increases for international programmes; and US Office of National AIDS Policy shifted its focus from domestic to international efforts in 2001.

⁵ See State Department, *United States Strategic Plan for International Affairs*, first revision (Washington, DC: Department of State, 1999), pp. 9 and 41.

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 community⁶

In the UK, the FCO's 2003 strategy paper raised the spread of disease as an ill-effect of globalisation and a risk to peace and development,⁷ although most of the attention to international health issues in Whitehall has traditionally come from the Department for International Development (DfID), whose White Paper on International Development also makes the links between globalisation and poor health.⁸ In Australia, communicable disease is raised (albeit briefly) as a global challenge in its 2003 White Paper on foreign and trade policy,⁹ while Foreign Minister Downer acknowledged that 'disease and global health issues certainly add to the uncertainty we face in the conduct of our foreign policy'.¹⁰ One of the clearest statements in terms of making the link between health and foreign policy, however, came in the 2002 report of the Romanow Commission on *The Future of Health Care in Canada*. The report was critical that 'the broader area of health promotion is very much an afterthought in Canada's foreign policy' and argued 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 report continued 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'.¹¹ The recommendations of the Romanow Commission were not much evidenced by the Canadian government's subsequent consultation paper on foreign policy, although health issues did receive greater attention in the summary of responses to the paper.¹² However, Prime Minister Paul Martin supported the inclusion of health in efforts to organise a summit of Group of 20 (G20) leaders to address the global challenges from infectious diseases.

Health concerns are therefore beginning to emerge on the foreign and security policy agenda of Western states, although they have not supplanted more traditional concerns.¹³ This policy shift can be most clearly observed in relation to biological

⁶ *Strategic Plan Fiscal Years 2004–2009: Security, Democracy, Prosperity* (Washington, DC: US Department of State and US Agency for International Development, 2004), p. 76.

⁷ Foreign and Commonwealth Office, *UK International Priorities: A Strategy for the FCO, Cmnd 6052* (London: HMSO, 2003), p. 13.

⁸ Department for International Development, *Eliminating World Poverty: Making Globalisation Work for the Poor* (London: HMSO, 2000), pp. 21 and 34.

⁹ Department of Foreign Affairs and Trade [Australia], *Advancing the National Interest: Australia's Foreign and Trade White Paper* available at: (<http://www/dfat.gov.au/ani>), accessed on 20 January 2004.

¹⁰ Alexander Downer, 'Why Health Matters in Foreign Policy', available at: (<http://www.foreignminister.gov.au/speeches/2003>), accessed on 16 January 2004.

¹¹ Roy J. Romanow, *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). Available at (<http://www.healthcarecommission.ca>), accessed on 20 January 2004.

¹² Department of Foreign Affairs and International Trade [Canada], *A Dialogue on Foreign Policy and A Dialogue on Foreign Policy: Report to Canadians*, both available at: (<http://www.foreign-policy-dialogue.ca>), accessed on 20 January 2004.

¹³ For a fuller discussion on health and foreign policy see Colin McInnes, 'Background paper: health and foreign policy', available at (http://www.nuffieldtrust.org.uk/global_health/pubs.php), accessed on 13 May 2004.

weapons, where not only is disease (such as smallpox) considered a potential weapon, but public health systems are seen as part of the defence (even deterrent) against the use of such weapons.¹⁴ More dramatic, however, in terms of global health impact has been the HIV/AIDS pandemic. In a little over two decades, the spread of the disease is such that UNAIDS estimates up to 44 million people are infected and that over 3 million died of AIDS in 2004 alone, of which 510,000 were children.¹⁵ The scale of the catastrophe has, of course, prompted humanitarian concerns; but HIV/AIDS has also begun to be considered within a security context, particularly in relation to national and regional stability. This was highlighted by the 2000 UN Security Council special session on the HIV/AIDS threat to Africa and the subsequent Security Council Resolution 1308 which recognised 'that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security'.¹⁶ Concerns raised in the security context include the disproportionate HIV infection rate among security forces, the economic burden caused by the disease, increased social fragmentation, reluctance to send or receive peacekeepers due to the risk of infection, and even its use as a weapon of war, principally through rape.¹⁷

The spread of acute and potentially epidemic infections from the developing world more generally, including Ebola, West Nile virus and monkeypox, has also heightened concerns within the security community over risks to the health and economic well-being of citizens and communities in Western countries. Although the causal factors for the spread of such diseases are complex, globalisation, including increased population mobility, features prominently. The 2002–03 SARS outbreak is a good example of the extent and speed with which new diseases can spread. The disease

¹⁴ See for example the comments of President George W. Bush in signing the Public Health Security and Bioterrorism Response Act, that 'Protecting our citizens against bioterrorism is an urgent duty of . . . American governments. We must develop the learning, the technology and the health care delivery systems that will allow us to respond to attacks with state of the art medical care throughout our entire country.' 'Transcript: Bush signs bioterror bill', Office of the Press Secretary, The White House, 12 June 2002, available at (<http://japan.usembassy.gov/e/p/tp-se1440.html>), accessed on 13 May 2004. See also Elizabeth Prescott, 'SARS: A Warning', *Survival*, 45:3 (2003) pp. 207–26.

¹⁵ UNAIDS, *Global Summary of the AIDS Epidemic, December 2004*, p. 1, available at (http://www.unaids.org/wad2004/report_pdf.html), accessed on 12 May 2005. Due to the social stigma of HIV/AIDS infection in many societies, as well as weaknesses in capacity to collect health information, data on morbidity and mortality remain estimates, although UNAIDS believes that the accuracy of its estimates is improving. See UNAIDS, *AIDS Epidemic Update: December 2003*, p. 1, at (<http://www.unaids.org>), accessed on 13 May 2004.

¹⁶ The full text of Resolution 1308 is available at (<http://www.reliefweb.int>). See also Security Council Press Release SC/7068, 'Examining implications of HIV/AIDS for UN peacekeeping operations', 28 June 2001, available at (<http://www.un.org/News/Press/docs/2001/sc7086.doc.htm>), accessed on 13 May 2004. The Security Council session was followed by a special session of the General Assembly on HIV/AIDS in 2001.

¹⁷ See for example International Crisis Group, *HIV/AIDS as a Security Issue*, June 2001, available at: (<http://www.crisisweb.org>), accessed on 2 February 2002; Stefan Elbe, 'HIV/AIDS and the Changing Landscape of War in Africa', *International Security*, 27:2 (2002), pp. 159–77 and *Strategic Implications of HIV/AIDS*, Adelphi Paper 357 (Oxford: IISS/OUP, 2003); R. Ostergard, 'Politics in the Hot Zone: AIDS and National Security in Africa', *Third World Quarterly*, 23:2 (2002), p. 342; P. Chalk, 'Infectious Disease and the Threat to National Security', *Jane's Intelligence Review*, September 2001, pp. 48–50. Much of this literature, however, fails to distinguish between HIV infection and AIDS. Soldiers infected by HIV may not see their health (and therefore operational efficiency) affected for a number of years. Indeed AIDS may not appear until they have left the armed forces. Although this may raise issues over the treatment of those infected (especially the cost and the opportunity cost in terms of military budgets), the operational consequences may not be as severe as initially feared.

began in southern China in November 2002 and began to spread internationally in February 2003. WHO issued global alerts on 12 and 15 March 2003, by which time the disease had already spread from China to Taiwan, Singapore, Vietnam and Canada. By the time the disease came under control in August 2003, 8,422 cases had been identified in 29 countries with 908 fatalities.¹⁸ SARS also highlighted sensitivities to economic effects. Although the number of cases and deaths from the initial SARS outbreak was relatively small in comparison for instance with tuberculosis,¹⁹ for the foreign policy community particular attention was paid to the considerable economic losses caused.²⁰ One estimate placed the losses at US\$100 billion.²¹ The macroeconomic effects of disease and poor health had already achieved attention, principally through the WHO Commission on Macroeconomics and Health,²² but SARS gave this a public and political prominence previously lacking. SARS also demonstrated how policy responses to emerging and re-emerging infectious diseases (ERIDs) can elicit a 'garrison mentality' in an effort to prevent the spread of infection. Stricter border controls and attempts to regulate migration have been key features in state responses to the spread of infectious disease, potentially disrupting the free movement of goods, people and services.²³

This article presents two key arguments. First, the manner in which public health issues have begun to appear on foreign and security policy agendas reflects more the concerns of the latter than those of public health. The emphasis to date has been on public health as a foreign policy and security risk, rather than on how foreign and security policy can facilitate or hinder public health. Second, the agenda has been dominated by two issues, the spread of selected acute and potentially epidemic infections and the risk of bio-terror. Yet, from the perspective of seeing health as threats to foreign policy and security, there are other issues which could be of equal concern. This article identifies two such examples – illicit activities and internal state instability. The focus of this article therefore is on the issues which are, or which might appear, on this developing agenda. Our main argument is to critique the narrow framing of the agenda to privilege one set of concerns over another. In the Conclusion, however, we briefly open this up to identify some of the other questions raised by closer cooperation between the two policy communities.

¹⁸ WHO, *Severe Acute Respiratory Syndrome (SARS): Report by the Secretariat*, EB113/33, 27 November 2003 (Geneva: WHO, 2003), p.1. For details of the geographic spread of cases see WHO, *Summary of Probable SARS Cases with Onset of Illness 2002 to 31 July 2003*, 31 December 2003, available at (http://www.who.int/csr/sars/country/table2004_04_21/en/), accessed on 13 May 2004. See also Kelley Lee, 'Decision making in the face of public health emergencies of international concern' in R. Smith and N. Drager, *Rapid Assessment of the Economic Impact of Public Health Emergencies of International Concern: The Case of SARS* (Geneva: WHO, in press); and Prescott, pp. 211–3.

¹⁹ G. F. Zhou and G. Y. Yan, 'Severe Acute Respiratory Syndrome Epidemic in Asia', *Emerging Infectious Diseases*, 9:12 (2003).

²⁰ For example Downer, 'Why Health Matters in Foreign Policy'.

²¹ National Intelligence Council, *SARS: Down But Still a Threat*, Intelligence Community Assessment ICA 2003–09 (Washington, DC: National Intelligence Council, 2003).

²² Reports from the Commission and details of its work can be found at its homepage: (http://www.cmhealth.org/cmh_papers&reports.htm).

²³ See, for example, Peter Spiro, 'The Legal Challenges SARS Poses', available at (<http://www.cnn.com/2003/LAW/04/29/findlaw.analysis.spiro.sars/>), accessed on 14 May 2004. Concerns over the spread of SARS from Toronto led the United States' Centers for Disease Control and Prevention (CDC) to issue health alerts to travellers, including those from Toronto. CDC, 'Update: Severe Acute Respiratory Syndrome – United States, 2003', available at: (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5217a4.htm>), accessed on 13 May 2004.

Infectious disease: a new security risk?

Health issues have been creeping up foreign and security policy agendas for some time. Although this movement was accelerated by 9/11 and subsequent concerns over bio-terrorism, its origins lie with the attempt to develop a new security agenda in the aftermath of the Cold War, one focused on novel risks and areas of concern. In this context ERIDs, with their capacity to cross national borders, threaten the well-being of domestic populations, and undermine the economic and military capabilities of states, began to find a place as a security issue. In 2000 for example, the US National Intelligence Council identified a range of risks from the spread of infectious disease, including increased social fragmentation, economic decline, political polarisation and tension leading to the risk of instability.²⁴ Of particular concern though was HIV/AIDS. By the mid to late 1990s, amid evidence of failure to stem the spread of the disease, HIV/AIDS began to attract the keen attention of the security policy community, prompting US Secretary of State Colin Powell to declare that it 'now represents so great a threat to stability in Africa, Asia and Latin America that it needs to be regarded as a national security issue'.²⁵ Similarly, Richard Holbrooke, former US ambassador to the UN and Director of the Global Business Council on HIV/AIDS, described the disease as 'a direct threat to social, political and economic stability'.²⁶

While HIV/AIDS has received particular focus, other acute infections of potentially epidemic proportions have also received attention. At the 54th World Health Assembly in May 2001, WHO urged member states to participate actively in improving epidemic alert and response measures to ensure 'global health security'.²⁷ A number of countries have already sought to strengthen disease surveillance and monitoring systems at the national and regional levels. For example, in 2000 the EU published an evaluation of arrangements for managing epidemiological emergencies involving more than one EU member state.²⁸ In the UK, the Department of Health commissioned an internal study of the public health implications of increased population mobility including infectious disease control.²⁹ Similar issues were raised in a study funded by The Nuffield Trust to review UK public health measures concerning population mobility and tobacco control in the context of growing

²⁴ US National Intelligence Council, *The Global Infectious Disease Threat and Its Implications for the United States*, National Intelligence Estimate NIE99-17D (2000), available at: <http://www.cia.gov/cia/publications/nie/report/nie99-17d.html>, accessed 5 August 2002.

²⁵ Quoted in J. Gow, 'The HIV/AIDS Epidemic in Africa: Implications for US Policy', *Health Affairs*, 21:3 (2002), p. 57.

²⁶ Quoted in J. Lobe, 'Spread of AIDS Seen as a Security Threat', Third World Network, available at: <http://www.twinside.org.sg/title/threat.htm>, accessed 5 August 2002.

²⁷ World Health Assembly Resolution 54.14, *Global Health Security: Epidemic Alert and Response* (Geneva: WHO, 2001).

²⁸ H. Brand et al., *An Evaluation of the Arrangements for Managing an Epidemiological Emergency Involving More than One EU Member State* (Bielefeld: LOGD, 2000).

²⁹ The report remains unpublished by the UK Department of Health. The UK Conservative Party announced plans to control immigration to prevent the spread of HIV and TB in the run-up to the 2005 General Election. See BBC News, 'Tories plan migrant health checks', http://news.bbc.co.uk/1/hi/uk_politics/4265461.stm, accessed on 15 May 2005; and politics.co.uk, 'Conservatives would turn away immigrants with TB', [http://www.politics.co.uk/election-2005/conservatives-would-turn-away-immigrants-with-tb-\\$13008625.htm](http://www.politics.co.uk/election-2005/conservatives-would-turn-away-immigrants-with-tb-$13008625.htm), accessed on 15 May 2005.

transborder health risks.³⁰ Japan, Australia and the US have all reviewed their policies on border control in light of growing concerns of the perceived risk from certain infectious diseases.³¹ In many cases, recommended policy responses have been focused on efforts to moderate perceived risks through control of population flows across borders or increased at-the-border screening. Examples include proposals for mandatory screening of all migrants in the UK for HIV/AIDS and in the US for tuberculosis.³²

The increased attention to infectious disease as a 'new security risk' has largely been focused on selected infections that have the potential to move from the developing to industrialised world.³³ In 2002–03 SARS joined a list of such diseases which now includes West Nile virus, Ebola and monkeypox. However, by constructing the link between infectious disease and security in this manner, the global health agenda risks becoming inappropriately skewed in favour of the interests of certain populations over others. By any measure, notably data on the Global Burden of Disease, these infections have caused a relatively minor number of cases compared, for example, to diarrhoeal disease. The latter, due overwhelmingly to unsafe water supply, sanitation and hygiene in the developing world, causes 1.8 million deaths each year, with 90 per cent of these deaths being children.³⁴

Perhaps ironically, some public health officials have been keen to emphasise the security implications of ERIDs as a means of pushing health higher on policy agendas, both domestically and internationally (including G8 Summits and the World Economic Forum). These initiatives have not always identified the risks involved in a securitising move and the result has been increased concern, not for shifting patterns of health and disease of world populations as a whole, but for selected infections that potentially threaten the privileged few.³⁵ This risks leading to

³⁰ Jeff Collin and Kelley Lee, *Globalisation and Public Health: A Review and Assessment of Public Health Measures in the UK Concerned with Transborder Health Risks* (London: The Nuffield Trust, 2002).

³¹ J. Gerard Power and Theresa Byrd, *US-Mexico Border Health: Issues for Regional and Migrant Populations* (London: Sage, 1998). Australia, Department of Immigration and Multicultural and Indigenous Affairs, 'The Health Requirement', Fact Sheet, Canberra, 2004. At the Japan/ASEAN Summit held in November 2001, the Japan-ASEAN Information and Human Network for Infectious Disease Control was formed.

³² Richard Coker and K. Lambregts van Weezenbeek, 'Mandatory Screening and Treatment of Immigrants for Latent Tuberculosis in the USA: Just Resistant?' *The Lancet*, 1 November 2001, pp. 270–6.

³³ A crucial report setting this agenda came from the Board on International Health of the US Institute of Medicine. See Institute of Medicine, *America's Vital Interest in Global Health: Protecting Our People, Enhancing our Economy and Advancing our National Interests* (Washington, DC: National Academy Press, 1997). See also for example Jennifer Bower and Peter Chalk, *The Global Threat of New and Reemerging Infectious Diseases: Reconciling US National Security and Public Health Policy* (Santa Monica, CA: RAND, 2003), pp. 61–74. Although the major theme is that disease may spread to the United States and elsewhere in the West, an important sub-theme is of concern that the economic burden of disease elsewhere may harm economic growth globally, thus affecting Western economies. See also A.M. Kimball and K. Taneda, 'Emerging Infections and Global Trade: A New Method for Gauging Impact', paper presented at Workshop on the Rapid Assessment of the Economic Impacts of Public Health Emergencies of International Concern, University of Toronto, January 2004.

³⁴ WHO, 'Facts and Figures: Water, Sanitation and Hygiene Links to Health', Geneva, 2004. Available at (http://www.who.int/water_sanitation_health/publications/factsfigures04/en/print.html) (accessed 31 March 2005).

³⁵ C. Murray and A. Lopez, *Global Burden of Disease* (Cambridge, MA: Harvard University Press, 1994), and 'Progress and Directions in Refining the Global Burden of Disease Approach: A Response to Williams' Discussion Paper' (Geneva: WHO, 2000).

a fortress mentality which seeks to control the transmission of infectious agents by regulating the flow of certain mobile populations, goods and services. For example, the Institute of Medicine proposed that the US introduce mandatory screening for tuberculosis (TB) of immigrants from high-prevalence countries, a proposal supported by the Centers for Disease Control and Prevention (CDC). The policy also argued for provision of a permanent residence card (green card) to be linked to the completion of an approved course of preventive treatment.³⁶ As Coker and van Weezenbeek convincingly demonstrate, not only do such policies have dubious public health benefits (not least because of the number of migrants, legal and illegal, not covered by such a scheme) but it overestimates the risks involved.³⁷

The concern over infectious diseases may therefore be understandable from a foreign and security policy perspective since they appear to pose risks to domestic populations, regional stability and economic growth. But this focus is problematic from a global public health perspective. Not only are the broader determinants of health underplayed (including poverty) but, from a global perspective, the health risks to populations in the industrialised world pall in comparison to those elsewhere. Moreover the focus on the spread of infectious disease obscures dangers from non-communicable diseases (including tobacco-related illnesses) which are related to foreign policy through international trade. In short, the attention given to the spread of infectious disease speaks more to the concerns of Western foreign (including economic) and security policy than it does for the concerns of global public health.

Bio-terrorism

In the aftermath of 9/11, much of the attention to the links between health and security policy has been focused on the perceived threats from biological weapons, most worryingly as wielded by terrorist organisations and/or 'rogue states' (what has been termed bio-terrorism).³⁸ Renewed concerns over biological weapons, however, had begun to emerge in the early to mid 1990s, supported by intelligence reports of a potential proliferation of materials to produce such weapons following the break-up of the Soviet Union.³⁹ Political and economic instability in the region,

³⁶ Institute of Medicine, *Ending Neglect: The Elimination of Tuberculosis in the United States* (Washington, DC: Division of Health Promotion and Disease Prevention, 2004).

³⁷ Coker and van Weezenbeek, 'Mandatory Screening and Treatment of Immigrants'.

³⁸ In his 2003 evidence to Congress, for example, the Director of the CIA referred to this as a matter of 'grave concern'. See CIA, 'DCI's Worldwide Threat Briefing: The Worldwide Threat in 2003: Evolving Dangers in a Complex World', 11 February 2003, p. 4, available at: (http://www.cia.gov/public_affairs/speeches/2003/dci_speech_02112003.html), accessed on 14 May 2004. See also The White House, 'Biodefense for the 21st century', 30 April 2004, available at: (<http://www.whitehouse.gov/homeland/20040430.html>), accessed on 14 May 2004. The link between public health and bio-terrorism in the US is apparent, for example, in the 2002 Public Health Security and Bioterrorism Preparedness and Response Act and in the work of the CDC. See CDC *Terrorism and Preparedness and Response Strategy*, version March 2004, available at: (<http://www.bt.cdc.gov/planning/tpstrategy/index.asp>), accessed on 14 May 2004. The so-called Bioterrorism Act is available at: (<http://www.fda.gov/oc/bioterrorism/PL107-188.pdf>).

³⁹ On the problem of Russian biological weapons 'leakage', see Jonathan Tucker, 'Biological Weapons Proliferation from Russia: How Great a Threat', paper presented at the 7th Carnegie International Non-Proliferation Conference, 11–12 January 1999, Washington DC, available at (<http://www.ceip.org/programs/npp/tucker.htm>), accessed on 2 February 2004. See also G. Christopher, T. Cieslak, J. Pavlin and E. Eitzen, 'Biological Warfare: A Historical Perspective', *Journal of the American Medical Association* (hereafter *JAMA*), 278:5 (1997), pp. 412–17.

accompanied by growing lawlessness and the rise of organised criminal groups, raised fears that materials were being sold to terrorist organisations and 'rogue states' such as Iraq, Iran, Libya, Syria, Cuba, and North Korea.⁴⁰ While selective attacks using biological weapons have been carried out in the past, the increased potential for causing harm to mass populations and the relatively low cost of such weapons are believed to make the weapons especially attractive to such groups. The use of biological weapons by Iraq against its Kurdish population in 1988, suspicions that the same government was stockpiling anthrax, botulinum toxin, smallpox and other agents prior to the Gulf War of 1991–92, the attempt by followers of Rajneesh Bhagwan to spread salmonella in the US, and the attack on the Tokyo subway using sarin by the Aum Shinrikyo cult in 1995, all contributed to a heightened sense of awareness that 'non-traditional terrorists' were becoming better organised, some seeking access to biological weapons. Indeed, in an age of 'asymmetric warfare', fears began to be expressed that biological weapons could become a weapon of choice not only for terrorists but for states seeking an edge over the powerful in terms of conventional military weaponry.⁴¹

Even before 9/11 there was growing discussion between the public health and security communities among the G8 countries of the need to improve preparedness and response measures in the event of a major bio-terrorist attack. Within the public health community, the focus was on enhancing response and recovery from such an event, recognising that 'we will not be able to prevent every act of BW (biological weapon) terrorism'.⁴² Indeed, arguing that 'the greatest payoff in fighting BW terrorism lies in improving our response to an incident', much effort was undertaken to anticipate strategic targets, improve surveillance,⁴³ draft contingency plans⁴⁴ stockpile vaccines and treatments, and train and inoculate health personnel.⁴⁵ Within the security policy community, efforts were made from 1994 to negotiate a legally binding instrument to strengthen the Biological and Toxin Weapons Convention (BWC) signed in 1972,⁴⁶ press rogue states to disarm, and improve intelligence on terrorist organisations.

The anthrax attacks following 9/11 brought into sudden focus the potential risks from terrorists wielding biological weapons. WHO encouraged countries to

⁴⁰ David Fidler, 'Facing the Global Challenges Posed by Biological Weapons', *Microbes and Infection*, 1999:1, pp. 1059–66; D. Leigh, 'Iraq Stockpiled Anthrax in Run-up to Gulf War', *The Guardian*, 15 October 2001. Evidence has recently emerged that the strain of anthrax found in Iraq – anthrax 14578 – may have originated in US labs. See comments by Senator Riegle, Congressional Record (Senate), 9 February 1994, available at: (<http://www.svsu.edu/~boles/index/iraq/ussuppliesiraqgas.htm>), accessed on 15 May 2005.

⁴¹ For example, CIA, 'DCI's Worldwide Threat Briefing', p. 4.

⁴² J. Simon, 'Biological Terrorism: Preparing to Meet the Threat', *JAMA*, 278:5 (1997), p. 428.

⁴³ R. L. Shapiro, C. Hatheway, J. Becher and D. L. Swerdlow, 'Botulism Surveillance and Emergency Response', *JAMA*, 278:5 (1997), pp. 433–5.

⁴⁴ J. B. Tucker, 'National Health and Medical Services Response to Incidents of Chemical and Biological Terrorism', *JAMA*, 278:5 (1997), pp. 362–8.

⁴⁵ D. R. Franz, P. B. Jahrling, A. M. Friedlander et al., 'Clinical Recognition and Management of Patients Exposed to Biological Warfare Agents', *JAMA*, 278:5 (1997), pp. 399–411. On 2 December 2002 the UK government announced its intention to inoculate a limited number of key health personnel in the event of a biological attack. See CDR Weekly, *Interim Guidelines for Smallpox Response and Management published by the Department of Health*, 5 December 2002, available at (<http://www.hpa.org.uk/cdr/PDFfiles/2002/cdr4902.pdf>), accessed on 15 May 2005.

⁴⁶ G. Pearson, 'The Complementary Role of Environmental and Security Biological Control Regimes in the 21st Century', *JAMA*, 278:5 (1997), pp. 369–72.

strengthen regional and global surveillance and response measures through the Global Outbreak Alert and Response Network,⁴⁷ and a series of meetings by the Global Health Security Group of the G8, formed in 2001, have been held to discuss global public health security.⁴⁸ Not least, in June 2002 US President George W. Bush signed the Public Health Security and Bio-terrorism Bill.⁴⁹ There was also a proliferation of public health literature on how to increase domestic measures to protect against, and respond to, various biological weapons. Other issues raised include clinical diagnosis and management,⁵⁰ and use of quarantine measures.⁵¹ Diplomatic efforts were also made to achieve a more effective BWC.⁵² However, there has been a clear tension between an internationally versus a domestically focused strategy. This is particularly apparent over vaccines. Although anthrax initially occupied popular attention after 9/11, fears of other infectious agents were soon raised. The US government had already ordered 40 million doses of smallpox vaccine in April 2001.⁵³ Following the anthrax attacks in September 2001, the US stepped up its stockpiling of the smallpox vaccine, joined by other countries including the UK.⁵⁴ Given this large scale purchasing, stocks worldwide were soon in short supply. Similarly, worldwide supplies of the antibiotic Cipro used to treat anthrax, rapidly became in short supply. This resulted in foreign policy tensions over hoarding of essential drugs by the US.⁵⁵

The US and other Western states (including the UK,⁵⁶ Canada and Australia) have all increased their efforts to improve domestic capacity to respond to public health emergencies caused by bioterrorism.⁵⁷ Policy responses in the US have also seen priority given to traditional security measures, notably efforts to shore up 'at the

⁴⁷ WHO, 'Countries Need to Plan Effectively for "Deliberate Infections" – WHO Leader Urges Health Ministers', *WHO Press Release*, 24 September 2001. The Global Outbreak Alert and Response Network is a system of 72 global and regional networks of laboratories, public health experts, and internet-based information systems that continually monitor reports and rumours of disease events around the world. The system is backed by WHO and expertise from more than 250 laboratories, and is linked to the International Health Regulations.

⁴⁸ See, for example, Health Canada, 'Ministerial Statement', Fourth ministerial meeting on health security and bioterrorism, Berlin, 7 November 2003. Available at (www.hc-sc.gc.ca/english/media/releases/2003/ministerial_statement.htm).

⁴⁹ Linda D. Kozaryn, 'Bush Signs Health Security, Bioterrorism Act' American Forces Press Service 13 June 2002, available at: (http://www.defenselink.mil/news/Jun2002/n06132002_200206133.html), accessed on 14 May 2004. The Bioterrorism Act is available at: (<http://www.fda.gov/oc/bioterrorism/PL107-188.pdf>).

⁵⁰ H. C. Lane and A. Fauci, 'Bioterrorism on the Home Front: A New Challenge for American Medicine', *JAMA*, 286:20 (2001), pp. 2595–7.

⁵¹ J. Barbera et al., 'Large-Scale Quarantine Following Biological Terrorism in the United States', *JAMA*, 286: 21 (2001), pp. 2711–17.

⁵² These efforts are detailed on the Biological and Toxic Weapons Convention website at: (<http://www.opbw.org/>). See also the resource page on strengthening the BWC held by the Department of Peace Studies, University of Bradford: (<http://www.bradford.ac.uk/acad/sbtwc/>).

⁵³ J. Laurance, 'US on Alert for Smallpox Terror Attack', *Independent on Sunday*, 22 April 2001.

⁵⁴ The UK Department of Health holds pre-11 September stocks for 3 million people which could be diluted to cover 15 million people. J. Meikle, 'Wanted: More Smallpox Vaccine', *The Guardian*, 28 October 2002.

⁵⁵ K. Singh, 'War Profiteering: Anthrax, Drug Transnationals and TRIPS', paper prepared for the Asia-Europe Dialogue Project (2001), available at (<http://www.ased.org>).

⁵⁶ For example, the UK Public Health Laboratory Service (PHLS), now the Health Protection Agency, issued guidelines for action in the event of an anthrax attack. UK PHLS, *Anthrax: Provisional PHLS Guidelines for Action in the Event of a Deliberate Release* (London: CDSC, 2001).

⁵⁷ See, for example, information on measures promoted or endorsed by the US Department of Health and Human Services at (<http://www.hhs.gov/disasters/index.shtml#bioterrorism>).

border' controls and improve systems of intelligence intended to prevent a bio-terrorist attack. The focus on improving domestic capacity, however, added to criticism over the US government's decision to pull out of negotiations on the BWC, reinforces the sense that national measures were being prioritised over international cooperation. The public health community, in contrast, has focused on developing effective responses in the likelihood that biological weapons are used. These measures are divided between improving international surveillance and monitoring, and strengthening domestic public health systems. What is clear however is that bio-terrorism's presence on the international agenda is because of the security risk it represents to the West, not because of its significance as a health risk; and that although public health systems have been involved in devising methods to protect against attack, this is within a national security context where national interests are paramount, as seen by the stockpiling of drugs and the prioritising of domestic concerns.

Health, internal instability and failing states

Considerable attention has therefore focused on the links between health and foreign and security policy in the two areas of infectious disease and bio-terror. The attention devoted to these two issues, however, has suggested a rather narrow agenda with only limited points of contact between the policy communities. What we now attempt to do is to demonstrate how the agenda is somewhat broader than this and provide examples of two other policy areas where public health intersects with the foreign and security communities. The first of these is internal instability, where links have been made but not to the same extent or with the same priority as for bio-terrorism and infectious disease; the second, illicit trade, where the links remain relatively under-explored.

The problem of internal instability loomed high on the international agenda for much of the 1990s. A key concern was that internal instability could spill over into the international, threatening regional stability and international trade.⁵⁸ But the focus on internal instability and 'failed states' also reflected human rights concerns which transcended traditional ideas of state sovereignty.⁵⁹ Although the attention given to these problems has been overtaken by the 'war on terrorism', concern over internal instability and failed states continues. The Bush Administration's 2002 *National Security Strategy*, for example, argued that 'When violence erupts and states falter, the United States will work with friends and partners to alleviate suffering and restore stability', although subsequent paragraphs made clear its concern that such states might be linked with terrorism and that US actions in these circumstances were not necessarily divorced from the war on terror.⁶⁰ The UK's 2003

⁵⁸ Typical of this is UK Prime Minister Tony Blair's comment on intervention in Kosovo, that 'We must act . . . to save the stability of the Balkan region, where we know chaos can engulf all of Europe'. Statement by the Prime Minister in the House of Commons, 23 March 1999, available at <http://www.fco.gov.uk/news/newstext.asp?2149> accessed on 20 June 1999.

⁵⁹ See, in particular, Nicholas J. Wheeler, *Saving Strangers: Humanitarian Intervention in International Society* (Oxford: Oxford University Press, 2000).

⁶⁰ The White House, *National Security Strategy of the United States*, p. 9. Available at <http://www.whitehouse.gov/nsc/nss.html>, accessed on 16 January 2004.

Defence White Paper similarly commented that 'Weak and failing states are an increasing problem for the stability of several regions especially on NATO's borders and in Africa', though it too made a link with international terrorism by commenting that such states 'can contain areas of ungoverned territory which provide potential havens and sources of support for terrorist groups'.⁶¹ What is unclear is the extent to which poor health can contribute to internal instability,⁶² and whether improved health and better health care provision can stabilise states, particularly in a post-conflict environment.

The argument that poor health can prove destabilising has two parts. The first is that poor health undermines the economic and social structures of the state. Not least, confidence in the state is reduced if it cannot provide a basic level of health care and protection against disease.⁶³ Poor health provision may contribute to social disorder by highlighting inequalities; but it may also present a government as ineffective regardless of whether it has the resources to deal with vital health issues. Poor health may also contribute to economic decline, fuelling discontent, by: forcing increased government spending on health as a percentage of GDP; reducing productivity due to worker absenteeism and the loss of skilled personnel; reducing investment (internal and external) because of a lack of business confidence; and by raising insurance costs for health provision.⁶⁴ The second part of the argument is that the tools of maintaining order, principally the security forces, are particularly vulnerable to sexually transmitted diseases (STDs) including HIV/AIDS.⁶⁵ To what extent this second argument holds for poor health more generally is, however, uncertain. *Prima facie* it would seem reasonable to expect security forces to receive better health provision in these circumstances, simply because state survival might hinge on this. But the social world is rarely as clear-cut as this and, even when it is, the law of unintended consequences may operate (for example, better health care for security forces may reinforce images of inequality, thus fuelling discontent).

The reverse of the coin is that state failure can lead to deteriorating health through economic weaknesses, the collapse of state institutions including the public health infrastructure, and the breakdown of social order leading to violent conflict. External assistance to secure a failing state may therefore lead to positive health outcomes within that state. Failed states might also have regional health implications. Most obviously internal instability may lead to mass migration (as happened in Rwanda and Kosovo, for example), creating vectors for the spread of infectious disease. The breakdown of law and order may also provide a fertile ground for the development of organised crime leading to an increase in illicit trade, including trafficking in drugs, weapons smuggling and people. All of these may have regional (or even global) health implications. The problem of failed or failing states may have traditionally been seen as a foreign policy problem, but the health implications at a national, regional and global level should not be underestimated.

⁶¹ Ministry of Defence, *Delivering Security in a Changing World: Defence White Paper*, Cmnd 6041-I (London: HMSO, 2003), p. 5.

⁶² Stefan Elbe for example has examined the impact of HIV/AIDS on stability. See his *Strategic Implications of HIV/AIDS*.

⁶³ US National Intelligence Council, *The Global Infectious Disease Threat*.

⁶⁴ See, for example, *ibid.* and R. Ostergard, 'Politics in the Hot Zone', p. 344.

⁶⁵ See, for example, P. Chalk, 'Infectious Disease and the Threat to National Security', p. 49; J. Lobe, 'Spread of AIDS Seen as a Security Threat'.

As an example to demonstrate the relationship between poor health and internal instability we use the results of the CIA's State Failure Task Force.⁶⁶ This study identifies three major variables in explaining state failure: (a) quality of life; (b) openness to trade; and (c) level of democracy. Health can contribute, directly and/or indirectly, to all of these. On quality of life, the study argues that the well-known linkage between infant mortality rates and the likelihood of conflict⁶⁷ is not a causal relationship; rather, high infant mortality rates indicate a poor quality of life, which in turn is a causal factor. In so doing the study appears to suggest that health is not itself directly a causal factor in state failure, but may be a contributory factor or indeed a reflection of imminent state failure. However, the study does not rigorously examine health in relation to the quality of life as a key variable. The second key variable, openness to trade, can also be affected by health conditions. The US National Intelligence Council for example estimated that infectious diseases would continue to disrupt trade and commerce on a regular basis throughout all regions of the world.⁶⁸ Examples of such disruptions include SARS, HIV/AIDS in South Africa, avian influenza in Asia, BSE and vCJD in the UK, plague in India, and cholera in Peru in the early 1990s. All of these threatened trade with and/or investment in states affected. Finally with regard to levels of democracy as a factor in state failure, the link with health is made explicitly in the 2002 US *National Security Strategy*. Here health is seen as part of the 'infrastructure of democracy'. The *Strategy* argues that health aid will only be effective if allied to good governance. The controversial implication of this is that health aid should be linked not to need – reflecting the humanitarian motives supposedly underpinning development aid – but to good governance and democratic reforms.⁶⁹ Health aid is therefore politicised in a manner which may disadvantage yet further those at greatest need. But as regards state stability, the assertion is clear: that democracy and good governance allow the effective transmission of aid, relieving health problems, but that corrupt or ineffective governance is wasteful of aid, leading to deteriorating health and increased social dissatisfaction.

The vicious cycle of poor health leading to conflict leading to worsened health may also be reversed. There is a growing body of work on how initiatives to improve health may be used to improve state stability, not least 'health as a bridge to peace' initiatives.⁷⁰ Examples include the work of WHO in Bosnia-Herzegovina⁷¹ and in the Maluku Islands in Indonesia.⁷² In Bosnia-Herzegovina there is anecdotal evidence that WHO and DfID programmes to rebuild the health system after the conflict

⁶⁶ D. C. Esty et al., 'State Failure Task Force Report: Phase II Findings', *Environmental Change and Security Project Report Issue 5* (1999), available at (<http://ecsp-si-edu/pdf/Report5-Sect2.pdf>), accessed 8 August 2002. Other studies of state failure exist which may similarly be used to demonstrate this link; our use of the CIA study is simply to demonstrate the potential links rather than to prioritise one set of findings over another.

⁶⁷ For example, US National Intelligence Council, *The Global Infectious Disease Threat*.

⁶⁸ US National Intelligence Council, *The Global Infectious Disease Threat*.

⁶⁹ *The National Security Strategy of the United States*, pp. 21–3 and especially p. 23.

⁷⁰ Department of Emergency and Humanitarian Action, *Conflict and Health*, Working Paper (Geneva: WHO, 2000). See also WHO, 'From Health Relief to Health Reconstruction: WHO Brief for Afghan Support Group Meeting, 5–7 December 2001', available at: (<http://www.reliefweb.int>), accessed on 5 August 2002.

⁷¹ WHO, *Peace through Health: Summary of WHO peace building experiences, principles and strategies in Bosnia and Herzegovina* (WHO/EUR/PAR, November 1999).

⁷² WHO, 'Peacebuilding through Health', *Health in Emergencies* (8), available at: (<http://www.reliefweb.int/w/Rwb.nsf/s/CF7700C552584AE2C12569CF0065A20A>), accessed on 5 August 2002.

assisted in overcoming separatist attitudes, reducing volatility and improving social cohesion. The negotiation of ceasefires to allow the delivery of humanitarian aid and immunisation programmes not only served as a respite from conflict, they acted as a confidence-building measure to allow negotiations for an end to the conflict.⁷³ On the other hand, WHO has recognised that health interventions which are based purely upon short-term considerations may have no effect upon peacebuilding, and may even prolong conflict.⁷⁴

Although the idea of health as a bridge to peace is widely associated with WHO, the role of health in conflict prevention has been picked up elsewhere. The Bush administration for example has implicitly identified health as a weapon in the fight against terror.⁷⁵ Improved health systems may be used as part of nation-building and to reinforce democratic principles; denying medical aid through sanctions may also put regimes under pressure, forcing change. However both the principles and practice of the Bush administration have been challenged. Health for nation-building has not been particularly evidenced by US policies in Afghanistan and Iraq, while the effectiveness and morality of such sanctions have been questioned.⁷⁶ Further, a number have argued that improving health care during a conflict may also be counter-productive on two grounds: it delays reaching the breaking point where one or both sides decide that they must sue for peace; and medical aid may be diverted from civilians to the military, allowing the latter to fight on.⁷⁷

Overall, the idea of health as a bridge for peace has attracted considerable attention. However, there is suspicion among some that it is 'ideology that is driving the movement at present'.⁷⁸ Critically, the evidentiary base appears slim and overly reliant on anecdotal evidence rather than rigorous and systematic empirical work.⁷⁹ Moreover, there has been little conceptual work done on key questions including: what works and why? What conditions are susceptible to such an approach? What level and form of health investment is required? When might it backfire and allow a conflict to continue? Can it be used to assist in ending conflicts, or just in post-conflict reconstruction? And can it be used to prevent conflict?

Health, globalisation and illicit activities

A second example of how the agenda might be broadened concerns illicit activities. A defining feature of globalisation is the increased flow of human social relations across territorially-based boundaries, notably the state. But alongside legal activities,

⁷³ A. Vass, 'Editorial: Peace through Health', *British Medical Journal*, 323, 3 November 2002, p. 1020; WHO Europe, *WHO/DFID Peace Through Health Programme: A Case Study Prepared by the WHO Field Team in Bosnia and Herzegovina* (Copenhagen: WHO, 1998); Graeme MacQueen and Joanna Santa Barbara, 'Peacebuilding through Health Initiatives', *British Medical Journal*, 321, 29 July 2000, pp. 293–6.

⁷⁴ A. Manenti, *Health as a Potential Contribution to Peace. Realities from the Field: What WHO has learned in the 1990s* (Geneva: WHO, 2001), p. 1. Available at (http://www.who.int/disasters/hbp/developing/HBP_WHO_learned_1990s.pdf), accessed 1 November 2004.

⁷⁵ *The National Security Strategy of the United States*, especially p. 23.

⁷⁶ R. Horton, 'Public Health: A Neglected Counterterrorist Measure', *The Lancet*, 358 (2001), pp. 1112. G. MacQueen, 'Iraq: Harm Reduction through Health', *The Lancet*, 360 (2002), p. 1031.

⁷⁷ For example, Vass, 'Editorial', p. 1020.

⁷⁸ Vass, 'Editorial', p. 1020.

⁷⁹ This point might be made more generally about the links between health and stability. Although there are good reasons to believe that such links might exist, the empirical evidence remains patchy.

Table 1. *The foreign policy and health implications of illicit activities.*

Illicit activity	Foreign policy implication	Health implication
Trafficking of illicit drugs	Revenues used to support organised criminal activity, terrorism	Increases and sustains widespread addiction to illicit drugs Increased morbidity and mortality from the use of illicit substances
Smuggling of people	Undermining of immigration policy Destabilisation of local community Financial burden on host country Lucrative source of earnings for organised crime	Health risks to undocumented migrants when being smuggled Increased risk of transmission of STDs from commercial sex workers
Smuggling of goods	Loss of revenue for national economy Revenues used to support organised criminal activity, terrorism	Increases supply of (e.g.) cheaper cigarettes Increases morbidity and mortality from tobacco-related diseases
Illegal weapons sales	Increased availability of weapons among terrorist organisations and civilian populations	Increased risk of injury or death from weapons

globalisation has entailed a wide range of illicit activities. Indeed the undermining of the state’s ability to control certain types of transborder flows, which circumvent state boundaries, has enabled such activities to flourish. By the mid-1990s organised crime was becoming a global network, with the groups involved closely linked by supply and demand chains beyond the reach of national authorities.⁸⁰ It is now estimated that organised crime generates US\$750 billion annually, much of it ‘washed’ by complex financial transactions into the global economy. At least three⁸¹ forms of illicit activity link health, foreign and security policy (see Table 1). First, the trafficking of illicit drugs has become a major challenge for both policy communities. Estimates of the total value of all sales of illicit psychoactive substances range from US\$180 bn to US\$300 bn. It is estimated that as much as US\$122 bn annually is spent in the US and Europe on the three most popular drugs – heroin, cocaine and cannabis. Of this, as much as US\$85 bn is laundered or invested in other enterprises,

⁸⁰ A good contemporary account is A. Nicaso and L. Lamothe, *Global Mafia: The New World Order of Organized Crime* (Toronto: Macmillan Canada, 1995).

⁸¹ Other forms of illicit activity with health implications are arms smuggling, illegal dumping of pollutants such as toxic substances, and the unregulated collection and use of biologicals including organs and blood products.

a sum larger than the GNP of three-quarters of the 207 economies in the world.⁸² This makes illicit drug trafficking one of the biggest commercial activities in the world and a major source of ill health. Importantly, globalisation has fuelled a restructuring and growth of the illicit drug trade since the 1960s when there occurred a surge in demand in the US and Western Europe. The drug trade has increasingly become a transnational phenomenon, benefiting from global communications, transportation and financial systems (to launder proceeds).

Second, there has been a growing illegal trade in the smuggling and trafficking of people since the end of the Cold War. Definitions of undocumented migration vary and reliable data is difficult to obtain. Yet it is now widely believed that smuggling and trafficking of people is worth an estimated US\$6 bn, making it more lucrative than the global trade in illicit weapons. The UN has estimated that four million men, women and children become victims of trafficking each year.⁸³ Some are captives taken as payment by mercenary armies. Some, especially young girls, are sold by their destitute families. Many are duped into slavery by fraudulent employment brokers who promise legitimate employment. In Europe, for example, there has been a significant increase since the mid-1990s in the trafficking of women from eastern Europe for forced prostitution. The trade is closely linked to organised criminal groups who are experienced at handling illicit drugs, weapons and other contraband.⁸⁴ In the US it has recently been estimated that 6 million out of a total 27 million foreign-born residents were believed to be 'illegal aliens', while Moscow is believed to have 400,000 undocumented foreign workers.⁸⁵ In the UK, high-profile cases of deaths of undocumented migrants hint at the degree of organised smuggling of migrants currently taking place across the English Channel.⁸⁶ The health implications of this growing trade arise from the risks to the health of the illegal migrants themselves, both during transit and at the point of destination where access to health care can be restricted. Illegal migrants may live in impoverished conditions, increasingly the risk of infections such as tuberculosis. They may engage voluntarily or otherwise in commercial sex work which increases the risk of contracting sexually-transmitted diseases. The neglected health needs of this population can, in turn, pose public health risks to the wider host community.⁸⁷

⁸² Paul Stares, *Global Habit: The Drug Problem in a Borderless World* (Washington, DC: Brookings Institution, 1996); and UN Office on Drugs and Crime, *Global Drugs Report 2000* (New York: United Nations, 2001). See also UN Office on Drugs and Crime, *Drugs and Crime Trends in Europe and Beyond*, 29 April 2004, available at: (http://www.unodc.org/pdf/factsheets/unodc_factsheet_eu_29-04-2004.pdf), *Global Illicit Drug Trends 2003* available at: (http://www.unodc.org/pdf/trends2003_www_E.pdf), both accessed on 13 April 2005.

⁸³ Interpol, *People Smuggling: Challenge and Response*, Interpol Fact Sheet (2004), available at (www.interpol.int).

⁸⁴ USAID, 'Women as Chattel: The Emerging Global Market in Trafficking', *Gender Matters Quarterly*, 1 February 1999.

⁸⁵ S. Camarota, *Immigration from Mexico: Assessing the Impact on the United States* (Washington, DC: Center for Immigration Studies, 2001); P. Stalker, *Workers without Frontiers: The Impact of Globalization on International Migration* (Boulder, CO: Lynne Rienner, 2000).

⁸⁶ Collin and Lee, *Globalisation and Public Health*.

⁸⁷ While the health risks arising from undocumented migration are real, the authors do not support policy proposals that target all migrants for testing, underpinned by threats of deportation or exclusion. Rather, such measures will discourage at risk populations from identifying themselves, putting the host population at further risk. See Collin and Lee, *Globalisation and Public Health* for a discussion of this issue.

Third, there has been an increase in the smuggling of contraband (including illegal weapons sales), some of which have direct health implications. Not the least of these is tobacco which causes an estimated 4.9 million deaths annually, a figure expected to rise to 10 m by 2030. The transborder problem of cigarette smuggling has become a major problem in the context of the globalisation of the tobacco industry, including a clear shift from traditional markets in North America and Western Europe to the developing world. Smuggling occurs when cigarettes manufactured legally are exported without domestic taxes, for sale abroad. These untaxed cigarettes are then illegally brought back into the producer country to be sold at a cheaper price on the black market. There is growing evidence that transnational tobacco companies are themselves implicated in smuggling operations, resulting in litigation and public investigations in the US, UK, Canada and elsewhere.⁸⁸ Smuggling enables tobacco companies to give international brands a local market presence and to undermine efforts by governments to raise cigarette taxes. It is estimated that one-third of the total number of cigarettes consumed worldwide are smuggled.⁸⁹ The scale of smuggling operations, the complex transborder networks of supply and distribution that exist, the central role of organised crime in such activities, the laundering of financial proceeds through the global financial system, and difficulties of national authorities in preventing such activities, make tobacco smuggling an issue that defies national boundaries.

The effective control of illicit activities such as these is in the shared interests of the health, foreign policy and security communities (see Table 1). The increased supply of illicit drugs,⁹⁰ greater availability of lower-priced (untaxed) cigarettes and alcohol, and public health risks to and from undocumented migrants have clear adverse impacts on health; the challenges of controlling illicit activities have been a long-standing source of foreign policy tensions; and the substantial funds earned from illicit activities have been found to support the activities of known terrorist organisations and organised criminal networks, creating serious security risks. So far such issues have remained outside emerging policy agendas, taxing the multiplicity of government ministries involved to work more closely together across sectors and internationally. Yet, with the continued acceleration of globalisation, it is likely that these issues will increase in significance.

As with health as a bridge to peace, the evidentiary base for understanding the impact of illicit activities on health, foreign policy and security remains slim. This is largely due to the difficulties of obtaining accurate and comprehensive data. Concerns about greater cooperation between the health and intelligence communities can also prevent the development of effective and appropriate policy measures, with medical professionals largely unwilling and unable to play a role in national security or law enforcement (for example, medical staff reporting of undocumented migrants seeking treatment). Nonetheless, there is growing research on health-related illicit

⁸⁸ F. Abrams, 'Tobacco firm may face inquiry over "smuggling"', *The Guardian*, 17 February 2000; and L. Joosens, *Tobacco Smuggling*, Tobacco Control Factsheets, International Union Against Cancer, 2002, available at (<http://factsheets.globalink.org/en/smuggling.html>).

⁸⁹ P. Jha and F. Chaloupka (eds.), *Tobacco Control in Developing Countries* (Oxford: Oxford University Press, 2000).

⁹⁰ This includes the illegal production and consumption of narcotics, the growing manufacture and distribution of counterfeit pharmaceuticals, and the poorly regulated use of legal drugs such as their sale on the black market. The latter two raise concerns about the undermining of therapeutic effectiveness of existing drugs, resulting for instance in the spread of drug-resistant infections.

activities based on interviews, survey data and documentary sources.⁹¹ More detailed research on what are the trends in illicit activities, what populations are at risk, and how the health and security communities can work more coherently to address shared needs, is urgently needed.

Conclusion

This article has examined the manner in which the public health community has begun to develop a relationship with the foreign and security policy communities. Its focus has been on the issues which have begun to appear on this new agenda, and it has made two key arguments. The first is that the agenda has been dominated by the concerns of foreign and security policy, not of global public health. The relationship between the two policy communities tends to be unidirectional, namely how selected health issues may create risks for (inter)national security or economic growth, and how therefore they might be issues of concern to foreign and security policy. The agenda is not one of how foreign and security policy can promote global public health.⁹² Australian Foreign Minister Alexander Downer's 2003 comment that global health could no longer be confined to health ministries, but must also be the concern of foreign ministries, implicitly suggests that what is driving this relationship are foreign policy concerns for protecting the national interest, not a concern for improving global public health.⁹³ Moreover the interests of the West are prominent on this agenda. Although this is not intended to dismiss humanitarian concerns in the West for health crises elsewhere, particularly HIV/AIDS, attention has generally focused on how health risks in the developing world might impact upon the West.

The second argument is that the agenda to date has been dominated by two issues: infectious diseases (including HIV/AIDS as a special case) and bio-terror. We argue that this is a narrow framing of the agenda and offer two examples of other issues which might be accorded greater attention. The first of these concerns the relationship between health and internal instability. Although this has received some limited attention it has failed to achieve particular prominence. This is despite continuing concerns in both the foreign and especially the security policy communities over internal instability, and the recognition in the public health community that internal instability is often detrimental to public health. The second, illicit activities, has received almost no attention despite very clear shared interests between public health and foreign and security policy on these issues.

This emerging relationship between public health, and foreign and security policy, however, raises a number of other questions beyond simply the manner in which the current agenda is framed. Although these wider questions are not the focus of this article, they are of broader concern to the issues raised here and it would therefore be

⁹¹ See for example Jeff Collin, Eric LeGresley, Ross MacKenzie, Sue Lawrence and Kelley Lee, 'Complicity in Contraband: British American Tobacco and Cigarette Smuggling in Asia', *Tobacco Control*, 2004, 13 (Supp. II): ii 104–ii 111; Joanna Busza, Sarah Castle and Aisse Diarra, 'Trafficking and health', *British Medical Journal*, 328 (2004), pp. 1369–71; and Guilhem Fabre and Michel Schiray, *Globalisation, Drugs and Criminalisation* (Paris: UNESCO, 2002).

⁹² The notable exception to this is the FCTC, though as noted above this proved an uphill task for the public health community. See Collin and Lee, *Globalisation and Public Health*.

⁹³ Downer, 'Why Health Matters in Foreign Policy'.

remiss not to identify them. In particular we would highlight two questions. The first concerns the agenda itself and, in particular, the lack of conceptual clarity over what WHO and others term 'global health security'. The growing awareness of links between the various interested sectors has led to a series of meetings in recent years, regionally and internationally, and from the G8 to more locally based initiatives. These meetings have in turn led to initiatives such as the Global Fund, Millennium Development Goals and FCTC. The existence of some common ground, however, has obscured more fundamental differences stemming from the lack of a shared conceptual understanding of health and security. In particular there is a lack of clarity over two questions crucial to the framing of a future agenda: whose health and whose security is at risk; and what issues should be part of the global health security agenda (and which are not).⁹⁴

Second, there remain unresolved questions over how the two sectors should cooperate and, indeed, whether such cooperation is in their mutual interest. Although some within the public health community have welcomed a closer relationship positively, in that it could give global health issues greater political prominence followed by more action and resources, others view this as problematic because of the skewing of the agenda. This emerging agenda leans inappropriately towards certain issues which, while important to the foreign and security policy communities, are not of highest priority for the public health agenda. Moreover, there are concerns over the role of medical personnel and other health professionals if this link is drawn more tightly. Specifically, could security or other political concerns impinge inappropriately upon the actions of health personnel? The tensions over reporting of undocumented migrants by health personnel is a good example. From the perspective of immigration policy or, given recent anti-terrorism concerns, security or law enforcement, health personnel may be required to report undocumented migrants. However, from a public health perspective, such actions not only politicise the role of health personnel, but are contrary to basic public health principles and good practice. Addressing these questions is beyond the scope of this article. Nevertheless, how they are answered is likely to have an effect upon which issues form part of the emerging agenda and which do not. This article suggests that this agenda so far is narrowly conceived, prioritising the foreign and security policies of Western countries. Without a broader understanding of the shared challenges facing the health, foreign policy and security communities, responses could ultimately be counter-productive to all concerned.

⁹⁴ We attempt to address these questions in Colin McInnes and Kelley Lee, 'Health and Security', *Politik* 8:1 (2005), pp. 33–45.