

D5 | HEALTH AND GLOBAL SECURITY: REASONS FOR CONCERN

While not overlooking the benefits that have resulted from linking health and global security (such as increased funding for certain health priorities and greater cooperation on some issues), this chapter, building upon the analysis advanced in *Global Health Watch 2*, raises serious concerns about how the relationship between global health and global security is construed and practised by powerful actors. Crucial to this effort is looking beyond the global health agenda itself, or simply defining health as ‘a security issue’, in order to view global health in terms of a three-way relationship between health, economics, and security. The central message here is that what counts as a ‘security issue’ – and who gets to define security – are matters of crucial importance.

Health, military spending, and the global financial crisis

At a time when vast resources have been committed to a rescue of the global financial system via a bailout of major banks in the global North, military budgets have continued to rise and steps towards achieving a nuclear-free world – although welcome – remain tentative, to say the least. As the Stockholm International Peace Research Institute (SIPRI) noted in its most recent report:

The financial crisis and economic recession that have affected most of the globe appeared to have little effect on levels of military expenditure, arms production or arms transfers. On the other hand, the crisis probably did undermine the willingness and ability of major governments and multilateral institutions to invest other, non-military resources to address the challenges and instabilities that threaten societies and individuals around the world.¹

Indeed, SIPRI found that, while in 2009 many smaller countries cut their defence budgets substantially, 65 per cent of countries for which data are available *increased* their budgets and that overall global military spending increased by 5.9 per cent.

How do these trends match with spending on international health and development? According to the Organisation for Economic Co-operation and Development (OECD), total net official development assistance (ODA) for health increased in 2009 by 0.7 per cent in real terms, or 6.8 per cent if debt relief – which spiked as a result of debt-forgiveness packages for Iraq and Nigeria – is excluded. Furthermore, while global military spending has

increased by around half since 2000, so, too, has ODA. It is necessary to take into account three key points.

The first is the vast difference in absolute magnitude as a measure of commitment to military security versus human security. While SIPRI estimates 2009 global military spending at \$1,531 billion,² total net ODA was just \$119.6 billion (7.8 per cent of military spending). This difference is even more pronounced when it comes to the United States, which makes frequent claims to global leadership in both security and health. The US defence budget grew by 63 per cent under the Bush administration and continues to grow under the Obama administration, by 7.7 per cent in 2008/09, with 2009 outlays for 'National Defence' estimated at \$661 billion.³ While US ODA has increased significantly in absolute and percentage terms, it still totalled only \$28.665 billion in 2009 (or 4.3 per cent of military spending).

The second is the relative vulnerability of military versus development spending as many countries seek to reduce overall public expenditure. As SIPRI noted:

Rising military spending for the USA, as the only superpower, and for other major or intermediate powers, such as Brazil, China, Russia and India, appears to represent a strategic choice in their long-term quest for global and regional influence; one that they may be loath to go without, even in hard economic times.⁴

While politicians in the global North are beginning to talk about the need to reduce military spending, there are also signs that global health financing is coming under increasing pressure as many countries reconsider their spending priorities.⁵

There is much to be learnt from a close observation of global trends in military, health, and development spending. While the idea that 'there can be no development without security, and no security without development' has become a popular mantra, it obscures the structural imbalance in spending between military security and global health and development.

Of course, while financial allocations give a clear indication of political priorities, there are problems with relying on a purely financial analysis. Foreign aid is far from being a panacea for global health problems, particularly when this masks – or serves to perpetuate – the operation of an inequitable global political economy and long-term capital outflow from the poorest regions. As a recent report by Global Financial Integrity estimates, illicit financial flows out of Africa in the period 1970–2008, a period covering the most recent phase of global economic integration, amounted to at least \$854 billion and perhaps as much as \$1.8 trillion.⁶ The extent to which foreign aid actually benefits the health of the poorest can also be called into question. Rather than calling for a straightforward switch from military spending to global health spending, then, it is more meaningful to ask how to foster the demilitarisation of global affairs *and* how to achieve a more health-equitable global economy.

Questioning 'global health security'

Global Health Watch 2 noted the efforts by WHO and the global North countries to promote the idea of 'global health security', understood as global cooperation in the detection of, and response to, public health emergencies (a term introduced by WHO in the revised International Health Regulations [IHRs] of 2005).⁷ However, efforts to promote such cooperation under the banner of security have run into serious problems, in part as a result of a failure to include equity in the definition of security.

Concern over emerging infectious diseases and bioterrorism has been growing since the early 1990s, particularly in light of globalisation. While these problems potentially affect all parts of the globe, concern is most strongly focused on those parts of the world that have already made the greatest progress in containing infectious disease threats, that is, the global North. WHO has accordingly made cooperation in this field the centrepiece of its work, developing the concept of 'global health security' from the late 1990s onwards. However, while it increasingly used the term 'security', WHO never secured a consensus on exactly what security means for a body committed to the equal representation of all UN member states.

This issue has become increasingly important. According to the IHRs, which came into force in 2007, member states are meant to cooperate on potential 'public health emergencies of international concern'. This umbrella term, in fact, conflates what are, in important respects, rather distinct phenomena, ranging from bioweapon attacks to 'naturally occurring' epidemics, potentially drawing WHO into the highly contested field of counter-terrorism. But while states are meant to develop detection and reporting mechanisms and to adhere to WHO-sponsored best practices, the IHRs have nothing to say about how the benefits of such cooperation should be shared, or how the obligations of the richer and the more powerful help the poorer and the less powerful.

In Chapter B8 we discuss how the issue of virus sharing in the context of influenza pandemic preparedness, raised first by the government of Indonesia in 2007, points to a fundamental inequity in global relations. We note in the chapter that: 'In the absence of reciprocal benefits, the International Health Regulations, for instance, which impose mandatory disease-reporting obligations on signatory member states, could reduce poorer front-line states to the role of pandemic "canaries" in an early warning system for emergent flu pandemics'.

It is important to highlight the broader implications for the concept and practice of global health security in terms of the global distribution of wealth, power, and resources for health. In particular, this (the virus sharing) episode shows the problems related to a concept of security that demands total transparency and cooperation on the part of all parties involved, but not equity and solidarity between them. It also shows how the political and economic issues of patenting and intellectual property rights lie behind efforts to develop global

health surveillance and security systems. It may be that diplomatic solutions can be found for the most pressing issues surrounding global health security. However, this entire episode has thrown further light on the problematic politics of security in a divided and unequal world. An adequate concept of security for global health must address the inequitable structure and unbalanced working of the global economic order as well as attempts to combat the effects of headline-grabbing viruses. Without this, the concept and practice of global health security will be more likely to divide the global community rather than bring it together.

Global health, foreign policy, and counter-insurgency

A third troubling development concerns increasing efforts to align the idea of health with a particular version of economic development, political organisation, and ultimately freedom, promoted by certain global North countries in general, and by the United States in particular.

The growing interest in global health as a security issue has been paralleled by a growing interest in using health programmes to achieve political objectives. Bodies such as the Commission on Macroeconomics and Health (which was tasked by WHO director general Gro Harlem Brundtland to investigate the relationship between economics and health) have claimed that health programmes can function in a virtuous relationship with economic growth and global security.⁸ Such arguments are being taken up enthusiastically by the US Department of Defense, which accounts for a growing share of US foreign aid spending.⁹

Of particular concern here are signs that health programmes are being pressed into service in support of specific political and military goals, namely the US war on terrorism and the occupation of Iraq and Afghanistan.¹⁰ For example, medical assistance provided by the US Marine Corps to local populations has been described as ‘one of its most effective weapons systems’ in ‘the ongoing effort to win the hearts and minds of Iraqis in Anbar province’.¹¹ Similarly, a review of the role of ‘medical diplomacy’ in stabilising Afghanistan notes that:

Medical interventions are an important component of a diplomatic strategy to regain moral authority for US actions, regain the trust of moderate Muslims, and deny terrorists and religious extremists unencumbered access to safe harbour in ungoverned spaces.¹²

The key rationale behind such initiatives is that medical aid can help in reaching out to populations that might otherwise be unsupportive of, or opposed to, the involvement of outside political and military forces. In sum, health programmes are being seen increasingly, in US foreign policy in particular, as a way to ‘win hearts and minds’ and to ‘drain the swamp’ of support for terrorism.¹³ In US military parlance, health initiatives are touted

as a key component of ‘stability operations’ in conflict and ‘pre-conflict’ zones.¹⁴ As such, they are becoming part of a broader turn towards counter-insurgency operations as an organising frame for military and security policy. Actors whose primary concern is health need to be aware of this trend and its implications.

This raises a number of potential problems. First, it has been widely observed that ‘humanitarian space’ has been shrinking over the last two decades. There are several reasons for this, mostly to do with the nature of post-Cold War conflicts and the collapse of state authority in many regions. But the efforts of external military actors to associate their interventions with humanitarian organisations and humanitarianism more generally have further politicised the role of health actors in conflict situations. While many NGOs have themselves sought to adopt overtly political roles in relation to political conflict and oppression, even a perceived association with military forces can have fatal consequences, as the killing of MSF (Médecins Sans Frontières) personnel in Afghanistan in 2004 showed. Second, the highlighting of health programmes in the context of ‘stability operations’ obscures the obligation to abide by humanitarian law when it comes to war and occupation. These are much broader than ‘reaching out’ to locals by offering vaccinations or running temporary clinics, and include the obligation to adhere to the discriminate, proportionate, and justifiable use of force. However, the most recent evidence from Afghanistan reveals a pervasive failure to do so in the case of US and coalition forces.¹⁵

Such developments take on wider significance when seen together with another trend. This is to emphasise the role of military forces, particularly the globally deployed US military, as ‘contributors’ to global health.¹⁶ To be sure, the US military does play a part in global infectious disease surveillance and has taken on a role in implementing the US president’s Emergency Plan for AIDS Relief. Military forces in other countries likewise may at times function as bellwethers of population health more generally. The idea that military forces are contributors to global health may also help to sensitise some policy-makers to the importance of health as a policy priority more generally. But this must be set against a more systematic appraisal of the relationship between militarism (as an ideology), militarisation (as a process of constant preparation for war), and military forces (as agents in their own right). At a minimum, the appraisal needs to take into account the significant societal resources devoted to the preparation for war; the effects of militarisation on the environment; and the effects of war on the environment, on social and economic infrastructure, and on the health of civilians and military forces.

The impact of migration control

A final concern has to do with the implications of the emerging global security infrastructures for the surveillance and control of human mobility

for health and human rights. In particular, there are concerns that these infrastructures extract a direct toll in terms of the deaths of people trying to migrate; generate large shadow populations without proper access to health services; and enforce social, economic, and political exclusion on a global scale.

It is now widely recognised that migration, driven in large part by the uneven development of the global economy, provides many benefits for migrants as well as for sending and receiving countries. But while migration is often supported on these grounds by economists, by business communities, and by sending countries, and while the right to asylum has been defended by many political actors, politicians in the global North countries have, for a variety of reasons, moved towards an increasingly restrictionist approach to human mobility, with exceptions made only for those deemed to be 'highly skilled'.

The global North countries have over the last two decades increasingly fortified their borders, while also seeking to exert increased surveillance and control over human mobility on a global scale (in part also justified with reference to counter-terrorism).^{17, 18} This, together with the dysfunctional state of the migration and asylum systems of many countries and the absence of a coherent global governance regime, has created a number of traps into which migrants and people seeking asylum have fallen, with a growing list of fatalities among those attempting to enter the United States and the EU by increasingly risky routes.^{19, 20} Human mobility itself has thus become a global security issue, in the sense that vast resources are being deployed in order to secure communities in the global North from unwanted people. The emergence of an increasingly sophisticated and powerful migration control regime along these lines reinforces a global order that remains in many respects inimical to human health and well-being.

Conclusions

This overview reveals serious problems in the relationship between global health and global security. Under a complacent belief that 'wealth buys health', the global community has failed to give health and health systems their due over decades of economic integration and structural adjustment inspired by neoliberal ideology. Indeed, the growing sense of a global health crisis articulated by social movements and security analysts during the 1990s is a marker of the extent to which neoliberalism, underpinned by global US military dominance, has failed to deliver equitable health, development, and security. The implications of financial and military overstretch – which were taken to new heights under the George W. Bush administration – have become glaringly obvious since the onset of the current global economic crisis.

In some ways, social movements for health are better placed than ever before to make the case for a new model of security that takes proper account of equity. But it is by no means certain that any rearrangement in the global balance of power will necessarily produce more health-equitable forms

of globalisation and security. The extent to which the current crisis offers an opportunity for a basic redesign of global health, security, and development remains to be seen.

Notes

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