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Discourses on the Securitisation of Public Health –
A Survey of Four Countries

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1. Introduction

While health and security were regarded as distinct political spheres only a decade ago, this can no longer be said to be true. Public health has to varying degrees been securitised in different national discourses and in multilateral discursive spaces such as the World Health Organisation (WHO) or the community of states parties to the Biological Weapons Convention (BWC). This has implications for both the provision of public health and the fight against deliberate disease in the form of biological warfare.

The first two papers in this series have been dealing with the securitisation of international public health and the securitisation of public health in the US, respectively.¹ Both of them utilized the concept of “securitization”, which was introduced into the security studies discourse during the 1990s by a group of scholars including Ole Waever and Barry Buzan – the so-called Copenhagen School.² The development of the concept has to be seen in the context of a more general trend to move beyond a focus on the nation state and on the provision or analysis of military security only³. In order to overcome the shortcomings of some competing approaches to broadening the concept of security, Waever and his colleagues proposed to concentrate on the specificity of security studies and reformulate the concept of security on that basis. Two operations are crucial in this context: speech acts (uttering security) and modalities (threat-defence sequences).⁴ The process of securitization is initiated through a

“speech act where a securitizing actor designates a threat to a specified referent object and declares an existential threat implying a right to use extraordinary means to fence it off. The issue is securitized – becomes a security issue, a part of what is security – if the relevant audience accepts this claim and thus grants the actor a right to violate rules that otherwise would bind.”⁵

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⁴ Waever, Securitization and Desecuritization, p.51.
⁵ Ole Weaver, ‘The EU as a sovereign actor. Reflections from a pessimistic constructivist on post-sovereign security orders’, in Morten Kelstrup and Michael Williams (Eds.), International Relations Theory and the
If a securitizing speech act is performed successfully – and, as will be shown in this paper, this is by no means always the case – the threat-defence sequence, which has been characterizing traditional thinking about security, has been successfully put into action for a new issue, one which was previously separate from the security discourse.

There are thus three elements to the securitization process: a securitizing actor, a referent object to be securitized, and an audience that accepts (or rejects) the securitizing move. Thus, by looking at speech acts the securitization concept allows to analyse and provides a link between both discursive interventions and policy measures beyond those that would normally be considered appropriate. Usually, such new policy measures would manifest themselves in shifting budgeting priorities, the creation of new bureaucratic units, or the re-formulation of mandates of existing bureaucratic structures.

In applying this framework, this series of papers analyses to which extent threats to public health through the deliberate spread of disease have become securitized. As detailed in the previous regime review paper, the emergence of the bioterrorist threat in the mid- to late-1990s in the US coincided with a reduced reliance on BW arms control in addressing the spectre of biological warfare. As a result, biodefence measures, with the concomitant securitization of public health have taken centre-stage in the effort to counter the newly identified existential threat of deliberate disease through bioterrorism.

This paper attempts to provide an overview of securitization moves and map the resulting changes in public health discourses and policies in four countries. These are the Australia, Germany, Canada, and South Africa. This selection aims at a wide geographical spread of the countries surveyed, taking into account country-related specifics. Clearly, the task of coping with the HIV/AIDS epidemic poses rather different challenges to the South African public health system as compared to that of for example Germany. It also includes countries operating in different international institutional contexts. While Canada and Germany are participating in the G-7 Global Health Security Initiative, Australia and South Africa are not.

The discussion of the discursive interventions in each of the four countries regarding public health in general and health security in particular will first of all draw on domestic discursive interventions on health and security, and its manifestation in health policies, organizational structures in and budgeting priorities for the public health sector. It will

secondly take into account the countries’ participation in the inter-review conference process of BWC states parties on the topic of “strengthening and broadening national and international institutional efforts and existing mechanisms for the surveillance, detection, diagnosis and combating of infectious diseases affecting humans, animals, and plants.” As the latter element of the public health discourse of the countries largely consisted of participation in an information exchange at an expert meeting and a meeting of BWC states parties in 2004, there is no need to provide an in depth analysis of this element of the international context of each state’s discursive interventions at this point. However, as the same cannot be said for the revision of the WHO’s international health regulations (IHR), this will be summarized in the remainder of this introductory section. Negotiations on the IHR took place largely in the context of regional groups, for which it is difficult to identify individual country positions, other than those of the most vocal countries.

As has been pointed out in the first paper of this series, the IHR of old became increasingly obsolete and out of touch with the public health realities of WHO member states first and foremost due to the wide-spread non-compliance of states parties with the reporting requirements under the IHR. Secondly, the large number of newly emerging and re-emerging infectious diseases, in particular the emergence of HIV/AIDS, showed the growing irrelevance of the limited number of diseases that had to be reported. The World Health Assembly (WHA), acknowledged this failure in 1995 and tasked the WHO with revising the IHR. In 2001 WHA resolution 54.14. “supported the ongoing revision, including criteria to define what constitutes a public health emergency of international concern”. The SARS outbreak in 2002/2003 clearly served as a catalyst in this regard and the discourse on the revision of the IHR gained momentum. Based on initial consultations with states parties the

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10 On the SARS outbreak see Institute of Medicine of the National Academies, Forum on Microbial Threats, Learning From SARS. Preparing for the Next Disease Outbreak, Washington, D.C.: The National Academies Press, 2004. Unless otherwise noted, the following account of the discourse on the revised IHR is based on a number of interviews with national delegates involved in this process. Interviews were conducted in Geneva during the week 5 - 9 December 2005.
WHO secretariat circulated a first draft of the revised IHR in early 2004.\textsuperscript{11} Extensive regional consultations were followed by three rounds of negotiations, which took place in Geneva between November 2004 and May 2005. The new regulations have been adopted by the WHA in May 2005.\textsuperscript{12}

Already the first draft IHR contained four major new elements which expanded the scope of the IHR considerably. These are: the requirement for states parties to “notify all events potentially constituting a public health emergency of international concern”; set up a national IHR focal point, and; implement “the minimum core surveillance and response capacities required at the national level in order to successfully implement the global health security, epidemic alert and response strategy.” In addition, the revised IHR were conceptualized as the legal framework for that strategy.\textsuperscript{13} Although a large part of the discourse on IHR revision was characterised by a consensus on the need to expand the scope of the regulations, just how far such an expansion should go, was contested among WHO states parties. Diverging views came to the fore in particular with respect to the question of IHR coverage of chemical, biological, radiological and nuclear (CBRN) weapons incidents. While some states parties – among them the USA – felt the IHR could also be utilised to gather information not otherwise obtainable on such incidents, states parties from the developing world – most notably from the South East Asian and Eastern Mediterranean regional groups under Iranian and Pakistani leadership – strongly rejected such an approach.\textsuperscript{14}

The evolution of the discourse on notification criteria contained in Annex 2 to the revised IHR is particularly instructive in this regard: the language provided by an Ad Hoc Expert Group report in February 2005 contained the “[r]elease in to the environment of a chemical or radionuclear agent that has contaminated or has the potential to contaminate a population and/or a large geographical area”\textsuperscript{15} as one of the criteria prompting notification to the WHO. In the final version of the IHR all references to chemical or radionuclear agents have been eliminated, because some delegations argued that their explicit mentioning would place too

\begin{itemize}
\item \textsuperscript{13} Ibid., pp.2f.
\item \textsuperscript{14} Interviews with delegates in Geneva, 7 and 8 December 2005.
\end{itemize}
much emphasis on CBW scenarios and thus risk going beyond WHO’s mandate. Instead, Annex 2 now lists the “[s]pread of toxic, infectious or otherwise hazardous material that may be occurring naturally or otherwise” as one of the criteria for notification.” In combination with references to “unexpected and unusual outbreaks of disease” in Annex 2 and the main body of the text, this wording was able to bridge the divide between those advocating a farther reaching securitization of the revised IHR, like the US, and those mostly concerned with limiting the degree of transparency that has to be provided under the IHR to information that is “commensurate with and restricted to public health risks,” like Pakistan.

2. Public Health Securitisation Discourses in Four Countries

2.1. Health and Security in Australia

Security-related aspects of public health policy in Australia received an initial increase in attention in relation to the emergency preparedness measures being conceptualized in the run-up to the 2000 Sydney Olympics. Further key events that triggered reviews and updating of the Australian health emergency policies were the 2001 terrorist attacks in New York and Washington, the anthrax attacks in the US, the Bali bombings in 2002, the SARS crisis in 2003, and the 2004/05 Tsunami in the Indian Ocean. Both in reaction to the Bali bombing and the Indian Ocean Tsunami, the Australian Department of Health and Ageing dispatched medical teams and supplies, and provided logistical support for the affected regions. In case of the Bali bombing this involved inter alia the evacuation of more than 110 injured patients and their treatment in Australian hospitals.

The aftermath of the Bali bombings also saw the addition of a new coordinating unit, which was established by the Australian Health Ministers’ Conference: the Australian Health Disaster Management Policy Committee (AHD-MPC), which was activated in the wake of

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16 Interview with delegate in Geneva, 8 December 2005.
the Tsunami in the Indian Ocean in December 2004 and which oversaw Australian policy responses to this disaster.\textsuperscript{22} In addition, a new National Emergency Medical Stockpile has been established.\textsuperscript{23} Not surprisingly, this emergency medical stockpile has attracted a substantial part of the Federal Budget allocated “to initiatives to strengthen national health security, preparedness and response capability in the event of a terrorist attack or a national health emergency in Australia.”\textsuperscript{24} For the 2004-05 federal budget AUS $15.3 million out of $40.2 were devoted to the medical stockpile. $10.1 million have been spent on improving the Australian disease surveillance system, $6.2 million to enhance diagnostic laboratory capacities of Australia’s public health system, and $4.4 million on limiting “access to radiological materials and to provide extra teams of specialist radiation analysts.”\textsuperscript{25}

Although a considerable amount of the above mentioned $15.3 million for the medical stockpile was spent on the procurement of a smallpox vaccine and thus a primarily bioterrorism-related expenditure, this figure is dwarfed by the investment in the protection of Australian citizens against a pandemic influenza or a bird flu outbreak. As outlined by the then Minister for Health and Ageing, Tony Abbott, the Australian government “will provide funding of $123.8 million in 2003-04 to purchase and stockpile effective antiviral medications that can treat and prevent influenza.”\textsuperscript{26}

Both these figures and the discursive interventions made by government representatives in relation to the public health risks that Australia is facing, point to weak attempts at securitizing public health. Although potential bioterrorist incidents are mentioned among these risks, they are usually embedded in the larger spectrum of risks, such as “the release of a chemical, biological or radiological agent, a bomb or other mass casualty disaster, or a communicable disease emergency, like SARS, Avian influenza, or a new pandemic influenza.”\textsuperscript{27} In line with this logic, the strengthening of the public health infrastructure addresses all these contingencies and – as briefly mentioned above – the funding pattern for

\textsuperscript{24} See ‘General Public Information’ op.cit.
\textsuperscript{25} Ibid.
\textsuperscript{27} See ‘Message from the Australian Government’s Chief Medical Officer’, op.cit.
“health security” reflects the dual-use character in the improvements that are being implemented.

In the larger context of terrorism preparedness, it is noteworthy that the “Australian counter terrorism responses are coordinated by the Protective Security Coordination Centre within the Attorney General’s Department.” The involvement of the Australian Defence Forces (ADF) is possible only upon a request by State or Territory governments which, according to the Defence Legislation Amendment (Aid to Civilian Authorities) Act 2000, requires the agreement among Prime Minister, Attorney-General, and Minister for Defence "that the State or territory cannot protect itself before they authorise the ADF to be called out." All this points to a decidedly subordinated role of the ADF in the protection against terrorist attacks in general and bioterrorist attacks in particular. With respect to the latter, ADF authorities on CBW terrorism have recognized that

“the move to religious terrorism increases the probability that future terrorist attacks will involve biological or chemical weapons. Improved technical skills and equipment make a bioterrorist attack both more probable and more likely, particularly if done on a small scale.”

This emphasis on small scale attacks is supported by another Australian military NBC authority, in whose opinion ‘biological threats had been used quite often in the past as “probably the bio-terrorism equivalent of the urban myth.”’ He cautions to base assessments and preparations for a bioterrorist incident on the 10 gramm scenario, not the one which assumes deployment of 100 kg of a biological warfare agent, which has been dominating much of US thinking about the bioterrorist threat. Assuming that this threat assessment is correct, it implies that the public health infrastructure is much more likely to be able to cope with such a smaller-scale bioterrorist incident, thereby reducing the need for ADF involvement, except in the most severe cases of BW use on Australian territory.

This brief survey shows that there are no indicators available which would suggest that the security aspects of disease outbreaks have taken over the reasoning that informs the provision of public health. Likewise, mass casualty terrorist attacks are not regarded as the

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29 Ibid.
32 Ibid.
number one security threat by the Australian military. Rather, the emergence of the bioterrorist threat is seen as one of many new challenges, one which has to be kept in perspective, and as such has not triggered the securitization of public health through discursive interventions on the domestic level.

This approach has also informed the Australian contributions to the BWC inter-review conference process. As mentioned above, this process has covered a number of issues, one of which has been the “strengthening and broadening national and international institutional efforts and existing mechanisms for the surveillance, detection, diagnosis and combating of infectious diseases affecting humans, animals, and plants” during the 2004 meetings of experts and of states parties. Australia contributed 10 working papers to these discussions, covering efforts at surveying and responding to threats to human, animal and plant health.

Underlying the Australian approach to addressing the country’s human disease surveillance and response systems, is the notion that “surveillance is fundamental to the prevention and control of all communicable diseases … [and] will deliver security benefits and public health benefits which, in turn, flow on to improved regional and international security.” Australia attempts to reduce the “intended high-impact and economic consequences … through early detection and response”, thereby also “reducing the BW threat.” Two disease surveillance networks form the backbone in this ‘deterrence by denial’ strategy: the communicable Diseases network Austrtalia (CDNA) and the already mentioned Public Health Laboratory Network (PHLN). While

“CDNA oversees the coordination of: national communicable disease surveillance, the response to communicable disease outbreaks of national importance; and field training of communicable disease epidemiologists, … PHLN is a collaborative group of

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33 Final Document of the Fifth BWC Review Conference, see note 6 above.
microbiologists from public health laboratories that provide the public health diagnostic capacity in States and Territories.”

Comparable federalist organisational principles are also identifiable in relation to legislation and response capabilities. In terms of the latter, the Australian government only “takes a lead role in outbreak investigations of national significance or when there are issues that relate to human quarantine.” As the working paper further outlined, there are eight human diseases that are subject to such controls. In such a scenario the Early Warning and Response Unit in the Department of Health and Ageing would coordinate the response to a disease outbreak. Indicators for a “hostile use of biological agents” are:

“(a) A single case of illness or death from potential bioweapons including *B. anthracis*, *Yersinia pestis*, *Francisella tularensis*, variola virus, viral hemorrhagic fever viruses, *Clostridium botulinum* toxin,
(b) A new disease unable to be diagnosed by laboratory tests,
(c) Unusual epidemiological characteristics or anomalies such as an unusual age group, location or exposure history,
(d) Several simultaneous epidemics in different locations or
(e) Serial epidemics of different diseases in the same population.”

In two other working papers the Australian delegation to the expert meeting of BWC states parties also explained its already mentioned integrated approach to disaster and emergency planning and management, in which the bioterrorist threat is taken seriously, without overshadowing other scenarios.

In addition to national efforts at disease surveillance and response, Australia attaches great importance to regional networking for the prevention or mitigation of disease outbreaks. Acknowledging that disease knows no borders, an Australian working paper on regional disease surveillance networks point out that surveillance has to be a real-time process in order to be most effective.

“requires a number of supporting systems including a network of high quality laboratories throughout the region with an expertise covering a wide range of infectious agents, and

37 Ibid., p.2.
38 Ibid., p.6.
39 These are: plague, rabies, cholera, yellow fever, viral hemorrhagic fever, smallpox, SARS, and highly pathogenic avian influenza.
40 Ibid., p.7.
political will with respect to support of the laboratories and the rapid release of data collected by the laboratories.”

However, reviewing a number of regional surveillance activities and networks, the working paper concludes that most, if not all of the established disease surveillance networks in the Asia Pacific region are lacking in their capacity to collect and diseminate real-time surveillance data. Greatest promise, from an Australian perspective, holds in this regard a potential Regional Outbreak Alert and Response Network (ROARN), whose establishment has been initiated by the Western Pacific Regional Office of the WHO. The Australian preferences for the WHO as the leading global actor in disease surveillance has been equally well articulated in yet another working paper submitted to the expert meeting of BWC states parties:

“In Australia’s view, WHO is the ideal organization to undertake global surveillance because of its role and responsibilities as the health arm within the United Nations family of international organizations, its responsibilities in compiling the International Health Regulations and is coordinating the review process. ... The wide-spread acceptance of the WHO is an essential requirement for global surveillance, as it is generally provided access on request and allows it to exercise a strong leadership role with respect to verification and control activities."

In this context Australia has placed great hope on the revision of the IHR, as these “would provide an fundamental tool to supporting the WHO’s disease surveillance activities.” Not only will the revised IHR increase transparency concerning diseases that could develop into health risks of international concern, but also serve as the foundation upon which to build improved national measures. As the community of BWC states parties as a set of actors is completely absent from these consideration, and also the deliberate use of disease in a bioterrorist scenario does not feature prominently, it is safe to say that also in the context of the expert meeting of the states parties to the BWC, Australia has not emerged as a proponent of the securitisation of international public health.

2.2. Health and Security in Canada

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43 Ibid, pp.1-3.
45 Ibid., p.3.
Primary responsibility within Canada for the provision of health services rests with the Department of Health (Health Canada) and the recently founded Public Health Agency of Canada. As part of providing a full range of health services, Health Canada also leads the Canadian government’s response to health emergencies and disasters. In this context the risks for which Health Canada seeks to be prepared are:

“Natural events and disasters such as outbreaks of disease, floods, earthquakes, fires and tornadoes.

Emergencies such as transportation accidents, large chemical spills, nuclear incidents, power outages and terrorist threats.”

The absence of an explicit mentioning of biological weapons or a bioterrorist threat that might pose a threat to public health in Canada – especially when contrasted with the clear references to nuclear and chemical incidents – is noteworthy. The low profile of the threat emanating from the deliberate release of a biological agent continues in other parts of the information which Health Canada is making publicly available. When discussing chemical, biological, radiological, nuclear and explosive (CBRNE) events, Health Canada spends some effort in outlining the department’s role in a radiological, nuclear or chemical emergency – in contrast to a biological emergency, which is not addressed at all in relation to the deliberate spread of disease by a terrorist organisation. In relation to Health Canada’s contribution to emergency preparedness, much more emphasis is being placed on preparedness for pandemic influenza – or a nuclear incident – than on a bioterrorist attack. As regards government responses to terrorism in general, this falls within the purview of the Department of Public Safety and Emergency Preparedness (see below).

The detailed planning for public health emergencies is the responsibility of the Public Health Agency of Canada (PHAC), more specifically its Centre for Emergency Preparedness and Response. This centre serves as “the health authority in the Government of Canada on bioterrorism”, and is subdivided into six offices, two of which deal with emergency preparedness and response, one which oversees laboratory security, and one which is in

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50 For an overview of the centre’s responsibilities and activities see http://www.phac-aspc.gc.ca/cepr-cmu/index.html
51 http://www.phac-aspc.gc.ca/about_apropos/index.html
charge of public health security. The latter of these offices is also home to the Counter-Terrorism Coordination and Health Information Networks (CTCHIN), whose mission is to

“raise awareness of, prepare for, coordinate with others and respond to current and emerging issues and threats related to chemical, biological, radiological and nuclear (CBRN) events. CTCHIN will provide early warning surveillance and be a resource of information on health related aspects of CBRN.”52

Part of these efforts are revolving around the Global Public Health Intelligence Network (GHPIN), which in its first incarnation was established in the late 1990s. It works similar to other internet search engines, only that it “continually scans more than 400 international sources for news of any outbreaks of 31 communicable diseases, as well as articles about natural disasters and drug-resistant pathogens.”53 These “hits” are subsequently processed and distributed to public health experts and organisations worldwide. In late 2004 an expanded version – GPHIN II – of the search engine was introduced:

“When GPHIN I provided service in English, GPHIN II is a more robust, adaptable system with multilingual capacity in Arabic, English, French, Russian, Simplified and Traditional Chinese, and Spanish. Users can review the documents in the language of their choice.”54

The Office of Laboratory Security in turn hosts three divisions one of which specifically deals with emergency and bioterrorism responses. It is tasked to

“develop polices, procedures and guidelines for biosafety emergencies, threat reduction initiatives and biological proliferation prevention programs
control and track the use of dangerous pathogens in Canada
monitor the accidental release of biological materials from certified and non-certified facilities and the instances of laboratory-acquired infections
effect the Emergency Response Assistance Plan (ERAP) for national transportation emergencies involving Risk Group 4 human pathogens
effect a national plan for 24/7 on-scene responses to suspicious packages and other bioterrorism events.”55

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52 ‘Counter-Terrorism Coordination and Health Information Network (CTCHIN)’, available at http://www.phac-aspc.gc.ca/cepr-cmiu/ophs-bssp/ctchin_e.html
In these efforts the PHAC’s Office of Laboratory Security cooperates with the Canadian Public Health Laboratory Network (CPHLN), which was organized in 2001 on an initiative of “provincial health laboratory directors who recognized a void in inter-provincial communication and in communication with their federal partner, Health Canada.”

Given the proximity of the establishment of the network to the anthrax mailings in the US in the fall of 2001, it is not surprising that one of the subcommittees which has been established since its inception is mandated to address the response to bioterrorism. One of the key achievements of this sub-committee has been the creation of “lab response capabilities for bioterrorism events to facilitate the early detection, prevention and intervention concerning such threats.”

As spelled out in the Canadian CBRN strategy, the department of Public Safety and Emergency Preparedness (PSEPC) is not only “responsible for coordinating the Government of Canada’s overall response to terrorist incidents, including CBRN incidents”, but also “has lead responsibility in implementing the Government of Canada’s National Security Policy.”

Within this CBRN strategy the Department of National Defence and its subsidiary organs, like for example Defence Research and Development Canada (DRDC), are “responsible for supporting domestic operations with CBRN military expertise, intelligence and scientific support.”

As another Canadian working paper submitted to the 2004 expert meeting of the BWC states parties – drafted by DRDC – explained, the “CBRN Research & Technology Initiative (CRTI) represents the Canadian commitment to providing science and technology (S&T) solutions for national security and CBRN preparedness.” This initiative again aims at increasing laboratory capacity for the early detection and identification of a CBRN event, of an intentional or national character. The innovative aspect of CRTI lies in the establishment of clusters of laboratories which transcends organisational boundaries, so as to overcome “the problems associated with a geographically dispersed population, transportation of samples, and the need for urgent access to federal expertise to support a local response.”

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57 Ibid., p.2.
59 Ibid., p.7.
60 Idem.
62 Ibid., p.1f.
Interestingly, the biological cluster’s activities have been related to supportive activities “in the investigation of the aerosol hazard from SARS in hospital environments” in 2003 and assistance following an outbreak of Avian influenza in 2004. This clearly points to the utility of such laboratory networks or clusters, and indeed their more likely use in “traditional” public health emergencies as compared to bioterrorist incidents.

The fact that much of the public health and emergency preparedness infrastructure is indeed dual use is acknowledged in yet another Canadian working paper submitted to the 2004 expert meeting of BWC states parties. According to this assessment, “the initial response would be the same in the event of either a natural or a suspected deliberate occurrence. In the event of a domestic outbreak, local health officials are the first line of both response and of investigation of causes.” Arguing from the position of being the world’s second largest country the Canadian contribution to the Inter-Review Conference process has also emphasized the need to bridge the “urban-rural divide” and to not lose sight of the fact that for many states the urban part of the population that needs public health services and also protection from the deliberate spread of disease is likely to be outweighed by the population living in rural areas. This, according to a Canadian working paper presents certain challenges, which in Canada’s case were overcome by establishing a health system that allows for swift communication of health related data both from the bottom up, i.e. from the local to the federal level, and vice versa.

In addition to these domestic activities to strengthen the Canadian public health system, the Canadian government also took the lead in establishing a regular exchange on health security issues in the G7 context. Beginning in 2001, the health ministers of the G7 plus Mexico – upon invitation of the Canadian government – have met annually to “take concerted actions to ensure the health and security of our citizens, and to enhance our respective capacities to deal with public health incidents.” The public statement of the initial meeting also made clear that the “objectives for the partnership [would be] within the framework of existing international agreements.” In that context Canada assumed a coordinating role and has been in charge of “establishing networks, linkages and collaboration

63 Ibid., p.2f.
67 Ibid., p.1.
agreed upon today.” Since then Canada’s activities in this so-called Global Health Security Initiative (GHSI) have included inter alia: the planning and coordination in September 2003 of “Exercise Global Mercury – a smallpox outbreak simulation exercise to evaluate health communications among our governments, in response to the fictitious discovery of an outbreak of smallpox.” Canada has also taken the lead in establishing the Global Health Security Laboratory Network, “which held a workshop on the transportation of infectious substances,” and on environmental sampling.

In sum, the observable securitisation moves both on the rhetorical and the implementation level are limited in number and scope. While the threat of bioterrorism is clearly acknowledged, it is usually placed in the context of naturally emerging or re-emerging diseases. Likewise, the “bio-threat” to public health is regularly subsumed in a more generic threat or risk assessment including chemical, radiological and nuclear incidents as well, for which emergency preparedness measures have to be drawn up and implemented. The organisational infrastructure for the provision of public health and emergency preparedness shows a similar pattern: as outlined above, only one of six offices of PHAC’s Centre for Emergency Preparedness and Response explicitly deals with public health security. And although the newly established public health surveillance capacities have been assigned bioterrorist response functions, their primary utilization so far seems to have been in the context of naturally occurring emerging or re-emerging diseases. Likewise, although the GHSI statements regularly invoke the increased bioterrorist threat, the actors involved in the network are firmly rooted in the realm of public health – not traditional security policy – and the measures taken and initiatives agreed upon serve clear public health purposes, most of which will admittedly be useful in a bioterrorist scenario as well. However, with the clear acknowledgement of existing institutional mandates and boundaries and the cooperative engagement with other international public health actors, like the WHO, the potential of the GHSI as a securitising actor appears to be rather limited.

2.3. Health and Security in Germany

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68 Ibid., p.2.
Lead agency of the federal government for the provision of public health in Germany is the Federal Ministry for Health (prior to the recent elections, Federal Ministry for Health and Social Security). The surveillance system in operation for the reporting of notifiable diseases follows the federal structure of the German state and relies on local and regional health authorities to feed data into “a distributed SQL database developed by the Robert Koch Institute (RKI).” This electronic surveillance system was established in 2001 and produced and processed already in its year of inception more than 4200 data sets. In 2002 “7700 outbreaks were reported through this system,” more than a third of which were Salmonella-related and none of which originated from a bioterrorist incident.

In addition to improving disease surveillance, the German government also started building up a smallpox vaccine stockpile, were initially 2 million doses of the vaccine were acquired immediately after the anthrax attacks in the US. By the end of 2004 the German Minister of Health reported not only that enough of the vaccine had been acquired to protect the whole German population, but also that Germany would make available 2 Million doses to the WHO in case of an emergency elsewhere.

With respect to the federal government’s response capabilities in case of a public health emergency, the creation of a new unit within the already mentioned Robert Koch Institute is noteworthy. The RKI is “the central federal institution responsible for disease control and prevention and is therefore the central federal reference institution for both applied and response-orientated research as well as for the Public Health Sector.” In reaction to the anthrax attacks in the USA the RKI’s Centre for Biological Safety (CBS) was founded in October 2001. According to the RKI’s webpage the Centre “is the central institution for issues of biological Safety. The centre’s tasks include, in close cooperation with the other departments of the Robert Koch Institute, the development of concepts for identifying attacks with biological agents using...”

73 Ibid.
75 See Bundesministerium für Gesundheit, Pressestelle, Ulla Schmidt: Gesundheitsvorsorge durch Pockenimpfstoff für die gesamte Bevölkerung in Deutschland gesichert - Deutschland stellt der WHO 2 Millionen Dosen Impfstoff zur Verfügung, available at http://www.bmg.bund.de/chn_041/nn_599776/DE/Presse/Pressemitteilungen/Archiv/Presse-BMGS-4-2003/PM-07-11-2003-4340,param=...html__nnn=true
epidemiological analyses and investigative epidemiology in addition to the diagnostics of relevant pathogens (prevention, identification and defence).”

The CBS has a workforce of 35 (out of 760 overall RKI staff), hosts the Federal Information Centre for Biological Safety (IBBS) and additionally engages in

“Diagnostics of infectious agents considered relevant for bioterrorist attacks;
Emerging microbial agents: diagnostics and pathogenesis;
Scenario modelling to prepare against bioterrorist attacks;
Coordination in Germany of national and international programs for biological security.”

This quote points to a somewhat confusing nomenclature in relation to the CBS: while in general the German term “biologische Sicherheit” in the context of the CBS seems to be translated into “biological safety”, only the organization chart uses the term “biological security” instead. In any case, the above mentioned international dimension of the CBS’ activities leads it to liaise with comparable institutions in neighbouring states, the newly established European Centre for Disease Prevention and Control (ECDC) in Stockholm, and in the context of the G7 (plus Mexico) Global Health Security Initiative (GHSI). With respect to the latter, one activity the German public health authorities have been engaged in relates again to the issue of smallpox vaccines. Here, the Paul-Ehrlich-Institute, which is located near Frankfurt and “has been playing a major role in controlling the safety and efficacy of biological drugs since they were first used in therapy and prophylaxis more than hundred years ago”, hosted a GHSI workshop on “Best Practice in Vaccine Production for Smallpox and Other Potential Pathogens”.

In addition to the above quoted working paper on a German electronic outbreak surveillance system, the German contribution to the 2004 expert meeting of the BWC inter-review

77 ‘Centre for Biological Safety’, available at http://www.rki.de/cln_006/nn_231526/EN/Content/Institute/DepartmentsUnits/CenterBioSafety/CenterBioSafety__node.html__nnn=true
79 According to the ECDC’s webpage, “the European Centre for Disease Prevention and Control is a new EU agency that has been created to help strengthen Europe’s defences against infectious diseases, such as influenza, SARS and HIV/AIDS.” See http://www.ecdc.eu.int/
conference process comprised another nine working papers plus a CD-ROM with related presentations and substantial background material. One of the papers on *Diagnostic Tools and Structures for Detecting Suspicious Outbreaks of Infectious Diseases* elaborated on the importance of microbial diagnostics for disease surveillance and pointed out that such diagnostics had “to rely on methods with high specificity and sensitivity to rule out false results and detect the concentration of the pathogen, if any is present.” Such reliable diagnostic results, the paper argued further, need to be obtained speedily, so as to “initiate a therapy, i.e. by vaccination, antibiotics, or neutralising agents.” Tests should also be robust, easy to handle and work in an automated environment. The paper also described a three-stage process implemented by the above mentioned Robert Koch-Institute, for the risk assessment of any sample in a microbial diagnostics context. Another German working paper expanded on these issues by examining *Rapid Procedures for the Detection of Biological Warfare Agents and Diagnosis of Related Disorders*. It argues that the “unambiguous identification of a biological warfare agent requires a combination of several results from different technical platforms” utilizing microbiological, immunological, and molecular genetic methods.

A practical example for *A Procedure for Differentiating Between the Intentional Release of Biological Warfare Agents and Natural Outbreaks of Disease* was provided in yet another German working paper with reference to a tularemia outbreak in Kosovo in 1999 and 2000. This case illustrates that “data and findings gathered by routine epidemiological and microbiological investigations often provide no definitive answer to this problem. For this reason a model with various criteria has been developed to calculate the likelihood … of the artificial genesis of a specific outbreak of disease.” The model incorporates socio-political, epidemiological and pathogen-related factors into its calculation of the likelihood of the intentional use of biological warfare agents. An analysis of the specific case of the tularemia epidemic in Kosovo which applied this model “indicates that a deliberate release of the

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83 Ibid., p.1

84 Ibid., p.2

85 Rapid Procedures for the Detection of Biological Warfare Agents and Diagnosis of Related Disorders. Submitted by Germany, document BWC/MSP/2004/MX/WP.4

86 Ibid., p.1


88 Ibid., p.1
causative agent of tularemia … as a biological warfare agent is doubtful.”

Related to this is the United Nations procedure for investigating the possible use of biological warfare agents. Here, the German delegation pointed out that the “guidelines and procedures described in Document A 44/561” of October 1989 constitutes the most recent and “best available to have been multilaterally agreed.” As scientific and technological progress might have rendered this document out of date, the German delegation convincingly argued that “it seems high time to update the lists of experts and laboratories as well as to assess the procedures and guidelines in the light of recent technological developments.”

With a view to other international activities the German delegation drew attention to several areas where Germany had contributed to mitigating the effects of diseases: apart from the already mentioned contribution of 2 million doses of smallpox vaccine, this includes inter alia the country’s support “of an EU-wide Communicable Diseases Network establishing an Early Warning and Response System (EWRS)” as well as its “contributing annually some 300 million euro through bilateral and multilateral channels to the international fight against HIV/AIDS.”

In sum, the observable health securitisation moves both in German health or security policy are limited in number and scope. This applies to both the rhetorical and the practical political level. While the threat of bioterrorism is clearly acknowledged, it is usually dealt with in either the context of terrorism as such or as a phenomenon that is both distinct and – with adequate effort invested – distinguishable from naturally emerging or re-emerging diseases. The above mentioned procedure for differentiating between intentional release of biological warfare agents and natural outbreaks of disease is a case in point. This assessment is further supported by the limited amount of new infrastructure that has been put in place to address the specific issue of health security. However, as outlined above, with respect to those few new units that have been established even the terminology used for their description is not entirely clear. While the majority of references to the Robert Koch Institute’s “CBS” refers to biological safety, only a few documents translate the German term “Sicherheit” into

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91 Ibid., p.3.

“security”. All this reflects the limited extent to which public health has been securitised in the German political and expert discourse.

2.4. Health and Security in South Africa

The South African public health system is operating under conditions that are quite different from those of the other three states discussed above. To start with, poverty (approx 50% of the population) and unemployment (approx. 38%) place an enormous burden on the public health system. According to a Department for International Development (UK) report “poverty is mainly rural, with 72 per cent of the poor living in rural areas. About 70 per cent of the rural population are poor.”

Following from this, a large segment of the population has to rely on the public health system, which is “under-resourced and over-used, while the mushrooming private sector … caters to middle- and high-income earners who tend to be members of a medical scheme (18% of the population).”

A further structural problem of the South African public health system is the brain drain of qualified medical and public health workers to more attractive workplaces abroad. This long standing problem has become so severe that both the Health Systems Trust (HST) – a public health NGO that “actively supports the development of comprehensive, effective, efficient and equitable national and district health systems” in South Africa – and the Public Health Association of South Africa (PHASA) have devoted time and effort to address the issue of human resource shortages in the public health sector. In case of PHASA this most recently took the form of a resolution during its third public health conference in May 2006 in which

“PHASA resolved to place on the agenda of the World Federation of Public Health Associations the issue of the developed countries poaching health care professionals from the developing countries, and place health as a human right back on the international agenda.”

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HST in turn elevated human resource problems in the public health sector to the key theme in its tenth annual report, the *South African Health Review 2005*. The South African government responded in August 2005 with a Human Resource Plan for Health to these challenges. According to the Minister of Health this plan

“should provide an overall framework that brings together various interventions that are currently underway to deal with the challenges around human resources. These interventions include:

- Bilateral and multilateral effort to manage international migration of health workers
- Integration of human resource planning in the building and revitalisation of health facilities
- Improvement of overall working conditions for health workers
- As well as the provision of rural and scarce skills allowances.”

Better staffing of the public health sector should also allow to address the substantive health challenges still posed by diseases like Malaria, Tuberculosis, and especially HIV/AIDS. Although in the case of Malaria and Tuberculosis case numbers have gone down somewhat they are still quite substantial: in 2004 some 13,260 cases of Malaria and over 48,000 cases of Tuberculosis were notified through the national disease surveillance system (see below). These figures are dwarfed, however, by the numbers involved in the HIV/AIDS epidemic in South Africa. According to one account “an estimated six million South Africans [out of a population of some 45 million are] expected to die from Aids-related diseases over the next 10 years.”

Given these figures “recent attempts to frame the global AIDS pandemic as a security issue” should not come as a surprise. Proponents of a stronger response to the disease might hope to gain increased government attention and funding for their cause if they couch the problem in terms of security. However, as Elbe points out, there are two dangers inherent in such an approach. First,

“the language of security … pushes responses to the disease away from civil society toward military and intelligence organizations with the power to override the civil liberties of persons living with HIV/AIDS. The security framework, moreover, brings into play a ‘threat-defense’ logic that could undermine international efforts to address

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the pandemic because it makes such efforts a function of narrow national interest rather than of altruism, because it allows states to prioritize AIDS funding for their elites and armed forces who play a crucial role in maintaining security, and because portraying the illness as an overwhelming "threat" works against ongoing efforts to normalize social perceptions regarding HIV/AIDS."\(^{103}\)

It is noteworthy that such a securitisation process would not involve a threat-defense sequence based on terrorism with biological weapons as a new existential security threat which requires the drafting of public health to fend off this new threat – as has been happening in the United States.\(^{104}\) As a matter of fact the absence of references to a potential bioterrorist threat in the domestic South African discourse on public health threats is quite remarkable: a search in the official documents and information material made available on the South African Department of Health’s webpage for both the terms bioterrorism and health security produced practically no results.

During the 2004 experts meeting of the BWC inter-review conference process South Africa introduced five working papers, one of which outlined the above mentioned the country’s *Human Disease Surveillance* system in some more detail.\(^{105}\) According to the paper, the notification system covers 45 notifiable medical conditions, all of which except two are infectious.\(^{106}\) In addition to a description of the notification process, the paper also addressed the limitations of the system, such as “the perceived lack of incentive for medical practitioners to notify or the high turnover of health officers involved in data collection and processing.”\(^{107}\) In another paper on *International Co-Operation for Disease Surveillance*, South Africa pointed out that some BWC states parties “experience challenges in establishing and maintaining effective disease surveillance, analysis and response systems.”\(^{108}\) Tackling these shortcomings in some national systems should utilize cooperative measures on both regional and global levels. With respect to the former, “regional groupings of countries could develop regional surveillance programs, possibly laying the foundation for regional response mechanisms.”\(^{109}\) On the global level BWC states parties are called upon the WHO in its efforts related to *inter alia* “improving health and epidemiological services in individual

103 Ibid., p.119.
104 See the previous Briefing Paper in this series.
106 Ibid., p.1.
107 Ibid., p.4.
109 Idem.
countries, with a specific allocation for disease surveillance and reporting activities.”\textsuperscript{110} All these proposals appear to be built on the conviction that “most unusual disease outbreaks will occur due to natural evolution resulting in micro-organisms with novel pathogenicities, and to the changing human demographics allowing known infectious agents to develop into epidemic or pandemic threats”\textsuperscript{111} – again, there is neither much evidence for a concern about bioterrorist threats lying at the heart of South African calls for improved disease surveillance, not are attempts identifiable to securitise public health on the international level.

3. Summary and Conclusions
The survey undertaken in this paper sought to establish the degree to which public health has been securitised in the four countries whose public health systems have been discussed. Although it is fair to say that on a general level, in none of the four countries had the spectre of a bioterrorist threat led to a successful drafting of public health to fight a bioterrorist incident, in all national discourses the changed international environment is acknowledged to some degree. Not surprisingly then, on a more detailed level results of the survey of the securitisation of public health discourse and policy vary among the four states, with Australia and Canada showing more signs of securitisation moves being undertaken than Germany and certainly more than South Africa.

As outlined above, the updating of Australian health emergency policies was informed by a number of international events, such as the 2001 Anthrax attacks in the US, the Bali bombings in 2002, and the SARS crisis in 2003. These events triggered a number of organisational, policy and budgetary responses in order to strengthen health security capabilities that could be utilized both in case of a terrorist attack or other health emergencies. Yet, with a view to the terrorist threat, neither mass casualty attacks not those involving biological agents are regarded as the most serious threat to Australian security. This approach is also reflected in the Australian thinking about international public health, were the WHO – not the community of BWC states parties – is the key discursive space to address disease surveillance questions. An attempt to have WHO’s mandate broadened so as to move towards more biological weapons related activities could not be observed in the Australian contributions to the BWC inter-review conference process.

In the Canadian public health system responsibilities for dealing with bioterrorist incidents are clearly allocated to the Centre for Emergency Preparedness and Response in

\textsuperscript{110} Ibid., p.3.
\textsuperscript{111} Idem.
PHAC, while the department of Public Safety and Emergency Preparedness is in charge of coordinating the government’s overall response to terrorist incidents. While these civilian agencies provide therefore the discursive space on the domestic level to speak “health security”, in practical terms the discursive interventions surveyed here indicate that more emphasis is placed on preparedness for a pandemic influenza than a bioterrorist incident. With respect to international public health the two most notable Canadian initiatives are the Global Public Health Intelligence Network (GPHIN) and the Global Health Security Initiative (GHSI). Although the names of both of them might suggest some degree of securitisation of public health involved, in case of GPHIN this is completely absent, and in case of GHSI it is largely restricted to the rhetorical level. Practical measures, as outlined for both Canada and Germany are confined to classical public health measures. In addition, GHSI as a whole recognises and respects the institutional mandates of other actors involved in international public health, most notably the WHO.

Like other governments, the German authorities have responded to the changed international public health environment by creating new organisational units in its already existing bureaucracy – for example in the form of the Centre for Biological Safety, at the RKI – and by stockpiling large quantities of vaccines against smallpox. Overall the German approach to increased disease surveillance and improved public health in general seems to be characterized by a heavy reliance on scientific and technolgical expertise. In addition, the work on improving procedures for distinguishing between unusual, but natural outbreaks of disease and the deliberate release of disease causing biological agents seems to indicate an approach which places emphasis on keeping the universe of actual bioterrorist incidents as clearly delineated and, following from this, as small as possible. In the absence of an international organisation overseeing the implementation of the BWC, which might also be atasked to investigate suspicious outbreaks of disease, the German delegation at the 2004 BWC experts meeting sought to resurrect the United Nations procedure for such incidents which was agreed upon some 15 years ago. Making this procedure somewhat more robust and dependable might in turn reduce incentives to task the WHO to investigate such outbreaks in a way that might compromise its impartiality.

For the South African public health system infectious disease – in the form of Malaria, Tuberculosis and most notably HIV/AIDS – represents a much more salient problem than for any of the other three countries addressed in this paper. Efforts to securitise public health as a result of changed threat perceptions based on a newly emerging bioterrorist threat are practically absent in the South African public health discourse. As briefly alluded to, the
HIV/AIDS epidemic might also lend itself to the securitisation of the public health system. Although this has not been the focus of this paper, from the discursive interventions surveyed, it would appear that such securitisation moves have not been undertaken in the South African context. The same applies to the South African discursive interventions regarding international public health.

In sum then, this survey of the discursive interventions on public health and health security points to a considerably lower degree of securitisation of public health policies in the four countries covered in this paper than that which was observable in relation to the USA.\textsuperscript{112} Although a survey based on four countries does not lend itself easily to generalizations, it would appear that given the findings of this paper and also in light of the WHO’s reluctance to be drawn into the verification of non-compliance with the BWC\textsuperscript{113}, there is only a very slight possibility that those advocating the securitisation of international public health based on the newly identified threat of bioterrorism will succeed in their endeavours. Similarly, based on the many acknowledgements that the WHO, and not the community of BWC states parties is the appropriate discursive space for addressing global public health issues, the BW control regime runs little risk of being absorbed by public health concerns. This would, at least in theory, allow BWC states parties to return to the more substantial issues involved in strengthening the BWC at the upcoming 6\textsuperscript{th} Review Conference of the BWC in November/December 2006.

\textsuperscript{112} See the previous briefing paper in this series.

\textsuperscript{113} See the first briefing paper in this series.