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HEALTH, POLITICS AND SECURITY*

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Abstract: This article explores the links between health, security and politics, with the objective of providing the groundwork for a political analysis of health in the discipline of International Relations. It makes two arguments. Firstly, it argues that health can be seen as form of politics; secondly, it suggests that security provides a good lens to analyse the political work of health. The article makes the case for seeing health as more than a medical condition and/or a set of technical solutions. Rather, health should be approached as a set of perceptions, understandings and practices that mobilize forms of power and are constitutive of social relations and the political realm. The article shows that the health-security nexus, and particularly its two articulations securitization of health and medicalization of security, constitutes a good indicator of how health is constitutive of politics at the international level.

Keywords: health, security, medicalization, medicine, power.

This article explores the links between health, security and politics, with the objective of providing the groundwork for a political analysis of health in the discipline of International Relations. It makes two arguments. Firstly, it argues that health should be approached as a political phenomenon, insofar as it helps to constitute the political realm. Secondly, the chapter suggests that a security perspective can be useful in the analysis of the political dimensions of health.

Section I proposes an approach to health as a form of politics, that is, as an assemblage of perceptions, understandings and social practices that have an impact upon the ways in which power is exercised and political communities are organized. Going beyond merely medical or technical definitions, the section illustrates the constitutive effects of health on two instances: the connection between social

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medicine and government; and the effects of health and disease upon social relations. Section II argues that a fruitful way to understand current articulations of the politics of health is through the prism of security. The argument highlights the growing prominence of the health-security nexus in political discourse and practice, and shows how it has been articulated. Specifically, it reflects about the political assumptions and implications of two articulations of the health-security nexus – the securitization of health and the medicalization of security.

I – THE POLITICS OF HEALTH

The complex interconnectivity of contemporary societies – with the increasing circulation of people and goods and the increasing interdependence of national economies – has made health a truly global phenomenon. This means not only that health problems are affected by global dynamics, but also that health policies are assuming a markedly global character.¹ From the ‘health of all peoples’ (in the Constitution of the World Health Organization) to ‘international health’ and then to ‘global health,’ there is a growing recognition that issues such as public health should be dealt with at the global level. Despite on-going debates about its exact meaning,² the notion of ‘global health’ has been widely adopted at the institutional level.³ Health is increasingly a matter of diplomacy, foreign policy and international politics.⁴

These developments make it increasingly important to understand the political dimensions of health. The discipline of International Relations has only just begun to consider health issues in detail. Whilst it has convincingly highlighted that health is an *international* political phenomenon, it is yet to explore the ways in which health is an international *political* phenomenon. This article aims to provide the groundwork for a political analysis of health in the discipline of International Relations.

At first glance, it seems obvious that health is political. After all, responses to health problems depend upon political decisions regarding the allocation of appropriate resources. According to this view, ‘health’ comprises a set of issues (such as infectious diseases or chronic conditions) and the institutions and policies aimed at resolving or preventing these issues. The present argument takes a different approach. Rather than analysing the impact of health issues as medical problems demanding technical solutions, this chapter suggests that the political

¹ For an introduction, see Geoffrey B. Cockerham and William C. Cockerham, 2010. Analytical contributions were provided by David Woodward *et al.*, 2001; Maud M.T.E. Huynen, Pim Martens, and Henk B.M. Hilderink 2005.

² See, for example, Koplan *et al.*, 2009; Bozorgmehr, 2010.

³ See, for example, the report United Kingdom Department of Health, 2007.

⁴ This has been discussed, for example, in McInnes and Lee, 2006; Davies, 2010; Labonté and Gagnon, 2010.

effects of health run at a deeper level. Drawing on insights from Sociology and Anthropology that have not been sufficiently considered by the discipline of International Relations,⁵ it is possible to see health, not merely as a set of given problems and solutions, but also as an assemblage of perceptions, understandings and practices through which problems and solutions are defined in certain ways. Health is a social and politically-constituted phenomenon: the definition of health problems draws on specific, socially-located assumptions about what constitutes an illness and a healthy body; at the same time, ideas about health are reproduced (or challenged) through practice. Health is thus something more than a purely technical or medical arena that can be isolated from the political sphere.

The politics of health is visible, not only in the ways in which health is ‘made’ politically, but also in what health ‘does’, that is, its impact upon the political sphere. Health and disease give rise to interventions that are also concerned with political organization and with categories such as identity, community and sovereignty. In order to fully explain what is at stake here, the politics of health can be illustrated by looking at two examples: first, the connection between social medicine and the rise of governmental power; second, the reconfiguration of social relations by medical practice. These examples allow us to begin to unpack the political dimensions of health.

SOCIAL MEDICINE AND GOVERNMENT

The development of modern medicine constitutes a good example of how the management of matters of health and disease assumed the form of a wider mechanism of regulation of the political sphere – in other words, a form of politics. For Michel Foucault, the natural consequence of conceiving health as something more than a medical condition is that the practice of medicine needs to be seen as going beyond the clinical relationship between doctor and patient. Rather, medicine should be considered as social insofar as it is concerned, not just with individual bodies, but with ‘the social body’ more generally (Foucault, 2000a: 136). Foucault sees the development of modern medicine as an important part of the process through which the state gradually became ‘governmentalized.’⁶ This process, which began in the fifteenth and sixteenth centuries, corresponds to the transition of the state from an instrument of sovereign power to a large-scale system of administration. This transition resulted from the weakening of feudal ties and the

⁵ For an introduction to the sociology of health, see Barry and Yuill, 2012; Bradby 2012. Useful volumes on the anthropology of health are Helman 2007; Good *et al.*, 2010.

⁶ On the connection between medicine and the governmentalization of the state, see Nadesan 2008: 93-137.

waning of the unitary spiritual power of the Church. The question of individual conduct could no longer be seen as regulated by the traditional networks of personal dependence and reciprocal obligation, and thus emerged as a matter of concern for the state.

The governmentalization of the state consisted of a shift in the means and aims of power. In what concerns the former, government signals a transition from sovereign coercion (direct or indirect) towards the management of conduct. Rather than being personalized in the figure of the sovereign and having the localized extraction of life and wealth as its privileged *modus operandi* (executions, collection of taxes), power became a network of relations between multiple nodes. These nodes – schools, hospitals, prisons, armies – interacted both intensively and extensively in the management of actions and dispositions, at both the individual and population level. Specifically, they defined the sphere of possibility and necessity for people's acts, behaviours, tastes and desires.

In what concerns the aims of power, government signals a shift from the exclusive concern with the protection and survival of the sovereign towards the optimization of the natural features and capacities of individuals and populations.⁷ In Nikolas Rose's words,

authorities came to understand the task of ruling politically as requiring them to act upon the details of the conduct of the individuals and populations who were their subjects, individually and collectively, in order to increase their good order, their security, their tranquility, their prosperity, health and happiness (Rose, 1999: 6).

This was done not exclusively out of a concern with the welfare of individuals and populations *per se*, but because this welfare – as well as the promotion of a sphere of consent and individual freedom – served the purposes of an efficient economic and political organization. As Barry Hindess has argued, “the long term objectives of government are best pursued through the free decisions of individuals” (1996: 125). The aims of government should not, therefore, be seen as motivated by the mere increase of the wealth and influence of the sovereign. Rather, the political rationality underlying governmental power was fundamentally liberal, and thus aimed at the maximization of economic usefulness in a society. Power as government aimed at the constitution of the conditions in which the capacities of individuals and the

⁷ For a detailed discussion of this transition, see Foucault 1990 [1976]: 135-159.

dynamics of populations could be fostered, so that life could become economically useful. This is a power that does not aim at constraining or repressing, but rather at maximizing the capacities of individuals and the natural dynamics of populations on the basis of this extensive knowledge. In other words, governmental power consists of a systematically defined regulation that aims at providing the conditions in which natural regulations can unfold.

It is in the context of this governmental rationality incorporating earlier disciplinary mechanisms that one can understand the development of a social medicine concerned with public health, with health education and with the prevention of disease – as opposed to doctors seeking to cure individual illnesses.⁸ In fact, social medicine can be seen as assuming different facets of the governmental rationality. To begin with, it corresponded to the broadening of the sphere of influence of the state and to the deployment of a series of new tools of intervention. This modality was particularly visible in Germany from the seventeenth and eighteenth century onwards: here, state medicine drew on the emergence of a *Staatswissenschaft*, a ‘science of the state’ through which the latter was understood as a multifaceted system of administration, collecting knowledge in order to adequately manage populations. The development of state medicine was, in Germany, connected to the deployment of a medical police, which for Foucault consisted of a series of elements: the systematic observation of healthy and unhealthy populations; the establishment of uniform parameters of medical practice and knowledge; an administrative organization for overseeing medical practice; and the creation of the figure of the ‘medical officer,’ appointed by the government, who took responsibility for a particular region.⁹ In a nutshell, the German model of medical police and state medicine demonstrate that the phenomena of public health and the monitoring and management of disease were important elements through which governmental power asserted itself.

Another modality of social medicine can be witnessed in the idea of urban medicine. Here, health and disease as political experiences provided the rationale underlying the reordering of urban space. In Thomas Osborne’s words, the government of health was tied to “a positive art of governing the city” (Osborne, 1996: 111). As Foucault observed in the case of France, medicine was not simply worried with observing and managing the dynamics of individuals and populations; rather, it assumed the task of managing “the living conditions of the existential milieu” (Foucault, 2000a: 150). There were different factors leading to this. To begin with,

⁸ For an historical overview of public health, Rosen 1993 [1958].

⁹ See the discussion in Foucault, 2000a: 140-41.

the prevailing assumptions at the time about the causes and conditions for the spread of disease emphasized the dangerous effects of enclosed spaces, narrow streets in which the air could not circulate (thus leading to the presence of miasmas), buildings without running water, the inexistence or inefficiency of sewage and waste disposal mechanisms. From the eighteenth century onwards, this preoccupation with public hygiene and sanitation was coupled with an anxiety about increasing urbanization. In Foucault's words, these urban fears included

a fear of the workshops and factories being constructed, the crowding together of population, the excessive height of the buildings, the urban epidemics, the rumors that invaded the city; a fear of the sinks and pits on which were constructed houses that threatened to collapse at any moment. (*ibidem*: 144)

Overall, then, urban medicine arose out of challenges posed by diseases and by the environment in which these were allowed to spread. However, this was not merely a matter of responding to a medical problem with a set of technical instruments. It is true that the 'solutions' put forward by urban planners and medical authorities were, at first glance, very technical – they included partitioning different areas of the city, opening wide streets and boulevards in which the air could be renovated, demolishing old buildings deemed insalubrious, constructing underground networks of sewers through which residual waters could be effectively drained. Nonetheless, it is important to note that the rise, within the urban space, of health as a domain of intervention corresponded to the reinforcement of a wider political concern with problems of 'circulation' – specifically, the proper circulation of people and goods so that capacities could reach an optimum level and risks could be minimized.¹⁰ The connection between medicine and urban planning constituted an instance of the governmentalization of understandings and practices of power. As McKinlay has put it, '[t]he city became a laboratory in which power and knowledge were not simply exercised but rethought, applied and re-evaluated.' (McKinlay, 2009: 181).

HEALTH AND SOCIAL RELATIONS

Another example of the politics of health can be taken from the sphere of social relations. At first glance, the idea that health and disease have a social impact seems very obvious; after all, throughout history diseases have often led to social turmoil

¹⁰ See, in this respect, Michel Foucault, 2007: 18.

and to transformations in customs. However, the argument here presented looks at the deeper, and often more surreptitious, constitutive effects of health – as an assemblage of perceptions, understandings and practices – upon the social realm. These impacts will be analysed here at three levels: the constitution of subjects, family relations and poverty.

To begin with, the politics of health should be seen as mobilizing power in the production of subjects. The idea that power is productive of subjects can be traced back to Foucault's early works on the disciplinary apparatuses of the modern era, in which he discussed "the myriad of bodies which are constituted as peripheral *subjects* as a result of the effects of power." (Foucault, 1994 [1976]: 36 - emphasis in the original): Foucault's concern with power at its extremities did not amount to defining the individual as being in opposition to power – as a pre-given reality that is constrained in the free development of its capacities. He wrote:

[t]he individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the vis-à-vis of power; it is, I believe, one of its prime effects. (*ibidem*: 36)

In sum, for Foucault power should be seen as productive or constitutive of subjects: it "categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him." (Foucault, 2000b [1982]: 331).

More than seeing power as a force of constraint, prohibition or repression, one must seek to "discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts" (Foucault, 1994: 35). Power is an intrinsic part of these instances of constitution.

Deborah Lupton has showed how health can be seen as a political mechanism for the construction of subjectivities. She analysed the politics of public health from the perspective of a Foucault-inspired notion of productive power. For her, public health is a form of power not in by constraining or determining the actions of individuals, but rather in the ways in which its discourses and practices "invite individuals voluntarily to conform to their objectives, to discipline themselves, to turn

the gaze upon themselves in the interests of their health” (Lupton, 1995: 11). Public health is not just the set of policies put forward by government bodies or medical authorities; rather, it informs into a wide range of organizations and institutions and seeps deeply into the consumer culture, the mass media, the family or the education system. As a social phenomenon, public health – as an ideal and a set of injunctions – thus aims at “constructing and normalizing a certain kind of subject; a subject who is autonomous, directed at self-improvement, self-regulated, desirous of self-knowledge, a subject who is seeking happiness and healthiness.”(*ibidem*). In sum, for Lupton the politics of health is visible in the way in which it constructs a figure of the desirable healthy subject, and thus interpellates individuals to voluntarily adjust their behaviours, habits and lifestyles in order to achieve that ideal – by following an exercise regime, by eating certain kinds of food, by buying certain kind of products.

The social-political impact of health can also be witnessed at the level of the family. As Foucault has noted, one of the consequences of the development of a social medicine concerned with matters of public health was the ‘medicalization’ of the family. The family assumed the responsibility, not only of providing care to its members, but also of being proactive in matters of health, by adopting certain practices (such as, for example, hygiene) which were aimed at warding off the multiple health risks that emerged with industrialization and urbanization. This had an impact upon traditional relationships between parents and children. In Foucault’s words,

[t]he family is no longer to be just a system of relations inscribed in a social status, a kinship system, a mechanism for the transmission of property; it is to become a dense, saturated, permanent, continuous physical environment that envelops, maintains, and develops the child’s body (Foucault, 2000c: 96).

The family became an important nodal point in what could be termed the socialization of individuals through health. As it was accorded a significant responsibility in shaping individuals’ behaviour in line with the injunctions of a healthy life, it became politicized. Specifically, it provided the necessary transmission belt for the politics of health – which, as was seen, is intrinsically connected to the development of a governmental power – to reach the lives of individuals and mark their socialization processes. The family was assigned ‘a linking role between general objectives regarding the good health of the social body and individuals’ desire or need for care’ (*ibidem*: 98)

Sarah Nettleton has provided an illustration of the impact of social medicine upon social and family relations. She discussed the evolution of the discipline and practice of dentistry, and argued that this evolution corresponded to the constitution of a social space in which forms of power were mobilized and practices were reproduced. For her,

dentistry did not merely involve the treatment of diseased mouths, but rather it was a system that monitored mouths, bodies, people and social relationships. Education was part of a process which enabled the dental regime to become continuous and integrated by ensuring that everyone oversees their own mouths (Nettleton, 1992: 95)

An important feature of the development of this ‘dental regime’ was, for Nettleton, the reconceptualization of the domestic space and of family relations. She argues, for example, that the concern with dental disease and a new awareness of the necessity of regular dental hygiene – as a necessary step to the health and wellbeing of the body – placed a new emphasis on domestic diligence, and particularly on the figure of the ‘caring mother.’¹¹

A final example of the social-political work of health can be seen at the level of the social place of the poor. As Foucault observed, one of the dimensions of the development of social medicine in England in the nineteenth century was the growth of a ‘labour force medicine,’ coming out of a growing concern with poverty as a danger to public health.¹² The connection between poverty and disease should not be considered a nineteenth century phenomenon. As Brian Pullan has shown in the context of the outbreaks of pestilence in the Italian cities from the fifteenth century onwards, in situations of epidemic the poor were often considered a health hazard to wealthier classes, and thus regarded with a mixture of fear and pity (Pullan, 1992). However, the political project of a social medicine directed towards the poor and the working classes was qualitatively different in that it mobilized these perceptions in a reconfiguration of the social place of these sections of the population. The definition of poor people and workers as objects of medical practices further enhanced the reach of governmental power and allowed for the extension of mechanisms of control. In Foucault’s view, this medicine “consisted mainly in a control of the health and the bodies of the needy classes, to make them more fit for labour and less dangerous to the wealthy classes.”(Foucault, 2000a: 155). The institution of a state-

¹¹ See the discussion in Nettleton, 1992: 56-63.

¹² See the discussion in Foucault, 2000a: 151-56.

funded welfare medicine, through which the poor were given the possibility of receiving free or low-cost medical care, was part of a broader move towards the creation of “an officially sanctioned sanitary cordon between the rich and the poor,” which included, for example, the parallel expansion of private medicine for those who could afford it (*ibidem*: 153).

In sum, this part of the argument has showed how the politics of health impacts at the social level. By looking at three examples – the construction of desirable subjects, the redefinition of family relations and the social place of the poor – it further demonstrated the main argument of this section: namely, that health should be approach as an assemblage of perceptions, understandings and practices that mobilize forms of power and are important components of the political process. Overall, this section has used the lens of a Foucaultian analytics of power to suggest that health is more than a medical condition or policy; rather, health plays a deeper role in the constitution of the political realm.

II – HEALTH AND SECURITY

Security has been one of the predominant lenses for considering health issues in the international arena (McInnes and Lee, 2012). From the 1980s onwards, the traditional view of security as the absence of military confrontation between nation-states was challenged by the growing awareness of other sectors (such as the economic or the environmental) and other referent objects (such as individuals or societies). These developments provided the context in which it was possible to speak of health as a threat to security. After the end of the Cold War, with the vacuum created by the diminishing relevance of the confrontation between the two superpowers, the security literature began to address the phenomenon of the so-called ‘new threats.’ Among these, the literature displayed an increasing concern with the possible impact of the spread of infectious diseases upon security, particularly upon the stability of the state and the preparedness of its armed forces (Garrett, 1996; Price-Smith, 2001; Peterson, 2002; Heymann, 2003). At the same time, with the emergence of the idea of human security, the impact of health issues upon the security of individuals and groups began to be recognized.¹³ Health came to be seen as an issue of security.¹⁴ The popularity of the notion of health security was further boosted by its use in reports of organizations like the WHO (2007).

¹³ The concept of human security was introduced in United Nations Development Programme (1994), “New Dimensions of Human Security: Human Development Report 1994”. On the connection between health and human security, see Chen and Narasimhan, 2003.

¹⁴ Some contributions to the ‘health security’ literature are McInnes and Lee, 2006; Elbe, 2010b; Lo Yuk-ping and Thomas, 2010.

There are strong reasons to argue that the health-security nexus is now a crucial feature of the discussion about health as an international issue. The idea that health is seen, or should be seen, as a security threat (be it to states, individuals or groups) has marked the way in which this issue is understood by academics and policy-makers. Considering in more detail the linkages between health and security can thus provide further insights into the analysis of the politics of health. The remainder of this section will address two articulations of the health-security nexus – the securitization of health and the medicalization of security – and assess the extent to which they allow us to understand the political dimensions of health. These two articulations refer to broad dynamics. Whilst these are by no means univocal or global, they point to important tendencies in the way in which this nexus has been conceived and put into practice.

THE SECURITIZATION OF HEALTH

In recent years, the concept of securitization has become very popular in the academic literature of Security Studies.¹⁵ For theorists working with the notion of securitization, security is not an objective reality – that is, an absence of threats – but rather the result of a speech act through which an issue is portrayed and framed as a threat. In the original formulation of this theory, the securitization of a problem results from the interaction between a securitizing actor, who mobilizes a security vocabulary, and an audience, who accepts such a move. More recently, securitization theorists have explored the interactions, bureaucratic procedures and institutional dynamics through which issues come to assume the status of threat. An example is Jef Huysmans' investigation of how securitization occurs not only through speech acts but also through the articulation of political acts and bureaucratic processes (Huysmans, 2006). Huysmans argues that the construction of security occurs in a field of forces in which actors and understandings interact. This sociology of security opens the way for a consideration of the political and institutional contexts in which securitizing actors are empowered, as well as for an investigation of the power struggles between professional agencies and political actors.¹⁶

The securitization perspective has been applied to the case of health. The case of infectious diseases, particularly HIV/AIDS, have been a fertile ground for scholars analysing the moves and processes through which political actors attempt to raise

¹⁵ The key texts of securitization theory are Wæver, 1995; Buzan, Wæver, and de Wilde, 1998.

¹⁶ In this respect, the work of Didier Bigo has also been influential. See, for example, Bigo, 2002; Bigo *et al.*, 2008.

health issues, from the usual remit of ‘low politics’ to the status of threats.¹⁷ These studies have explored how certain actors have portrayed health problems as threats to security in order to raise awareness and justify particular policies. They have shown how securitizing moves have been undertaken with different intentions and rationales. For example, portraying health as a threat to national security allows for traditional procedures and legal requirements to be circumvented or reinterpreted by the political authorities of the nation-state in question – a good example being the invocation of the higher interests of the state by countries such as India in order to bypass international patent laws and thus develop affordable anti-retroviral treatments. In addition to this, civil society actors and advocacy groups can securitize health from a human security perspective, thus seeking to attract more resources and alter political priorities, so that health issues can be adequately addressed. Finally, health can be securitized from an international security perspective. In this case, the threat that is invoked is that issues such as epidemic diseases can lead to social unrest, regional instability and international conflict. This securitizing move might, for example, be invoked with the objective of justifying tough policies towards the citizens of neighbouring countries – such as border restrictions or ‘crack-downs’ on immigration.

The connection between the securitization of health issues with such ‘rule-bending’ or ‘game-changing’ measures is not accidental. According to securitization theory, portraying an issue as a threat to security carries with it a certain logic, that is, a particular script of how politics should be organized. Specifically, securitization theory has focused on the existential and the exceptional. According to this view, a problem becomes a security issue by being portrayed as a threat to the very existence of a given referent (a state, for example); as a result, exceptional measures to counter this problem are needed. Security, therefore, “is the move that takes politics beyond the established rules of the game and frames the issue either as a kind of politics or as above politics.” (Buzan *et al.*, 1998: 23). In sum, by calling for a transformation of political procedure, the securitization of an issue introduces a different kind of politics predicated upon expediency, secrecy, and fast and unchecked measures.

In addition to this interpretation of security as a kind of ‘ultra-politics,’ securitization theory has also focused on the more surreptitious effects of security upon the political realm. Here, the focus is placed not on securitizing moves emphasizing emergency or exception, but rather the often mundane practices

¹⁷ See, for example, Davies, 2008; Elbe, 2009; McInnes and Rushton, 2010; Rushton, 2010.

through which threats are constructed or emerge – such as bureaucratic acts of categorization, or the placing of immigration, crime and the spread of disease along the same continuum. As Didier Bigo has argued, the political effects of security “are so embedded in these routines that they are never discussed and presented as exceptions, but on the contrary as the continuation of routines and logics of freedom” (Bigo, 2007: 128). This suggests a different *modus operandi* for security. The withdrawal of issues from the sphere of public deliberation is undertaken not by ‘elevating’ these issues to the status of emergencies, but by ‘lowering’ them to the status of routines. The political effects are therefore more insidious and harder to scrutinize. Jef Huysmans and Alessandra Buonfino have elaborated on these two logics of securitization. Exploring the security framing of immigration and asylum, they differentiated the ‘politics of exception’ from the ‘politics of unease’ (Huysmans & Buonfino, 2008: 767) Whilst the former corresponds to the classical understanding of securitization as ultra-politicization, the latter is predicated upon

the construction of a continuum of threats and unease. Instead of dramatic speech acts articulating existential threats and thereby legitimating calls for exceptional politics, security practice consists of knitting various discourses of unease and danger into a patchwork of insecurities that facilitate the political exchange of fears and beliefs and the transfer of security practice from one policy area to another. (*ibidem*: 782)

Based on this interpretation of securitization as implying shifts in political procedure, the political impacts of linking security and health can begin to be dissected. One of the most important themes has been the way in which the securitization of health – by invoking an existential threat against which emergency measures are needed – reinforces claims to national interest and legitimizes egoistic and non-cooperative behaviour on the part of states. As Colin McInnes and Kelley Lee (2006: 22) have noted, tying together the realms of health and security has often lead, not to the mobilization of political will and resources for dealing with health problems, but rather to the predominance of state interests; in their words, “the agenda has been dominated by the concerns of foreign and security policy, not of global public health.”. A similar point has been made by Stefan Elbe (2010a: 484): in relation to the case of influenza H5N1 (avian flu). Elbe observed that the securitized international response to this virus was detrimental to international cooperation. More precisely, it entangled virus-sharing mechanisms (essential for the purposes of vaccine development) in “a wider set of non-technical and non-medical disputes,”

deriving from the fear, expressed by some states, that the demands of more powerful players would result in a loss of sovereignty and affect their ability to access affordable medicines. Elbe concludes that the securitization of infectious diseases can “structure global health debates in ways that are not conducive to achieving higher levels of international health cooperation.” (*ibidem*).

In fact, for some authors, the securitization of health issues has reflected and reinforced underlying power inequalities in the international sphere. This is one of the main arguments provided by McInnes and Lee (2006: 22), for whom the health-security nexus in contemporary world politics has been skewed in favour of the interests of states in the West. They argue that the importance given to two health issues in particular – infectious diseases and bio-terrorism – reflects a predominantly Western agenda, and results in attention being focused “on how health risks in the developing world might impact upon the West”, in detriment of arguably more serious problems for the populations of developing countries, such as diarrhoea. Sara Davies goes in the same direction and complements this idea. She argues that the securitization of infectious diseases in the international sphere has resulted in health cooperation mechanisms that seek to address the spread of disease to Western states, rather than preventing their outbreak in the developing world. She highlights the complicity of the World Health Organization in the development of mechanisms of disease surveillance and containment that prioritize “the protection of Western states from disease contagion.” (Davies, 2008: 295).

Another problem with the securitization of health issues has recently been highlighted: the fact that it contributes to silencing certain voices and further marginalizing certain groups – thus reproducing inequalities and dynamics of exclusion. In fact, Lene Hansen (2000) argued that this is one of the problems of the logic of securitization, which tends to privilege (and further empower) the voices of elites, whilst silencing those that are unable to make successful claims to insecurity. The field of health offers many examples of how the framing of disease through the prism of security and fear leads to the stigmatization of vulnerable groups – the historical linkages between disease outbreaks and attitudes to immigrants is one of them. A more recent example is HIV/AIDS. As Hakan Seckinelgin, Joseph Bigirumwami and Jill Morris (2010) have observed in relation to the case of HIV/AIDS in Burundi, portraying this condition as a security threat has at least two detrimental effects. On the one hand, it fails to address the fact that certain groups, namely women, are particularly vulnerable to HIV/AIDS – not only to infection but also to its economic and social impact. On the other hand, securitization may lead to the creation of new vulnerabilities: they argue, for example, that the connection between

HIV/AIDS and security has resulted in a logic in which “the main body of a society – and, within that, women – are considered generic threats to security.” (*ibidem*: 532). Identifying women as threats can thus lead to additional violence, particularly in post-conflict situations. As a result, the authors argue for HIV/AIDS to be dislodged from the security logic and for attention to be paid to broader structural vulnerabilities.

In sum, the health-security nexus, when substantiated in the securitization of health, can be seen as a set of understandings and practices that have impacts upon the political procedure and the political realm more generally. In particular, the securitization of health leads to issues being seen either as existential threats requiring exceptional measures or as requiring technical/bureaucratic procedures that fall below the radar of democratic scrutiny. In both cases, the health-security nexus is constitutive of the political realm: it brings with it a series of assumptions regarding the exercise of political power and the organization of political communities, and it shapes political practice accordingly. The argument will now analyse another articulation of the health-security nexus: the medicalization of security.

THE MEDICALIZATION OF SECURITY

The concept of ‘medicalization’ has been an important feature of the sociology of health since at least the 1970s. According to the medicalization thesis, the development of medicine as a profession has been accompanied by the expansion of the medical jurisdiction over social problems and of medical power more generally.¹⁸ This power can be witnessed in the ways in which the medical profession wields expert knowledge with the objective of shaping behaviour and achieving more social influence and command over resources. Underlying many of the formulations of this thesis there is an assumption that medicalization is a form of social control; in other words, that the power exercised by the medical profession is fundamentally constraining or repressive, manifesting itself in mechanisms of surveillance, enticement, and more or less subtle coercion.

This view of medicalization has been questioned in light of Foucault’s understanding of power. For Lupton, it is simplistic to assume that doctors are figures of domination, or that medical power is an extraneous imposition upon individual bodies and societies. She calls for a more nuanced view:

¹⁸ For examples of this thesis, see Turner, 1987; Conrad, 1992.

[i]n their efforts to denounce medicine and to represent doctors as oppressive forces, orthodox critics tend to display little recognition of the ways that it may contribute to good health, the relief of pain and the recovery from illness, or the value that many people understandably place on these outcomes. They also fail to acknowledge the ambivalent nature of the feelings and opinions that many people have in relation to medicine, or the ways that patients willingly participate in medical dominance and may indeed seek ‘medicalisation’... Rather than there being a struggle for power between the dominant party (doctors) and the less powerful party (patients), there is collusion between the two to reproduce medical dominance (Lupton, 1997: 98).

Lupton’s view of medicalization is in line with the analysis of the politics of health provided earlier in this paper: health consists of a series of perceptions, understandings and practices which are not only superimposed upon the social and political realm, but also constitutive of it. In this sense, the term medicalization can be applied to two interrelated phenomena. Firstly, it refers to the process through which medically-defined conceptions of the ‘healthy body’ are embedded within notions about desirable social relations, and the ways in which these substantiate themselves into practices (be they practices of health promotion or self-directed practices) and have political effects. Secondly, medicalization refers also to the process through which social and political problems are understood as medical problems, and thus requiring medical solutions. In both of these situations, the question is not one of criticizing medicalization because it is ‘bad’ or ‘harmful’ to personal autonomy. Rather, the point is to trace the deep effects (including the tensions and dangers) of the mobilization of medical knowledge in the definition of social problems and solutions – and thus of the political realm.

Stefan Elbe has provided such an analysis of the medicalization of security. His starting point is a reversal of the question usually asked when dealing with the health-security nexus. Instead of enquiring into the effects of a security vocabulary and rationality upon health policies, he explores the ways in which ideas of health and health security debates “also begin subtly to reshape our understandings of security and insecurity in international relations.” (Elbe, 2010b: 14). This complements an assessment of the assumptions and implications of the securitization of health, and provides another perspective on the constitutive role of the politics of health.

For Elbe, one can observe the growth of a logic of medicalization in international politics. This means that the influence of medicalization can now be seen to go

beyond the redefinition of social problems and deviant behaviour. Rather, for him, “the principal effect of the recent rise of health security is to infuse the logic of medicalization much more deeply into the domains of national and international politics, and indeed into the practice of security.”(*ibidem*: 186) Elbe distinguishes three dimensions to the medicalization of security: insecurity is increasingly seen as a medical problem caused by the outbreak of disease; this leads to a greater role for medical professionals in international affairs; finally, security problems defined in a medical sense call for interventions with a broad social and political reach.¹⁹

Overall, then, the medicalization of security is leading to important shifts in what regards the role of the state and the nature of foreign and security policies. It results in “the linking of proper statehood to a range of public health activities” – including the control of infectious diseases, the management of biological threats and the containment of ‘time-bombs’ such as obesity, smoking and alcoholism (*ibidem*: 175). By assuming a markedly epidemiological dimension, political power becomes further governmentalized, insofar as the tendency to manage the conduct of individuals and populations with a view of maximizing their health and economic utility is reinforced. This tendency results in a whole range of new medical interventions, both at the domestic and the international levels: policies of surveillance of healthy and unhealthy populations; the triage of individuals according to risk factors; processes of containment and exclusion of ‘risky individuals’; the establishment of patterns of normality and deviance, with the resulting stigmatizing effects. In sum, both within Western states and beyond, the health-security nexus is changing notions of proper statehood and turning foreign and security policies into “a technology for intensifying the medical control of populations”(*ibidem*: 185).

Some of the practical implications of this medicalization of security for foreign and security policies have begun to be scrutinized. Scholars have noted, for instance, the rise of a ‘therapeutic’ approach to governance, which is intrinsically tied to the ‘pathologisation’ of populations and societies, as these are portrayed as helpless, traumatized and in need of outside guidance. This approach has been attacked for being disempowering of local populations, and for serving to legitimize the perpetuation of external interference. Vanessa Pupavac has used the case of international intervention in Bosnia to analyse the development of an international therapeutic paradigm, which seeks to resolve social and political problems by addressing the psycho-social issues faced by ‘traumatized populations’ (Pupavac, 2004, 2002). For Pupavac, the result is a pathologisation of war-affected populations

¹⁹ See the discussion of these dimensions in Elbe, 2010b: 23-29.

that in fact disempowers them by establishing relationships of dependency. At the same time, the focus on the psycho-social dimension elides underlying material and structural problems affecting war-torn societies.²⁰ As a result, the discourse of pathologisation, in addition to legitimizing the maintenance of intervention, ends up reproducing the very conditions that made it necessary in the first place (Hughes and Pupavac, 2005).

To sum up: the medicalization of security constitutes another articulation of the health-security nexus at the international level. In conjunction with the securitization of health, it provides an indication of how concerns with health and disease can be seen as having a constitutive impact upon world politics. Not only they play an important role in the reconfiguration of the domestic sphere – by altering normal political procedure and by partaking in broader shifts regarding the conceptualization of the purposes of the state – but they also have very concrete effects upon the nature and character of foreign and security policies. Overall, then, this section suggests that the health-security nexus provides a useful perspective into the political work of health.

CONCLUSION

This article put forward two main arguments: firstly, that health can be seen as form of politics; secondly, that security provides a good lens to analyse the political work of health. It made the case for seeing health as something more than a medical condition and/or a set of technical solutions. Rather, health should be approached as a set of perceptions, understandings and practices that mobilize forms of power and are constitutive of social relations and the political realm. The article showed that the health-security nexus, and particularly its two articulations securitization of health and medicalization of security, constitutes a good indicator of how health is constitutive of politics at the international level: by changing political procedure, by altering foreign and security policy priorities, or by challenging existing notions of statehood and intervention.

Admittedly, the paper has painted a rather gloomy picture of the workings of the health-security nexus. It highlighted the dangerous effects of securitization by showing how it has traditionally entailed the bypassing of democratic decision-making and public scrutiny; it pointed out the tendency of medicalization to lead to the encroachment of management and government in the lives of individuals and societies. This should not be interpreted as implying that securitization and

²⁰ Moreover, as Augustine Park (2009) has noted, therapeutic interventions can also contribute to reproducing structures of gendered vulnerability.

medicalization are necessarily ‘bad.’ In fact, one can argue that they have had important benefits. The securitization of HIV/AIDS – even though one can argue to what extent it was entirely successful²¹ – did manage to attract political attention and resources, which in turn resulted in some good to those affected by the disease. At the same time, medicalization raises important points about the need to tackle acute and chronic health problems, and has contributed to a growing awareness of the need for healthier lifestyles.

Overall, then, this paper does not dispute that ‘more health’ (to be free from ailments) and ‘more security’ (to be free from threats to physical and personal integrity) are good things. It has, however, highlighted some of the tensions and dangers surrounding both ‘health’ and ‘security’ when they are understood as forms of politics. The paper has engaged with some of the dangers of the concept of health by highlighting some of its political assumptions and implications. This does not mean that the concept should be discarded or that health policies should be called off, but rather that one needs to have a more cautious and reflective stance when studying the connection between health and politics, at both the domestic and international level.

In fact, if the premises of this paper are taken to their logical conclusion, there are many reasons for sticking with the concepts of health and security. Given the important role of health concerns and policies in the configuration of relations between individuals, societies and political power, and given that security can provide a useful entry-point when assessing the political work of health, then the health-security nexus has the potential to provide alternative understandings and to inform alternative practices. Given that, as has been shown, both concepts are to a great extent social constructs, then it is possible to reconsider health and security and to link these concepts in a way that minimizes the dangers of existing formulations – whilst informing policies that can address the real health problems that are faced by people everywhere around the world.

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²¹ See, in this respect, the discussion in McInnes and Rushton, 2010.

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