I. INTRODUCTION

Based on commissioned papers, seminars, and workshops (in Tokyo, Cairo, and Geneva), we have drawn the following conclusions about health and human security.

First, “human security” means different things to different people, and conversations about connecting health to the concept can be quite confusing. Clarity can be advanced by linking human security to concrete challenges, like specific aspects of world health.

Second, health can add value to our understanding of human security because good health and human survival are ultimate goals of any human security agenda. Thus, health and mortality indicators can help map the magnitude, distribution, and time trends of human insecurity.

Third, adopting a human security perspective can strengthen global health action by identifying gaps and opportunities, pointing to some practical recommendations for the Commission.

This note aims to brief the Commissioners at its Stockholm meeting about the evidence underlying these conclusions. Our purpose is to stimulate discussion, highlight issues, and focus on several recommendations that, we believe, should be considered by the Commission. Scientific support of this note is available in other documents.

II. EMERGENCE OF THE CONCEPT

We found that productive dialogue about human security with diverse constituencies was enhanced by providing some background information on why the concept emerged in the 1990s.

We postulate that three major trends – new conflicts, poverty, and globalization – created the context for the emergence of human security. Of these, the most influential was change in the world peace and security environment occasioned by the end of the Cold War. In the absence of the bipolar stalemate imposed by the nuclear arms of two superpowers, new threats to peace emerged in the post-Cold War decade. Many of the “new wars” have taken place within, rather than among, nation states, sometimes sparked by ethnically-based fissures in so-called “failed states.” Increasingly, it became clear that people could not be protected solely through reliance on military defense of national borders. Secondly, an improved understanding of human development spotlighted the
neglected everyday insecurities faced by the world's poor and excluded. When given voice, poor people repeatedly underscored the many insecurities of daily life – income insecurity, inter-personal violence, and the catastrophic impact of health crises. Thirdly, the process of globalization -- accelerated transnational flow of goods, services, finance, information, technology, ideas, people, and diseases – has generated new risks and vulnerabilities. In a matter of months, the 1997 Asian financial crisis engulfed a vibrant economic region and impoverished literally millions of people. The past decade also witnessed the global transmission of new (and old) infectious diseases, such as HIV/AIDS. Even the September 11th terrorist attack and the subsequent anthrax bioterrorism in the US underscored the transnational vulnerability of the rich as well as the poor. These factors generated impetus for re-examining traditional thinking about security. Human security emerged as a policy concept with the potential to capture and translate some of the world’s pressing demands for more effective responses in our globalizing times.

In response, the policy research community has produced a rich and growing literature on human security. Although modern concepts of “security” can be traced back to the European Enlightenment, human security emerged only recently. In the early 1990s, the Common Security Forum, an international research network, began exploring new dimensions of security, building on the earlier work of the Palme Commission on Peace and Disarmament. In 1994, the UNDP introduced the concept in support of its Human Development Report. In the latter half of the 1990s, the term entered into UN inter-governmental discourse. Some governments, led by Canada, began employing the term to describe the imperatives for humanitarian action to protect people against gross violations of human rights. The campaign against landmines was seen as a successful example of advocacy for human security. Canada financed a “commission on sovereignty and humanitarian intervention” which recently issued its report, “Responsibility to Protect.” At about the same time and in response to the Asian financial crisis, the Japanese Government under Prime Minister Obuchi began to promote a comprehensive approach to human security that included both peace and development.

These activities culminated in the establishment of our Commission on Human Security. A parallel effort, started by the Canadians, is a Human Security Network that includes foreign ministry participants from more than a dozen countries (Austria, Canada, Greece, Ireland, Jordan, Mali, the Netherlands, Norway, Slovenia, South Africa, Switzerland, and Thailand). Among these countries, Switzerland has also financed human security studies. Steadily growing also is an international research network on human security, mostly based in Canada. While our Commission and the foreign policy network are time-limited, the increasingly internationalized Canadian research network appears likely to continue working well beyond the issuance of our Commission Report. Indeed, one Canadian group is planning the publication of a “Human Security Report” that will focus on global violence.
III. HEALTH LINKAGES

Global health has been steadily drawn into these human security developments. Linkages have developed in a series of health fields: (1) conflict and violence; (2) global infectious diseases; and (3) poverty and inequity.

**Conflict and Violence** – The terrorist attack of September 11th, the war in Afghanistan, and earlier conflicts in Kosovo, Bosnia, Rwanda, Sierra Leone – all illustrate the changing nature of warfare. Most are within rather than among nation states, driven by inter-group hostilities and fueled by the proliferation of small arms. Unlike many previous wars, civilians are not simply “collateral damage,” but often the intended targets of violence. The conflicts usually provoke the massive flow of refugees and generate large numbers of internally displaced people. They often entail gross violation of human rights and war crimes, including genocide and rape.

Health programs as part of humanitarian interventions have become inextricably drawn into these complexities, creating new challenges for the health field. Conflict often exposes long-standing neglect of basic health infrastructure, and inevitably erodes the social trust that underlies the functioning of all social institutions, including health services. Emergency health interventions must be navigated through unstable and rapidly-changing political, military, and ecologic contexts. The tradition of “medical neutrality,” sanctioned by humanitarian law and human rights covenants, has sometimes become difficult if not impossible to uphold. Humanitarianism all-too-often is overwhelmed by political and military imperatives. Medical workers must cooperate, operate alongside, or integrate with other actor groups (UN, NGOs, military), each with its own mandate. Press and media coverage has become intensive in real-time, sometimes sparking strong public reactions and driving political decision-making.

**Global Infectious Diseases** – Many factors explain the prominence of infectious diseases on the global agenda – the discovery of more than two dozen new agents, the spread of antibiotic resistance, and the devastating impact of new epidemics, such as cholera in Latin America, plague in India, Ebola virus in Africa, dengue fever in Southeast Asia, and bovine spongiform encephalitis (mad cow) and hoof-and-mouth disease in Europe. Public fears have been aroused; the economic costs have been staggering; and even governmental credibility has been questioned.

Among the epidemics, two infectious agents have powerfully influenced thinking about health and human security. Nearly two decades after its discovery and worldwide spread, the global HIV/AIDS pandemic became recognized as one of the world’s major human security threats. More than 40 million people are HIV positive, and AIDS causes nearly 5 million deaths annually. In 1999, the UN Security Council declared AIDS a national security threat, especially in heavily infected sub-Saharan African countries. The G8 meetings in Okinawa (2000) and Genoa (2001) accorded high priority to AIDS; last year a special session of the UN General Assembly was devoted to HIV/AIDS; and earlier this year, a Global Fund for AIDS (and tuberculosis and malaria) was launched.
The anthrax bio-terrorist attack in the US introduced an entirely new dimension to health and security. Widely feared but historically well-documented, the use of germs as a bio-weapon became a reality within the most powerful nation in the world. The anthrax attacks generated unprecedented public fears and fueled a media frenzy. Although anthrax caused directly only five deaths, the still unsolved attacks virtually paralyzed the postal (and congressional) systems. At one time or another, about one-third of US Centers for Disease Control workers were assigned to combat anthrax. Fears about other biological agents arose; the U.S government, for example, was compelled to rebuild its stockpile of nearly discarded smallpox vaccines. The attack also exposed long-standing weaknesses in America’s public health infrastructure and underscored the centrality, like fire and police, of public health protection.

Poverty and Inequality – The multiple insecurities of daily life among ordinary people, especially the poor, gained political visibility in the 1990s. The 1994 Human Development Report proposed that human security complemented human development since without a sense of security, exercising freedom of choice in development would be impossible. The relationship of poverty and human security was vividly demonstrated during the Asian financial crisis when millions of people were suddenly impoverished due to macroeconomic shock. While human development is a positive concept focusing on growth with equity, little attention had been devoted to protecting people during economic downturns in a volatile global economy.

These connections were highlighted by the World Bank’s “voices of the poor” studies. When given the opportunity, the poor consistently expressed fears about the multiple insecurities of everyday life. Not only did the poor fear loss of jobs and local violence (including corrupt police), but sickness also ranked very high due to fears of pain and suffering and worries about economic bankruptcy. For the poor with fragile asset bases, catastrophic illness among working adults not only deprives the family of daily wages but also puts enormous pressures on a family’s limited resources. Compulsory health expenditures often precipitated a vicious spiral of illness, asset depletion, and impoverishment.

III. Global Map of Human Insecurity

Health linkages to human security share at least four commonalities. First, they underscore new (as well as old) risks and vulnerabilities in our globalizing times. Human security as a concept did not arise by happenstance but emerged to help policy-makers grapple with unprecedented threats to people’s safety in a globalizing world. Second, a people-centered perspective helps to illuminate concerns that are not well captured by traditional thinking. Included are threats that disrupt ordinary people both in times of crisis and in the chronic struggle of daily living. Third, the depth and extent of these crises are far more profound than simply “health problems.” Rather, the challenge for health is to protect people under complex circumstances that deeply disturb multiple societal functions and institutions. Finally, reducing health insecurity requires action at all levels of society, from communities to national and global systems.
Who are the most vulnerable? Where are they located? Which insecurity threats are more significant? Because good health and human survival are among the most important goals of human security and because mortality data are among the most reliable statistics available, a global mapping of human insecurity is possible through an analysis the WHO Global Burden of Disease data set.

Of the world’s population of 6 billion people, 56 million died in Y2000 (Figure 1). In other words, an average of one person out of 100 dies each year. The causes may be classified into three groups – communicable diseases, non-communicable diseases, and injury (Figure 2). Analyses of human survival statistics reveal widely varying risks and vulnerabilities according to age, gender, economic status, geography, and other characteristics. In terms of human security, the following observations are relevant.

Although violence is a major cause of death, the direct casualties of war constitute only a small fraction of deaths worldwide. In Y2000, about 5 million or 10 percent of world deaths were due to injuries. Of the injury deaths, one-third were intentional and two-thirds were accidental. About 310,000 of the 1.6 million intentional deaths were due directly to the violence of conflict. Obviously, conflict generates many-fold more deaths from other causes, for example due to hunger and infectious disease. Moreover, the mortality impact of conflict can be extended into time, generating higher illness and deaths for a decade or longer. Nevertheless, deaths due to inter-personal violence were two-fold greater than those directly due to conflict, and self-inflicted deaths three-fold more numerous. The highest national rates of interpersonal violent deaths were in developing countries such as South Africa and Brazil, and the highest rates of suicides were in Scandanavia and China, especially among young Chinese women. There is some evidence that severe economic inequality correlates with high levels of inter-personal violence in a society.

Poverty-linked infectious diseases and malnutrition were major killers, claiming nearly one-third of world deaths. Common childhood infections -- the immunizable diseases, diarrhea, and respiratory infections – comprised the overwhelming share of 17 million deaths, mostly among children. The significance of this toll in comparison to conflict-related deaths is revealing. Even if deaths from conflict were ten-fold or twenty-fold larger than those due directly to violence (3 to 6 million), the deaths associated with poverty would still remain much larger than conflict-related deaths. Most of these deaths are either preventable or treatable with the world’s existing knowledge, technology, and resources. In Africa for example, up to three-quarters of deaths are theoretically preventable. These endemic diseases linked to poverty are silent but exact a heavier toll than more visible infectious epidemics. Among all infectious diseases, rapidly rising is the death toll from AIDS which became the fourth ranked cause of death in developing countries. In some heavily-infected countries of sub-Saharan Africa, AIDS has dropped average life expectancy by more than a decade, and HIV is a growing human security threat throughout Asia and Eastern Europe.
Figure 1: Global Mortality

Annual deaths: 55.7 million
World population 6.04 billion

Deaths (population)
- Americas 5.9 m (827 m)
- Africa 10.5 m (633 m)
- SE Asia 14.2 m (1,535 m)
- W Pacific 11.4 m (1,687 m)
- Europe 9.6 m (873 m)
- Middle East 4.0 m (481 m)

Source: Global Burden of Disease 2000, WHO

Figure 2: Causes of Death

Source: Global Burden of Disease 2000, WHO
There is a North-South divide in the significance of various infectious diseases, and an “iceberg effect” may disguise the comparative priority of different diseases. Public concerns in the North naturally focus on unanticipated and comparatively infrequent epidemics, including bioterrorism, while people in the South are devastated by the common childhood infections plus the neglected or orphaned diseases of the poor, such as tuberculosis and malaria. Priorities, therefore, differ between countries and regions. In addressing human security, this divide must be addressed in a balanced manner. Also, some crises like bioterrorism are an emergency because they generate a sense of urgency, while endemic diseases may remain silent, exacting a much larger human toll especially among poor children. Health threats to human security, therefore, may be visualized as an iceberg – an urgent visible tip but a much larger invisible submerged base (figure 3). This visibility and silence is a public policy dilemma, because a free press in a democracy will compel public action for the former but not the latter.

Gender and ageing are important and growing dimensions of human insecurity worldwide. In a classical study, Amartya Sen showed that the world population was missing about “100 million women,” due to differential treatment of boys and girls. This gender gap against females was found to be particularly large in South and East Asia. In some exceptional situations, however, males may suffer disproportionately. Increasing death rates among Russian men after the collapse of the Soviet Union reflected the insecurity of those unable to cope with economic and political transitions. Because of declining fertility and improving longevity worldwide, many populations are ageing rapidly, underscoring the importance of human security for an expanding elderly population. While population ageing is especially marked in Japan and Europe, the “greying of populations” is also dramatic in some developing countries, such as China.

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**Figure 3: Iceberg Analogy**

Visible/Loud
- Outbreaks (ebola, West-Nile)
- Bioterrorism (anthrax, smallpox)

Submerged/Silent
- Failed basic health systems
- Catastrophic illness for the poor
IV. ACTION AGENDA

Our analyses of health and human security suggest several practical actions that the Commissioners may wish to recommend in its Final Report. Action will be needed at many different levels (community, national, and global) and among different actor groups (government, UN, business, and non-governmental organizations). An illustrative framework for considering various health actions in support of human security is shown in Figure 4.

Five action recommendations are offered here to stimulate Commissioner discussion. First, given the magnitude of the pandemic, the greatest in human history exacting a larger death toll than the Black Death of the 15th century, combatting the AIDS pandemic must be ranked very high on list of human security priorities. Second, as a public good, a “core public health” infrastructure should be developed in all societies that focuses on protection, prevention, and early warning. Third, to protect against downside risks, risk-pooling should be considered and health insurance systems should be developed. Fourth, new partnerships among health and allied institutions, including government, business, and civil society, should be encouraged to develop new and more effective institutional capabilities. Finally, the global health institutional architecture should be reviewed to consider the human security dimensions of global health. Commissioned research on these options are underway, and this note briefly describes the recommendations.

AIDS – is without doubt one of the premier threats to human security, and the Commission should not ignore it. HIV/AIDS will soon exact the largest toll in human history, greater than the combined deaths of the two world wars of the last century. What the Commission should recommend requires discussion because there are many debates.
in the AIDS field. One is prevention versus treatment; ultimately human security can only come from prevention but treatment enhances human security also. A second is access to anti-retroviral drugs. Lack of access to life-saving drugs has now entered centrally into discussions about intellectual property and the WTO/TRIPs negotiations. Indeed, in the United States, intellectual property related to drugs is a central dimension of health security among elderly Americans on prescription medications. The Commission should emphasize the importance of public action against AIDS, underscore the importance of political leadership and financing, and address some of the central human security dimensions of AIDS control.

Protection, Prevention, and Early Warning – A human security perspective points to the failings of “core public health” infrastructure everywhere, including the US. Like fire and police protection, a core public health infrastructure should be build in every community, in every country. Given the diversity of health and human security challenges, there should be latitude to develop a core capacity for meeting the priority needs of specific communities and countries, linked horizontally into a global system. The function of that core infrastructure is to offer public health protection and prevention against catastrophic health threats, like epidemic disease or bioterrorism. Early warning systems should be developed but cannot be expected to anticipate or prevent all crises. Core public health functions must be assumed by government as neither the commercial sector nor civil society can be an adequate substitute.

Risk Pooling and Health Insurance – Health is not an average, secular, long-term process; rather, illness can strike suddenly with catastrophic consequences. Pooling risk through insurance can help people absorb the shock of crises. Innovations in community-based health insurance have been developed in India, Uganda, China, and many developing countries. In response to demand from its membership, the Self-Employed Women’s Association in India began a health insurance scheme. Female workers in the informal economy pay modest monthly premiums to cover health catastrophes, including life and property insurance. Enabling the poor to access health services through insurance may be the most viable route of advancing the primary health care movement of the 1980s, which faltered. Diverse community-based systems will require the support of national and global systems for spreading risk and fiscal sustainability.

New Partnerships – Health interventions cannot operate in isolation but should be linked to broader social, economic, and political interventions in complex crisis situations. Cooperative partnerships should be developed that emphasize complementary roles in the protection of people, in times of crisis or under circumstances of deprivation. Coordination of emergency assistance is one example of partnership. But equally important is stronger partnerships in development action in support of poverty alleviation. The past decade has witnessed the proliferation of many new institutional arrangements that could be directed towards human security, for example a public-private partnership in research and development for a vaccine against AIDS.
Global Institutions and Policies – For the past half a century, the UN and Bretton-Woods system have addressed world peace and economic development through separate institutions and mechanisms. Peace was assigned to the UN Security Council and economic development was to be addressed by development banks, UN agencies, and overseas development assistance. Threats to human security have pushed the system into various reforms. The AIDS pandemic, for example, has propelled the international system to begin developing new institutions and mechanisms for addressing human insecurity (UNAIDS and UN Global AIDS Fund). The recent Monterrey conference on financing development proposes to double foreign aid, and the Commission should consider recommendations to shape the global architecture in support of human security equitably shared. Institutional developments should be considered for prevention, protection, and early warning systems and for risk pooling insurance systems. Developing global support for strengthening such systems at the community and national levels will require either special arms in existing global institutions or new global organizations altogether. In these regards, the Commission may wish to consider the Japan-sponsored UN Trust Fund for Human Security as one instrumentality of the overall reform of global institutions.

V. POLICY CLARIFICATION

These actionable recommendations will require a framework for presentation and for galvanizing support. Our exploration of health linkages illuminated some of the policy issues that the Commission must confront and resolve.

While compelling in terms of responding to new challenges, human security has been the target of sharp intellectual criticism. The litany includes that human security is:

- too vague and imprecise to provide policy guidance
- in competition with “national security”
- “old wine in new bottles,” combining well-accepted traditional concerns about “freedom from fear” and “freedom from want.”
- too idealistic failing to take into account real-world politics of geopolitical power in a rapidly changing international system
- over-focused on people rather than the state, thus allowing the concept to be used as a “fig leaf” for concealing political interference by superpowers into the internal affairs of weaker sovereign states.

Perhaps the most powerful argument against the concept of human security is its breadth. If human security is truly comprehensive, it may become impossible to develop priorities or translate the concept into practical action. A series of associated terms has developed – people’s security, security of displaced persons, refugee security, employment security, environmental security, and health security. How can all of these insecurities be grouped together into a single concept? Which threats should be prioritized? Can any be excluded?
Our work on health and human security reaffirms, however, that human security has risen dramatically in international discourse. With or without our Commission, the concept will continue as high priority on the global agenda, mostly because objective events propel its importance – September 11th, conflicts in the South, persistence of poverty in a globalizing era. Rather, the challenge to the Commission is whether it can develop a thematic that captures the spirit, value, and practical potentiality of the concept for acceptance by diverse constituencies. Our interactions with different audiences offer some insights on some of these challenges, as follows:

**Human security and national security** -- There is confusion about health linkages to human security vs national security. The infectious disease unit of WHO, for example, has begun to align its work with national security. It is proposing that the global control and surveillance against epidemic diseases, including bioterrorism, should work with and be financed by national departments of defense. Yet, our investigation demonstrates broader health concerns. Human security should underscore the ultimate dignity of individuals that should not be compromised under national security considerations. Yet, human security does not remove the need for national security, but that the concepts are complementary calling for a stronger people’s orientation to traditional national security and an approach to security that is more inclusive of people’s concerns. In many cases, the security of individuals is not possible without national security.

**Democracy and human rights** -- Health is a basic human right, and health protection against conflict and violence, infectious diseases, and poverty-linked health threats are central concerns of citizens that find their political expression in democratic systems. The failure of universal access to primary health care, especially for the poor, may be seen as a violation of human rights. As discussed in several seminars, however, the correlative duty or obligation of protecting health as a human right may be imperfect under situations of history, economic resources, and public systems capabilities. Advancing health and human security may be seen as strengthening basic human rights, and health is one critical dimension of human rights.

**Comprehensiveness** – Our analysis of health linkages confirms that the concept of human security should be comprehensive, not forced into restrictive narrowness. Given the nature of the health linkages described, it would be impossible to impose an artificial narrowness. Human security, it should be underscored, may be defined by both “what it is” as much as by its people-centered “value-base,” its insights into new strategies, and its capacity to mobilize and energize diverse constituencies. In these respects, human security may follow the path and lessons of the Brundtland Commission on environment and development. That commission coined the term “sustainable development,” also a broad and comprehensive concept, that both clearly defined and strongly enhanced that commission’s impact. The concept’s value-base helped to improve its usefulness for planning environment and development actions and for galvanizing diverse groups for social action. We believe that human security as a comprehensive concept managed and communicated well holds similar potential.
**Equity and Interdependence** -- A central challenge for the Commission is to articulate a value-base to human security, for without values, security is rather meaningless. Global equity, we believe, should be addressed directly in our engagement of the public and political leadership in both the North and South. In the interest of global equity, priority should be accorded to advancing human security among the world’s poor and excluded. Yet, the Commission must consider “interdependencies” among different threats and diverse populations, so that human security is not treated as simply a charitable gesture. Even the world’s wealthiest and most powerful should understand the self-interest importance of human security, beyond pure altruism. One commentator suggested that our task is “to link the fears of the rich to the health needs of the poor!” Recent debate on the relationship between conflict and development or terrorism and poverty are illustrative. Both are important, and a key Commission decision is whether they should be considered separately or in an integrated fashion. On the one hand are the “gated community” strategies of walling out threatening people, such as violent criminals or terrorists, at the community and national levels. On the other hand are the “preventive” strategies that seek to reduce or mitigate the forces generating the threats, such as poverty or social exclusion. While focusing actions on the world’s poor and excluded, the Commission should articulate arguments to consider human security as interdependent, in which the human security of any individual is linked to the human security of others around the world.

**Public Fear and Public Goods** – Insecurity may be objective or subjective. Objective insecurity relates to real physical threats; subjective insecurity is based on perceptions, of which fear is paramount. A health approach to insecurity recognizes both forms of insecurity. Subjective insecurity, including mental distress, may be as significant as objective threats. One of the central roles of government and its institutions is to generate public confidence and reduce fear. The foundation of human security, therefore, is to recognize central aspects of public health as a core “global public good.” As demonstrated by the September 11th and anthrax attacks, the general public expects a core level of public health protection against both objective and subjective insecurities. Like police and fire protection, these protective health functions are not possible from either the private market or civil society. By considering human security as a core public good, human security becomes an all-inclusive goal of high priority public action.