M. Pietraś, *International health security*,
„Rocznik Instytutu Europy Środkowo-Wschodniej" 21 (2023), z. 2, s. 7-34,
DOI: https://doi.org/10.36874/RIESW.2023.2.1

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International health security

Międzynarodowe bezpieczeństwo zdrowotne

Abstract: The paper proposes the classification of health security as one of the non-military security dimensions of the second generation, determined more by globalization processes than by the end of the Cold War (first generation). The cognitive goal of the article is to identify and analyse the elements of the structure of international health security such as 1) the essence and specificity of securitization of threats to health security; 2) health security threats; 3) the referent object or whom it concerns; and 4) measures to ensure it. Specific to this dimension is the political motivation for its securitization. In the world of interrelated and global mobilities, what is significant for health security is the diversity of the development level, preferred values, and, consequently, the diversity of sensitivity and susceptibility of national healthcare systems to cross-border threats.
Keywords: international health security, cross-border character of health security threats, securitization, provision of health security
Streszczenie: W artykule zaproponowano klasyfikację bezpieczeństwa zdrowotnego jako jednego z pozamilitarnych wymiarów bezpieczeństwa drugiej generacji, zdeterminowanego bardziej procesami globalizacyjnymi niż końcem zimnej wojny (pierwsza generacja). Celem poznawczym artykułu jest identyfikacja i analiza elementów struktury międzynarodowego bezpieczeństwa zdrowotnego, takich jak: 1) istota i specyfika sekurytyzacji zagrożeń bezpieczeństwa zdrowotnego; 2) zagrożenia bezpieczeństwa zdrowia; 3) przedmiot odniesienia lub którego dotyczy; oraz 4) środki to zapewniające. Specyficzna dla tego wymiaru jest polityczna motywacja jego sekurytyzacji. W świecie wzajemnie powiązanych i globalnych mobilności istotne dla bezpieczeństwa zdrowotnego jest zróżnicowanie poziomu rozwoju, preferowanych wartości, a co za tym idzie, zróżnicowanie wrażliwości i podatności krajowych systemów opieki zdrowotnej na zagrożenia transgraniczne.
Słowa kluczowe: międzynarodowe bezpieczeństwo zdrowotne, transgraniczny charakter zagrożeń bezpieczeństwa zdrowotnego, sekurytyzacja, zapewnienie bezpieczeństwa zdrowotnego

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Health security is a value, the object of political practice and cognition. Its emergence at the turn of the 20th and 21st centuries confirms the broadening of the subjective and objective scope of security, determined by the change of social reality and by new threats. In recent decades, this process has accelerated, thereby contributing to an increase in the number of non-military dimensions of security resulting from the securitization of threats specific to each dimension. In the 21st century, in addition to terrorism, the highest dynamic – the height of which was the Covid-19 pandemic – was shown by public health threats. Their cross-border nature made them an international security dimension, also essential for the national security of states.

The paper proposes to classify health security as one of the non-military security dimensions of a second generation, acknowledging that the first generation is the five dimensions proposed by the Copenhagen School after the end of the Cold War. The second generation is security dimensions determined first of all by globalization processes, their specific narrowing of time and space, and by people's mobility. The criterion for distinguishing between the two generations is the different quality (the end of the Cold War, globalization processes) of independent variables at the level of the international system that determine the securitized security threats.

The cognitive goal of the paper is to analyse the elements of the structure of international health security such as 1) the essence and specificity of securitization of threats to health security; 2) health security threats; 3) the referent object or whom it concerns; and 4) measures to ensure it. With regard to each of the elements, the study focused on their specificity and the individual autonomy characteristic of international health security. An attempt was made to answer several questions: What is the specificity of securitization of threats to health security? What is the scope of the threats to it? Who does health security apply to? How to ensure health security?

The research methodology covers 1) the application of the assumptions of the Copenhagen School, security dimension, and their securitization as well as the Welsh School's concept of human security; 2) identification of the independent variables of health security; 3) the concept of levels of analysis distinguishing between the level of the international system and that of the state; and 4) research techniques such as analysis of the content of documents and the state of research.

1. Specificity of securitization of threats to international health security

The concept of *health security* probably first appeared in the United Nations Development Program (UNDP) published in 1994. It was used in connection with the concept of *human security*, regarded as one of the seven components of the latter[1]. That attention was only paid to health security relatively late – as compared with other non-military dimensions of security – is surprising inasmuch as the Preamble to the WHO Statute stipulates that the health of the people is the basis for achieving peace and security[2], with the interdependence between health and security being clearly indicated. However, this reasoning was not reflected in the political decisions and actions during several decades after the end of World War II. In the world of two-bloc rivalry, and mutually assured destruction by nuclear weapons, health threats were classified as so-called *low politics*[3], as a humanitarian rather than political problem[4]. The elimination of smallpox in the 1970s was conducive to thinking that the risk of global infectious diseases was low, at least in developed states[5].

Health threats were securitized and included in the analysis of security when its meaning was redefined after the end of the Cold War, although it was not the fact of its end that was decisive; two factors are essential, firstly the change of social reality. Under the conditions of the general growth in the importance of non-military security threats in the environment of globalization processes, and people's mobility, there was an increase in the diversity, intensity, and number of victims of health threats, mainly from epidemics. The second factor is a philosophical inspiration in the form of the biopoliticization of security and politics[6] and the accompanying permissive intellectual climate.

1 *Human Development Report 1994*, New York 1994, pp. 24-26.
2 *Konstytucja Światowej Organizacji Zdrowia*, Dz.U. 1948, no. 61, item 477.
3 D. Fidler, *Health as foreign policy: Between principle and power*, "Whitehead Journal of Diplomacy and International Relations" 2005, vol. 6, no. 2, p. 180; A.M. Farrell, *Managing the dead in disaster response: A matter for health security in the Asia-Pacific region*, "Australian Journal of International Affairs" 2018, vol. 72, no. 6, p. 554.
4 J. Youde, *The securitization of health in the Trump era*, "Australian Journal of International Affairs" 2018, vol. 72, no. 6, pp. 535-536.
5 A.M. Farrell, op. cit., p. 554.
6 M. Dillon, L. Lobo-Guererro, *Biopolitics of security in the 21st century*, "Review of International Studies" 2008, vol. 34, pp. 265-266 and 269.

This means a specific synergy of the change of reality and the resulting new threats and their intellectual acceptance[7].

Essential for the change of reality justifying the inclusion of health problems and health threats in the thinking about security and its provision was – on the one hand – the increasingly frequent and intense recurrence of health threats in the form of infectious diseases, their epidemics and, with time, pandemics, and on the other hand, it was the intentional use of pathogens in order to have a destructive effect on public life. The growing threat of infectious diseases was a "multiconstituent" and multi-stage process. Especially significant was the emergence and spread of new infectious diseases[8] like HIV/AIDS, cholera epidemics in Peru (1991), SARS in 2002-2003, bird flu from 2003 onwards, H1N1 flu in 2009-2010, MERS in 2015, Zika fever (2015-2016), or SARS-CoV-2 from 2019 onwards[9]. Diseases like tuberculosis, regarded as being under complete control, began to be dangerous again[10]. Infectious diseases became increasingly resistant to the prevailing treatment methods. These changes demonstrated the political importance of threats to health and the need for international cooperation. There was discussion on this microbiological shift in security studies[11], with the turning point being the HIV/AIDS epidemic[12], shaping the conviction that infectious diseases are a security threat. There was an increasingly growing awareness – especially in developed countries – that exacerbating the health condition of populations may lead to instability of social life and its "traditional" threats,

7 M. Pietraś, *Kategoria "bezpieczeństwo zdrowotne" w studiach bezpieczeństwa*, [in:] H. Chałupczak et al. (eds.), *Zagrożenia bezpieczeństwa w procesach globalizacji. Zagrożenia zdrowotne*, Lublin–Zamość 2022.

8 A. Gliński, Z. Żmuda, *Epidemie i pandemie chorób zakaźnych*, "Życie Weterynaryjne" 2020, vol. 95, no. 9, pp. 554-559.

9 G. Rockenschaub, J. Pukkila, M. Profili, *Towards health security. A discussion paper on recent health crises in the WHO European Region*, Copenhagen 2007, p. 13; J. Younde, *The securitization*…, p. 536; A. Gliński, Z. Żmuda, op. cit., p. 554.

10 A. Price-Smith, *The health of nations: Infectious disease, environmental change, and their effects on national security and development*, Cambridge 2001, p. 3.

11 S. Elbe, A. Roemer-Mahler, Ch. Long, *Medical countermeasures for national security: A new government role in the pharmaceuticalization of society*, "Social Science and Medicine" 2015, vol. 131, p. 264.

12 S. Harman, *Global health governance*, London 2012, pp. 89 et seq.; S. Elbe, *Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security*, "International Studies Quarterly" 2006, vol. 50, no. 1, pp. 119 et seq.

while the health of the people means more stable and secure societies[13]. Nor should the cases of bioterrorism be ignored[14].

The second factor in the securitization of health threats was the "permissive" intellectual climate, i.e., the biopoliticization of security. Inspiration was provided by Michel Foucault's philosophy presented in the 1970s; to Foucault, the point of reference was not the state's territory or identity of its population, but human life. He believed that the main task of modern political power is the "administration of life"[15].

These factors did not decide the "automatic" inclusion of health threats in thinking about security and the practice of its provision. This happened as a result of the securitization of those threats, i.e., the recognition of them as existential for security. The concept of securitization was proposed by the Copenhagen School of Security Studies in the late 1980s and early 1990s[16]. It creates the theoretical framework – despite certain controversies – for the inclusion of threats in the analysis of security and the practice of its provision, substantiating subsequent non-military security dimensions, including health[17].

O. Waever and B. Buzan defined securitization as an effective speech act, through which a specific social phenomenon, e.g., a public health threat, is treated intersubjectively by a particular subject (actor) as an existential threat to the indicated referent object, e.g., the state, in order to justify the application of extraordinary countermeasures against this threat[18]. The securitization process combines three elements: 1) the speech act recognizing the indicated phenomenon as an existential threat; 2) the securitizing subject (actor), formulating the

13 G. Rockenschaub, J. Pukkila, M. Profili, op. cit., p. 13.
14 J. Kięczkowska, *Bioterroryzm jako zagrożenie dla bezpieczeństwa zdrowotnego*, "TEKA of Political Science and International Relations" 2019, vol. 14, no. 1, pp. 31-43.
15 M. Foucault, *The history of sexuality*, vol. 1: *The will to knowledge*, London 1998, p. 139.
16 B. Buzan, O. Waever, J. de Wilde, *Security. New framework for analysis*, Boulder 1998; O. Waever, *Securitization and desecuritization*, [in:] R. Lipschutz (ed.), *On Security*, New York 1995.
17 H. Stritzel, *Towards a theory of securitization: Copenhagen and beyond*, "European Journal of International Relations" 2007, vol. 13, no. 3, p. 357; C. Yuk-pink Lo, N. Thomas, *The macrosecuritization of antimicrobial resistance in Asia*, "Australian Journal of International Affairs" 2018, vol. 72, no. 6, p. 568; S. Bade, D. Jalea, *Twenty-five years of securitization theory. A corpus-based review*, "Political Studies Review" 2022, vol. 14, no. 1, pp. 2-11.
18 B. Buzan, O. Waever, *Regions and powers. The structure of international security*, Cambridge 2003, p. 491.

speech act; and 3) public opinion, which accepts or rejects the content of the speech act.

A securitization act reflects political and social preferences, thus being a kind of political decision[19]. Not without reason does the Copenhagen School emphasize the privilege of political power centres in formulating it[20]. A valuable proposal, a modification of the assumptions of the Copenhagen School, was suggested by H. Stritzel, drawing attention to the position power of the subject formulating a speech act, especially if this is the state apparatus with its international position[21].

The problem of "position power" is essential for showing the actor (subject) that initiated the securitization of health threats. It is not the UNDP, which first used the term *health security* in 1994. This actor is the U.S., with its hegemonic position at the turn of the 20th and 21st centuries, which links health threats with foreign and security policy. In 1999, the United States National Security Council for the first time recognized the HIV/AIDS health problem, an infectious disease spreading cross-border, as a national and global security threat. This view was expressed in 2000 by the United States National Intelligence Council[22]. In 2001, State Secretary Colin Powell recognized that the HIV/AIDS epidemic in Africa was a problem of U.S. national security[23].

The speech acts of U.S. institutions and politicians for the securitization of infectious diseases are unambiguous and began to be reflected in foreign policy, especially in the forum of the UN and the UN Security Council (UNSC). In 1999-2000, the U.S. Ambassador to the UN tried to convince UN Secretary-General Kofi Annan, who resisted these arguments, that HIV/AIDS – reducing the population of a state and destabilizing its social life – is not a humanitarian problem but one of security[24]. In 2000, U.S. Vice President Al. Gore suggested in the UNSC that the concept of security should take infectious diseases into account[25]. The United States, in the speech act of its politicians,

19 Ibid., pp. 112-114.
20 B. Buzan, O. Waever, J. de Wilde, op. cit., pp. 31-32.
21 H. Stritzel, op. cit., pp. 364-370.
22 *The global infectious disease threat and its implications for the United States*, NIE 99-17D, January 2000.
23 S. Peterson, *Epidemic disease and national security*, "Security Studies" 2002, vol. 12, no. 2, p. 44.
24 J. Youde, *The securitization*…, p. 537.
25 S. Peterson, op. cit., p. 43.

thereby treated pandemic-related health threats as a security problem rather than humanitarian. With the exception of the term of Donald Trump's presidency, the United States exercised the role of the leader of global actions for healthcare.

Under the conditions of hegemonic "position power" in the early 21st century, the United States began to include health threats caused by pandemics in the decisions of the UN Security Council. Using the Council's "institutional position", the United States strengthened the speech act and securitization of health threats. On 10 January 2000 – at the beginning of the new millennium and for the first time in the UNSC's history – the HIV/AIDS epidemic was referred to as a threat to security and development[26], with UNSC resolution no. 1308 having been passed on 17 June 2000[27]. The UN General Assembly passed a similar resolution on 2 December 2004[28].

The securitization of health threats by the UN Security Council with the involvement of the U.S. was carried out with regard to the HIV/AIDS epidemic as a cross-border infectious disease. A *modus operandi* was created resulting in similar responses by the UNSC to further epidemics. In 2014, resolution no. 2177 recognized the Ebola virus epidemic in Liberia, Guinea, Sierra Leone, and Nigeria as a threat to peace and international security with a high potential to destabilize the situation in the region[29].

In comparison with the resolute response to the Ebola virus threat, the UNSC's response to the Covid-19 epidemic is surprising. The WHO announced the outbreak of the pandemic on 11 March 2020, but the UNSC addressed this threat as late as June. Earlier, on 3 April 2020, the UN General Assembly ONZ had, in its adopted resolution, recognized the Covid-19 pandemic as a global problem that required global cooperation[30]. On 1 July 2020, the UNSC passed resolution no. 2532, recognizing that the Covid-19 pandemic may threaten peace and se-

26 *The impact of AIDS on peace and security in Africa*, Security Council, 4087th Meeting Monday, 10 January 2000, S/PV.4087

27 Resolution 1308 (2000) adopted by the Security Council at its 4172nd meeting, on 17 July 2000, S /RES/1308 (2000).

28 United Nations, General Assembly Resolution A /59/565.

29 Resolution 2177 (2014) adopted by the Security Council on 18 September 2014, S/RES/2177 (2014).

30 Resolution adopted by the General Assembly on 2 April 2020, A/RES/74/270.

curity, and demanding that armed conflicts impeding its prevention should cease[31].

This tardiness of response, which could be explained by the political position of China as the place where the pandemic appeared, was criticized by analysts[32]. It also contrasted with many statements by politicians, who treated the pandemic in their speech acts as a threat to security, using the metaphor of war. Even Donald Trump recognized that he was a wartime president[33]; President E. Macron declared that France was at war, and Chinese President Xi Jinping spoke about the war of the Chinese against Covid-19[34]. UN Secretary-General A. Guterres said that the world was experiencing the blackest scenario since the UNO was established, threatening international security, and the WHO Director-General used the war metaphor to emphasize the enormity of the challenges[35]. The concerted formulation of the speech act securitizing Covid-19 – in contrast to HIV/AIDS or even Ebola – involves numerous politicians as well as international functionaries.

The securitization of health threats, cross-border epidemics, and the involvement of the U.S. in this process, as well as leaders of other states in the case of Covid-19, justifies several conclusions. Firstly, the subjects (actors) that formulate the speech act are Western developed states, with the leadership role of the U.S. and its strategic preferences and interests. The U.S. perceived epidemics as threats arising in the states of the global South and feared that under the conditions of people's global mobility, they would be transmitted to the developed states. In this context, the act of securitization was treated pragmatically, as a way to arouse the interest of the media, societies, political elites, and international institutions, and to increase funding for health threats. This also meant focusing on the concerns of the "North" and perceiving the "South" as the source of disease threats[36]. Likewise, it

31 Resolution 2532 (2020) adopted by the Security Council on 1 July 2020, S/RES/2532 (2020).
32 B. Charbonneau, *The COVID-19 test of the United Nations Security Council*, "International Journal" 2021, vol. 76, no. 1, pp. 6-16.
33 "The Guardian", 22 March 2020.
34 I. Wright, *Are we at war? The politics of securitizing the coronavirus*, "E-International Relations", 10 January 2021, p. 2.
35 D.E. Duarte, M. Valenca, *Securitizing Covid-19? The politics of global health and the limits of the Copenhagen School*, "Contexto International" 2021, vol. 43, no. 2, p. 236.
36 L. Weir, *Inventing global health security, 1994-2005*, [in:] S. Rushton, J. Youde (eds.), *The Routledge handbook of global health security*, New York 2015, p. 20.

confirmed the growing significance of the actors of politics in the securitization of the second generation of non-military security threats. It appears that in the securitization of these first-generation threats, e.g., ecological, the speech act was already formulated during the Cold War, first of all by the scholarly circles and the epistemic communities that they formed[37]. Politicians took the role of the accepting "public", which was confirmed in the early 1990s in the security strategies of NATO, OSCE, and many countries, including Poland in 1992. As regards the scholarly circles, these are absent from the securitization of health threats.

Secondly, the dominance of political will in the securitization of health threats has contributed to an increase in the importance of the problem of desecuritization and the instrumental significance of the two opposing actions. Securitization can dynamize political actions for the increased funding and development of national healthcare systems, and for increasing development aid for these purposes. A tendency to desecuritize occurs when health threats are under control, solved as a result of "normal" politics rather than extraordinary measures[38].

Thirdly, a feature of cross-border securitized health threats is the large sphere of their impact, even on the global scale, as demonstrated by the Covid-19 pandemic. In this context, critics of the mechanism of securitization accused it of Eurocentrism, i.e., focusing on threats in Europe, at the average level. Influenced by such views, B. Buzan and O. Waever proposed the concept of macrosecuritization, at the global level[39]. In addition to pandemics and antibiotic resistance, they included the Cold War, wars against terror, and combating piracy[40].

The securitization of health threats supported by the U.S. with the involvement of the UNSC met with the "asymmetrical" acceptance of the international community. On the one hand, it began to be reflected in the decisions of international, global but also regional, especially Western, organizations. In 2004, the UN report *A more secure world:*

37 L. Brown, *Redefining national security*. Worldwatch Paper 14, Washington DC 1977, wrote about ecological and economic security, and J. Mathews-Tuchman, *Redefining security*, "Foreign Affairs" 1989, vol. 68, no. 2, p. 162, about economic, ecological, and demographic security.

38 A.M. Farrell, op. cit., pp. 551-553.

39 B. Buzan, O. Waever, *Macrosecuritization and security constellations: Reconsidering scale in securitization theory*, "Review of International Studies" 2009, vol. 35, no. 2, p. 257.

40 C. Yuk-pink Lo, N. Thomas, op. cit., p. 569.

Our shared responsibility pointed, using the example of HIV/AIDS, to links between health and security[41]. In the program for 2006-2015, the WHO made the debate on health security its priority[42]. The ASEAN carried out the securitization of health problems during the SARS epidemic in 2003[43]. The NATO security strategy of 2010 underlined "health risks"[44]. In the EU, health security appeared in the communiqué of the European Commission on 11 November 2020, that is during the Covid-19 pandemic[45]. On the other hand, during the period before the Ebola pandemic, many states of the global South opposed the use of the term "health security" and the identification of healthcare measures with security actions. They, therefore, opted for the desecuritization of healthcare. The reasons for such a stance were varied. On the one hand, there were differences between the developed and developing states in defining health security. On the other hand, the developing states viewed the securitization of health threats by the developed states as the particularistic interests of the rich North, which wanted to protect itself from pandemics occurring in the states of the poor South[46]. In this context, i.a. Brazil, India, Indonesia, and Thailand expressed their opposition to the attempt, mainly by the U.S., to introduce the term "global health security" with a suggestion that it should be a superior category organising international cooperation in healthcare. As a result of the opposition by the foregoing and other states, the WHO refrained from using the term "health security"[47]. However, after the outbreak of the Ebola epidemic in 2014, the opposition of the developing states to linking health problems with security abated. The Ebola epidemic was perceived as a global crisis, exposing

41 *A more secure world: Our shared responsibility*, Report of the High-level Panel on Threats, Challenges and Change, New York 2004, p. 12.
42 *Eleventh General Programme of Work, 2006-2015*, WHO, A 59/25, 24 April 2006.
43 M. Caballero-Anthony, *Health and human security challenges in Asia: new agendas for strengthening regional health governance*, "Australian Journal of International Relations" 2018, vol. 72, no. 6, p. 602.
44 *Koncepcja strategiczna NATO z 2010.*
45 *Budowanie Europejskiej Unii Zdrowotnej: Zwiększenie odporności UE na transgraniczne zagrożenia zdrowia*, COM(2020) 724.
46 A. Kamradt-Scott, *Securing Indo-Pacific health security: Australia's approach to regional health security*, "Australian Journal of International Affairs" 2018, vol. 72, no. 6, p. 501.
47 Ibid.

social inequalities inside the states and between them as well as the weaknesses of the global system of healthcare management[48].

Consequently, a political consensus developed on presenting public health threats by using the language of the analysis of security problems. In 2014, the U.S. initiated the program *Global Health Security Agenda*. It was conceived as the actions by states, international organizations, and civil society organizations to promote global health security, reduce threats caused by epidemics, and promote and implement the WHO's international health regulations. The program, initiated and supported by the U.S., contributed to the integration of actions for health security at the level of the global international system.

The political consensus, achieved in the middle of the second decade of the 21st century, concerning the presentation of health threats as a security problem, did not limit the discussions in academic circles and their critical opinions[49]. Attention was drawn to the fact that the global problems of healthcare become a priority only when the Western developed states are endangered. In the case of the Ebola epidemic, the media coverage caused the fear of Western societies and pressure on centres of political power. Consequently, the problem concerning African countries turned into the problem of Western states, their societies, and their security. A conviction was expressed that discussion on health security is the reflective thinking about the power structures and interests of highly developed states, striving to protect their populations against diseases in developing states[50]. This disparity between the interests of the developed and developing countries caused the WHO to balance in its documents the requirements of human health and international security.

Furthermore, during the Ebola epidemic, it was observed that the developed states, when involved in fighting the epidemic, did not focus on social, economic, and political causes of the weaknesses of healthcare systems in African states but on inventing vaccines and medicines. It appears that what was essential for such measures was

48 A. Roemer-Mahler, S. Rushton, *Introduction: Ebola and international relations*, "Third World Quarterly" 2016, vol. 37, no. 3, p. 373.

49 S. Rushton, *Global health security: Security for whom? Security from what*?, "Political Studies" 2011, vol. 59, no. 4, pp. 779 et seq.; S. Elbe, op. cit., pp. 119 et seq.

50 A. Kamradt-Scott, op. cit., p. 509.

the interests of Western pharmaceutical companies. Reports wrote about the "pharmaceuticalization" of the global policy of healthcare in connection with its securitization. It was claimed that health securitization creates solutions that facilitate subsequent pharmaceutical responses[51].

In addition, it was emphasized that the focus on selected health threats like the sudden rapidly spreading epidemics and biological weapons leads – which was experienced during the Covid-19 pandemic – to the creation of a hierarchy of health threats, which does not reflect the actual problems of the majority of the world's population[52]. That these threats are hierarchized, reflects the fears of the societies in developed countries.

An analysis of the securitization of health threats is essential for defining the term "health security", which appeared under conditions of more and more frequent epidemics, increasingly large numbers of victims, and, at a certain moment, conflicts of interest between the developed and developing states. Despite over 20 years of its presence in the scientific discourse and political practice of states and international organizations, this term is still ambiguous and without an agreed-upon definition, even within the organizations of the UN system.

The dominant term in the literature is "health security". The documents of international organizations, especially those of WHO, also use, clearly under the influence of the U.S., the terms "global health security" and "global public health security", understood as indispensable measures to minimize susceptibility to sudden events that threaten the collective public health of the population living in a particular geographic region[53]. The focus of this is on cross-border health threats, which initiated their securitization at the beginning of the 21st century. Regarding the term "*global health security*" it was accepted that it contains three elements 1) security meaning the absence of threats; 2) health as a condition – according to the 1946 WHO Statute – of physical, mental, and social well-being; and 3) the global environment,

51 A. Roemer-Mahler, S. Rushton, op. cit., p. 376.
52 D. DeLaet, *Whose interests is the securitization of health serving?*, [in:] S. Rushton, J. Youde (eds.), op. cit., pp. 339 et seq.
53 *A safer future: Global public health security in the 21st century*, Geneva 2007, p. IX.

in which health is determined by the flow of viruses and by the social and ecological effects of the economic order.

In terms of the concept of "health security", it has been pointed out that it is ambiguous and does not explicitly answer the questions: Security for whom?, Aimed to protect what values?, Against what threats?, and How to ensure it[54]? It was agreed that the analysis of the concept assumes focusing on such problems as protection against threats, the change of social, economic, technological, and other conditions that caused the earlier approaches to healthcare to become outdated, the involvement of new subjects including military personnel, and the existence of connections with the interests of states' foreign policy[55].

To recapitulate the understanding of international health security, it should be emphasized that it is the result of the securitization of health threats with a fairly clearly defined identity but with vague boundaries, especially of the objective scope. This process reflects the dynamic of the redefinition – as its element – of understanding security in the environment of double change at the level of the international system. It is determined by the simultaneously occurring and "overlapping" processes of the end of the Cold War and its characteristic understanding of security as well as globalization processes and its specific changes in social life, by people's mobility and interdependencies[56]. Under such conditions, the objective and subjective scope of the understanding of security changes and health security is part of the process, being classified into the second generation of its dimensions. In the interdependent world and that of global mobilities what is vital for health security is the diversity of the development level, of preferred values, and consequently, the diversity of the sensitivity and susceptibility of societies and their healthcare systems to cross-border threats. Under these conditions, health security is socially constructed. First, the spread of health threats is the result of social behaviours, people's mobility, but also of diverse resistance to these behaviours. Second, a response to these threats in the form of their securitization or desecuritization is individualized and depends

54 A.M. Farrell, op. cit., p. 555; S. Rushton, op. cit., p. 781.
55 A.M. Farrell, op. cit., p. 555.
56 M. Pietraś, *Pozimnowojenny paradygmat bezpieczeństwa in statu nascendi*, "Sprawy Międzynarodowe" 1997, no. 2, pp. 29-52.

on preferred values, the economic situation, and the efficiency of national healthcare systems.

2. Threats to international health security

The analysis of each dimension of security requires the identification of its specific threats. It is they that are securitized. F.X. Kaufman defined them as the possibility of the occurrence of one of various negatively evaluated phenomena[57]. They do not need to be identified exclusively with an intentionally acting enemy, nor with phenomena or not necessarily intentional processes that may cause an existential effect. Health threats can be destructive to human life and health, but they can also destabilize social life, and be connected with other threats, also the "traditional" ones like military threats.

A feature of health security threats is their complexity and essentially their "hybrid character", combining non-intentional processes, phenomena, with the possibility of their intentional, hostile use. This means a diversity of threats. And their range is open to discussion. They include infectious diseases, occurring as epidemics or pandemics, and, in their context, the problem of crossing the species barrier, the phenomenon of bioinvasion, the problem of growing antibiotic resistance as well as bioterrorism and the possibility of using biological weapons.

A special health security threat is infectious diseases. It was the HIV/AIDS epidemic that initiated the securitization of health threats, while the Ebola and Covid-19 epidemics reinforced this process. Epidemics with global victims took place in the 20th century, causing the overburdening of healthcare systems in many countries at that time. Since the beginning of the 21st century, there has been a distinct increase in the diversity and intensity of epidemics. Initially, new pathogens emerged like the Nipah, Marburg, Ebola, and MERS-Cov. viruses, coronavirus, SARS, the A/H5N1 flu, and also A/H1N1, A/H7N9, A/H5N6, in different places around the globe[58]. Then, pre-

57 F.X. Kaufman, *Sicherheit als soziologisches und socialpolitisches Problem*, Stuttgart 1970, p. 167.

58 L. Gostin, A. Ayala, *Global health security in an era of explosive pandemic potential*, "Journal of National Security Law and Policy" 2017, vol. 9, no. 1, p. 53.

viously known infectious diseases reoccurred such as cholera, tuberculosis, flu, measles, cerebral meningitis, or yellow fever. Significant factors in the frequency and intensity of epidemics were created by urbanization processes and the increase in people's global mobility, thereby causing the world to become more sensitive and susceptible to infectious diseases, which are more and more difficult to contain within state frontiers. Former UN Secretary-General Kofi Annan called them "problems without a passport", which require a collective, global response[59].

One of the examples of the potential for national and international security threats caused by epidemics are the Ebola and Covid-19 viruses. Ebola was identified in March 2014 in Guinea, spreading out into other West African countries like Sierra Leone, Liberia, Nigeria, Mali, Senegal, and outside Africa where it reached Spain, the United Kingdom, and the United States. Consequently, it caused threats to the national security of those countries as well as the possibility of destabilization of the situation in the region, threatening national security on a global scale[60]. The Covid-19 pandemic affected the whole world. In early June 2023, since the outbreak of the pandemic, Covid-19 had infected over 690 million people, with ca. 6.9 million fatalities, moreover, with economic effects being difficult to assess.

The crossing of species barriers is becoming a health security threat. Consequently, there is a growing interdependence between the health of people, animals, and the environment. However, the problem is the limited level of knowledge about the relationships between these elements. Additionally, the globalization processes and the growing mobility of people and animals increase the sensitivity and susceptibility in the relationships between people, animals, populations, and the environment. The risk of epidemics increases as a result.

Invasive alien species, previously living in a specific environment, are another threat. Their spread is called bioinvasion and is a result of the conscious introduction of certain species by people in order to control others. Used already in the first half of the 20th century, it was

59 K. Annan, *Problems without passports*, "Foreign Policy", 9 November 2009.

60 O.F. Ifediora, K. Aning, *West Africa's ebola pandemic: Toward effective multilateral responses to health crisis*, "Global Governance" 2017, vol. 23, p. 226.

treated as a biological problem. With time, it began to be perceived as an economic problem related to globalization processes and to the security problem. There is a serious fear that these microbes, called globalization pathogens, may spread on a global scale and threaten the health of people and food security[61]. They may weaken the state's strength, its demographic and economic capabilities, introducing the element of biosecurity into the thinking of its overall security[62].

Health security threats also include antibiotic resistance. Antibiotic-resistant infectious diseases that appear in one country pose a threat to the health and economic processes of other countries. It is estimated that in the second decade of the 21st century, drug-resistant pathogens caused ca. 700 thousand deaths annually. In 2013, health ministers of G-8 countries recognized antibiotic resistance as the main challenge to health security, pointing to several characteristics: 1) it does not have a country of origin; 2) there are many causes of antibiotic resistance in people and animals at the same time; 3) connecting this resistance with the food chain requires complex solutions concerning different areas of social life, rather than simple ones[63].

A more spectacular and intentional health security threat is bioterrorism, which is the intentional use of biological agents in order to cause victims, terrorize people, and initiate expected changes. At the turn of the 20th and 21st centuries, several such attacks were carried out in the U.S. After the 11 September 2001 terrorist attacks, letters containing anthrax bacteria were sent to people in New Jersey. 5 people died, 17 persons became ill and a panic arose among the civilian population. Several infected facilities, i.a. the Supreme Court buildings and post offices, were closed, thus disrupting social life.

A feature of health threats – apart from the early-analysed direct negative impact on people – are the links between the environment of social life, in which the threats arise, and the impact on social life, thus changing it. The first element of these links means that of significance for health threats, the intensity and dynamics of their manifestation, are social, economic, cultural, etc. determinants such as poverty,

61 Ch. Bright, *Invasive species: Pathogens of globalisation*, "Foreign Policy" 1999, vol. 116, pp. 51-64.
62 P. Stoett, *Framing bioinvasion: Biodiversity, climate change, governance*, "Global Governance" 2010, vol. 16, pp. 103-110.
63 C. Yuk-pink Lo, N. Thomas, op. cit., pp. 570-571 and 574.

unemployment, migration and other forms of people's mobility, urbanization, limited access to healthcare systems, social exclusion, and armed conflicts. These conditions create an environment conducive to these threats and at the same time, they individualize the sensibility, susceptibility, and limited resistance of states to them. An especially favourable environment for the spread of health threats, as shown by the Covid-19 pandemic, is created by globalization processes[64]. Anti-vaccination movements also contribute to this.

On the other hand, in addition to directly impacting people, health threats can be a factor destabilizing social life. An opinion is even voiced that pandemics may cause destruction of social life and of economic activity which is comparable to war, natural disasters, or financial crises. This in turn reinforces arguments that these threats should be treated as a security problem rather than a simple health phenomenon, not only because of the health expense but also the economic and political costs[65].

3. The reference subject of international health security

The object of discussion, or even dispute, is the answer to the question of who is the referent subject of health security threats? Who does health security concern? Michel Foucault distinguished between two tendencies of thinking about security: geopolitics and biopolitics. In the former case, the referent subject is the state, in the latter – first of all a human individual functioning at the micro level[66]. Does, however, the answer to the question of who is threatened have to contain the juxtaposition between referent objects? Perhaps they can complement each other? Taking into account the specificity of health threats impacting people but also social systems, the other way of thinking is suggested with an assumption that there is no one referent subject that "monopolizes" thinking about health security. There are several subjects or other referent objects. They determine their own functioning and are located on several levels of social life.

64 Ch. Jenkins et al., *Global public health: A review and discussion of the concepts principles and roles of global public health in today's society*, "Global Policy" 2016, vol. 7, no. 3, p. 334.
65 L. Gostin, A. Ayala, op. cit., p. 57.
66 M. Dillon, L. Lobo-Guererro, op. cit., pp. 274-275.

It is the human being but also a community as a population, the state, but also the international system.

A special place in thinking about the referent subject for the securitization of health threats is occupied by the individual. The 1994 UNDP report also combined the term and conception of "human security" with health threats. There are many signs that the report significantly contributed to linking health threats with the concept of human security and with the individual as a referent object. Inspired by the Frankfurt School and its critical theory, this conception meant a departure from the state-centric thinking about security and the focus on human security[67]. For that reason, it provoked discussion on possible change in the paradigm of thinking about security[68], since it focused on threats to human security and it was subsequently accepted by the UN in 2012. It became useful for the securitization of threats caused by HIV/AIDS.

However, individual tragedies of HIV/AIDS-affected persons are not the only social effects of this epidemic, they also threaten the social communities in which these individuals function. These communities became the referent object of the securitization of health threats. In Africa, the deaths of infected teachers brought about consequences for the educational systems of many states, and the deaths of soldiers – for the armies of those states. The philosophical inspiration of M. Foucault's biopolitics contributed to recognizing the population as the referent object and the one threatened by pandemics, and consequently, the survival of the species[69]. The example of HIV/AIDS has demonstrated that epidemics cause threats not only to the national security of states but also to the international system, its stability, and security[70].

It follows from the conducted analysis that there is no simple answer to the question: who do health security threats concern? The discourse on this theme was dominated by human security and the

67 K. Booth, *Security and emancipation*, "Review of International Studies" 1991, vol. 17, no. 4, pp. 313-326; *Critical theory, security, and emancipation*, [in:] R.A. Denemark, R. Marlin-Bennett (eds.), *The international studies encyclopaedia*, vol. 2, Malden 2010, p. 718.

68 R. Paris, *Human security. Paradigm shift or hot air*?, "International Security" 2001, vol. 26, no. 2, pp. 87 et seq.

69 M. Dillon, L. Lobo-Guererro, op. cit., p. 266.

70 S. Elbe, op. cit., pp. 336-338.

human individual. However, this is not the only subject. There are also threats to communities or systems like states and populations within which individuals are functioning.

4. Provision of international health security

Health security is a value; achieving it requires actions, and it should be remembered that what is at stake is not only people's health but also the effects of health threats to social systems – including on the global scale – to economic processes, the stability of social life, and its security. Health is not the only protected value. These actions are undertaken in the environment of global health interdependencies, and hence it is necessary to organize them at the level of the international system, and at the level of states and their healthcare systems.

These measures at the level of the international system to ensure health security are taken with regard to the world as a whole and to regions. At the global level, the system of global health security governance functions as an element of the global governance system[71]. Its distinctive feature is the hybridity of subjects that share the common goal of coordination of actions in order to effectively solve the cross-border health problems that require cross-border cooperation[72]. D. Fidler defined global health governance as the use by states, intergovernmental organizations, and transnational subjects of formal and informal institutions, norms, and instruments serving to respond to health threats. Their efficacy requires cross-border, collective actions[73].

The system of global health security governance is distinguished by several features. First, it is the diversity of subjects. In addition to states, there are intergovernmental organizations and transnational, including philanthropic, subjects. The main international organization that coordinates the functioning of the system is the WHO[74]. Apart from the standard-setting function, it takes operational measures as

71 K. Marzęda-Młynarska, *Globalne zarządzanie bezpieczeństwem żywnościowym na przełomie XX i XXI wieku*, Lublin 2014, pp. 32-93.
72 J. Youde, *Global health governance in international society*, "Global Governance" 2017, vol. 23, p. 590.
73 D. Fidler, *The challenges of global health governance*, New York 2010, p. 3.
74 J. Stażyk-Sulejewska, *The role of international institutions during a pandemic*, [in:] J. Itrich-Drabarek (ed.), *Contemporary states and the pandemic*, New York 2023, pp. 135 et seq.

part of numerous programs. Non-state actors (subjects) play a vital role in determining the global healthcare agenda, the object of negotiations, the decisions taken, and in mobilizing financial resources. After the year 2000, an important element of the functioning of this system was the public-private partnership, significant for providing development aid for healthcare[75]. These actions are also participated in by such foundations as the *Bill and Melinda Gates Foundation* and *GAVI, The Vaccine Alliance*. Second, this system regulates a broad range of phenomena that make up global health threats, taking account of their "medical" specificity but also the social contexts. Third, it is not easy to show the "boundaries" of the system, because it comprises organizations dealing exclusively with healthcare but also those for which this is one of the areas of their activity; the WHO is not the only structure.

A vital element of the system of global health security governance is norms. These include the WHO Statute and international agreements, whose goal is to prevent the international spread of infectious diseases. Among the international agreements especially significant are the *International Health Regulations* – IHR. They were negotiated in 1969 and concerned 6 diseases[76]. Under the conditions of the growing number of epidemics and the necessity of enhancing the effectiveness of the response of the international community, new IHR were negotiated in 2005[77] and came into force in 2007. This agreement increased the number of infectious diseases to be regulated and went beyond infectious diseases, taking into account other health threats, including industrial accidents, natural disasters, and armed conflicts. The system of international monitoring of these threats was also strengthened, and the common goal of those measures was to strengthen international health security[78]. The regulations were ratified by 196 states, 194 being WHO Member States.

An opinion is advanced that despite being a "harsh" law, the IHR does not have an effective mechanism for enforcing the adopted ob-

75 J. Youde, *Global health governance…*, p. 595.
76 *International Health Regulations* (1969), Third annotated edition, Geneva 1983.
77 *International Health Regulations* (2005), Second edition, Geneva 2008.
78 L. Gostin, A. Ayala, op. cit., p. 64; A.M. Farrell, op. cit., p. 552; A. Bouskill, E. Smith, *Global health and security. Threats and opportunities*, Santa Monica CA 2019, p. 6.

ligations. They are even called "toothless" regulations. Indonesia, for example, refused to provide H5N1 virus samples during the epidemic in 2007. In autumn 2019, China refused to inform the WHO about the outbreak of the Covid-19 epidemic. This information reached the WHO on 31 December 2019, when the initial local epidemic was becoming a global pandemic. It was estimated in 2012 that ca. 15% of states-parties fulfilled the IHR standards[79]. This happened despite the fact that the IHR regulations impose on states the obligation to inform the WHO about an increase in the incidence of some diseases. It is estimated that in 2001-2020 the WHO was informed about over 70% of cases of infectious diseases[80]. The limited efficacy of the execution of IHR regulations came under criticism; the response to the Ebola virus epidemic was recognized as too slow[81], so an attempt was made to develop alternative solutions. On 13 February 2014, the United States proposed the *Global Health Security Agenda* initiative, which was supported by ca. 50 states and intergovernmental organizations, including the WHO, but was opposed by the developing states. The criticism of the system of global health governance grew under the conditions of the Covid-19 pandemic and was an incentive to initiate the current negotiations on further amendments to the IHR.

A significant element of the system of global health security governance is the funding instruments. In the period before the securitization of health threats, the financing of responses to those threats was limited. Their securitization brought about a change of political priorities and an increase in funding. Development assistance for healthcare programs began to grow. From 1973-2004 it rose ca. 5.4% annually, and from 1998-2002 on average 13% per year, to amount to ca. 13% of the total value of development assistance in 2002-2004[82]. Over 56% of funds were transferred in the form of bilateral aid and ca. 7% of the volume of this assistance was provided by non-governmental

79 A. Bouskill, E. Smith, op. cit., p. 6.

80 *Acute public health events assessed by WHO Regional Offices for Africa, the Americas, and Europe under the International Health Regulations (2005)*, 2020 Report, WHO, Geneva, February 2022, p. 18.

81 O.F. Ifediora, K. Aning, op. cit., p. 227.

82 *Recent trends in official development assistance for health*, OECD, Paris 2013.

organizations and private foundations[83]. The global financial crisis after 2008 significantly reduced development assistance for healthcare.

A feature of the system of health security governance is its multilevelness, confirmed by the existence of regional systems. Within the WHO, six regional offices were created for Europe, Africa, the Americas, Southeast Asia, the Eastern Mediterranean, and the Western Pacific, while the Pan-American Health Organization was founded in 1902. An element of the regional level of health security governance is also regional organizations because the response to health threats is one of the areas of their decision-making and actions. In 2003, because of the SARS epidemic as well as subsequent epidemics, the ASEAN permanently changed the agenda of Asia's security problems and included health threats in it. In 2003 – and repeatedly in subsequent years – the ASEAN organized a summit with the participation of Japan, China, and South Korea concerning regional health security[84]. After the end of the SARS epidemics, health threats were included in the multi-sector approach to security in the region[85]. In 2017, Australia proposed the *Indo-Pacific Regional Health Security Initiative.* It was recognized that national and regional health security are interrelated, and focus was given to countering threats that cause epidemics, i.a. through strengthening national healthcare systems. The *Indo-Pacific Centre for Health Security* was established within the structure of Australia's Ministry for Foreign Affairs and Trade.

After numerous epidemics during the 21st century, the level of institutionalization of actions for health security in Asia is the highest. The ASEAN is, however, the only regional organization countering health threats. The Ebola virus epidemic and then the Covid-19 pandemic became a challenge to numerous regional organizations, including those in Africa, especially to the African Union, the Economic Community of West African States (ECOWAS), and the national healthcare systems of the African states. Criticism was levelled at the limited institutional potential and slow response resulting from the lack of sufficient resources and preparedness to counter these threats[86]. The

83 J. Youde, *Global health governance…*, p. 593.
84 M. Caballero-Anthony, op. cit., pp. 603-608.
85 *ASEAN Post-2015 Health Development Agenda 2016-2020*, Jakarta 2018.
86 O.F. Ifediora, K. Aning, op. cit., p. 227.

level of development and efficacy of the regional health security systems is significantly diversified.

An essential element of multilevel health security governance is national healthcare systems; they are a necessary, although insufficient, element consisting of two kinds of actions. Firstly, health diplomacy or state actions at the level of the international system, and secondly, the development of national healthcare systems, i.e., actions directed within the state.

Health diplomacy or medical diplomacy is the term identified with the international actions of many subjects, not only states. For the needs of the conducted analysis, it will be identified with actions of the state, with the evolution of the objective scope of the state's foreign policy, and its organizational structures[87]. It is sometimes understood as an alternative concept to the concept of health security[88], however, this view is not shared in the present paper. Health diplomacy is treated as the activity of states focused primarily on countering cross-border health threats through cooperation with other states, international and transnational organizations, or participation in health security governance, and also, as the activity aimed at strengthening national healthcare systems, first of all, in the developing states[89].

It is not possible to ensure health security without efficient national healthcare systems, vital for actions at the level of states and at the level of the international system. An opinion is voiced that the state's ability to detect and respond to epidemics is of crucial importance for halting their spread[90]. Hence, the 2005 IHR contains the requirement for building national healthcare systems. Problems concerning their functioning are emphasized such as high costs, which result in the difference between the health security of states at the high and low level of development. Another problem is the efficacy of healthcare systems in countering health threats, and their resilience to these threats. Pandemics may overburden national healthcare systems. This

87 See B. Surmacz, *Ewolucja współczesnej dyplomacji. Aktorzy, struktury, funkcje*, Lublin 2015.
88 K. Bond, *Health security or health diplomacy? Moving beyond semantic analysis to strengthen health systems and global cooperation*, "Health Policy and Planning" 2008, vol. 23, p. 377.
89 I. Kickbusch, G. Silberschmidt, P. Buss, *Global health diplomacy: The need for new perspectives, strategic approaches and skills in global health*, "Bulletin of the World Health Organization" 2007, vol. 85, no. 3, p. 230.
90 L. Gostin, A. Ayala, op. cit., p. 69.

was confirmed by the Covid-19 pandemic with regard to many developing countries[91]. For that reason, the preferred direction of action for health security is to strengthen but also carry out a kind of standardization to achieve the minimum common equipment across national healthcare systems. Such a norm was formulated in the 2005 IHR, and the states-parties are obligated to implement a set of standards called the minimum care capacity requirements. In 2015, only 64 states informed that they had implemented the standards, and 48 did not even provide such information[92].

To sum up, international health security has been classified as the second generation of non-military security dimensions, determined more by globalization processes than by the end of the Cold War, and reflects their new quality. The paper focused on defining the structure of this concept by analysing the securitization of health threats, their structure, the referent object of health security, and actions to provide it. First, health security is the result of politically motivated securitization, carried out by the developed states, of cross-border health threats in the environment of global mobility. Second, the main feature of health security threats is their diversity, comprising infectious diseases, the problem of crossing the species barrier, the phenomenon of bioinvasion, the problem of growing antibiotic resistance and bioterrorism, and the possibility of using biological weapons. Third, there is no one referent object that "monopolizes" the thinking about health security. It is the human individual but also the community as a population as well as the international system. Fourth, actions to ensure health security are taken at the level of the international system and the system of security governance at this level, as well as at the level of the state, where there are national healthcare systems.

91 O. Nkang, O. Bassey, *Securitization of global health pandemic and reiterating the relevance of 2005 International Health Regulations: Covid-19 and human security in Africa*, "African Journal of Empirical Research" 2022, vol. 3, no. 1, pp. 38-39.

92 L. Gostin, A. Ayala, op. cit., p. 65.

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