SARS-CoV-2: How a Development Issue Became an International Security Priority

SARS-CoV-2: de cómo un tema de la agenda de desarrollo se convirtió en una prioridad para la seguridad internacional

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Abstract:
This paper discusses the relationship between development and security in the context of the SARS-CoV-2 pandemic. Global health and military expenditure are compared and a distinction made between the concepts of security and protection. In addition to a review of the responsibilities countries assumed on adopting the International Health Regulations (2005), the global health security index is analyzed and found to come up short in its ranking of countries that allegedly have the best-equipped health sectors. The article concludes that prevention and the building of safe societies are the most effective means of achieving the development goals.

Resumen:
En este trabajo se analiza la relación entre las agendas de desarrollo y seguridad a la luz de la pandemia provocada por el SARS-CoV-2. Se comparan el gasto en salud y el gasto militar mundiales. Se establece una distinción en conceptos como seguridad y protección. Se hace un recuento de las responsabilidades que el mundo ha asumido al adoptar el Reglamento Sanitario Internacional de 2005 y el resultado de ello. Se revisa el índice mundial de seguridad sanitaria y sus desaciertos a la hora de calificar a los países, presumiblemente, mejor equipados en materia de salud. El artículo termina con la aseveración de que la prevención es la mejor manera de concretar los objetivos del desarrollo a la par de la construcción de sociedades seguras.

Palabras clave:
SARS-CoV-2, seguridad, desarrollo, Reglamento Sanitario Internacional de 2005, prevención, pandemia, seguridad en salud.

Key Words:
SARS-CoV-2, security, development, International Health Regulations (2005), prevention, pandemic, health security.

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Introduction

Few would disagree that health is one of the main topics on the development agenda. Suffice to look at the Sustainable Development Goals (SDGs), the third of which, focused on "good health and well-being," aims to improve the health of societies, reduce child and maternal mortality, combat a range of diseases, improve health systems and guarantee access to essential health services. Clearly, the pandemic unleashed by SARS-CoV-2, the pathogen that causes the disease known as COVID-19, has had a negative impact on this and the other SDGs, but that is not all: the spread of the disease worldwide has shown how a health issue can quickly cross over from the development to the security agenda.

This is not the first time health has been viewed through the looking glass of security. At the time of the terrorist attacks of September 11, 2001, on the United States, anthrax spores were mailed to public figures. The attack raised fears, both in the United States and elsewhere, that viruses, bacteria and toxins were being deliberately manipulated to cause harm and a biosecurity agenda was subsequently drawn up to protect societies from weaponizable toxins and chemical and biological agents. While the emphasis on this possibility is understandable, bundling anthrax, smallpox and other pathogens in the same category as terrorism—viewed ever since as the main threat to international security in this century—limited international cooperation and, more importantly, the response capacity of the community of nations.

Health, as a security issue, succumbed to the terrorist threat and the emergence of unknown diseases or the reemergence of others due to natural causes and not necessarily plots by terrorists or criminals was overlooked.

SARS-CoV-2 has shed light on two challenges related to post-September 11 biosecurity: firstly, emphasizing terrorism and naming it the number one threat to international security eclipsed other threats, like epidemics and pandemics attributable to natural causes, which have proven to be just as, if not more lethal to societies,[1] and secondly, it created a bias *vis-à-vis* the disruptive potential of new or reemerging diseases as threats to international security. In other words, health was important to international security only insofar as it involved events primarily intended to do damage.

In this paper, I will look at how high health ranks on global security and development agendas before going on to discuss why it is that, even though SARS-CoV-2 is the second pandemic of the twenty-first century[2] and despite the appearance of numerous new or emerging diseases, the international community, at least until December 2019, was more concerned with the use of viruses, bacteria and toxins to inflict harm than the possibility of a disease attributable to natural causes—for example, zoonosis—sparking off the most serious global crisis of recent decades. Finally, I will suggest how to analyze epidemics and pandemics from the perspective of international development and security agendas.

Health, development and security

The SARS-CoV-2 pandemic has demonstrated how ill prepared the nations of the world are to deal with a highly contagious and potentially lethal disease. The spotlight has inevitably turned to the budgets countries allocate

[1] It is estimated that three times more people died of the Spanish flu—erroneously named because it actually originated in the United States—than in World War I. See Redacción BBC Mundo, "La enfermedad que mató más gente que la Primera Guerra Mundial," in BBC News, October 13, 2014, at *https://www.bbc.com/mundo/noticias/2014/10/141013_salud_primera_guerra_gripe_espanola_men* (date of reference: February 12, 2021).

[2] The first pandemic of the twenty-first century was AH1N1 influenza, which hit Mexico and the world in 2009.

to health, health policies, the human resources available to treat patients, the number of hospital beds available, production of medical supplies, the functioning of biomedical research laboratories, the production of vaccines, etc. As is to be expected, there are those who rant and rave about global military spending, resurrecting an age-old debate that struck a chord during the Cold War: the relationship between disarmament and development. Under this premise, if countries spent less on weapons, this would almost immediately benefit development and, by extension, health.[3]

The good news is that while we spend massive amounts on defense, we allocate a lot more resources to health. So while global military spending stood at US$ 1.92 trillion in 2019, equivalent to 2.2% of gross world product (GWP) or US$ 249 per capita,[4] spending on health in 2017—the most recent period analyzed by the World Health Organization (WHO)—totaled US$ 7.8 trillion, equivalent to approximately 10% of GWP or US$ 1080 per capita.[5] In short, the world spends four times more on health than it does on defense.

That said, spending more on health does not necessarily mean that money is being spent wisely. As can be seen in Graph 1, the United States, the country that spends more than any other on defense, is also the country that spends most on health. On average, the United States spends US$ 11 072 per capita on health—around twice that of the Netherlands, Denmark and Luxemburg, and two-and-a-half times more than Japan, all countries deemed to have efficient health systems, or at least up until the SARS-CoV-2 pandemic.

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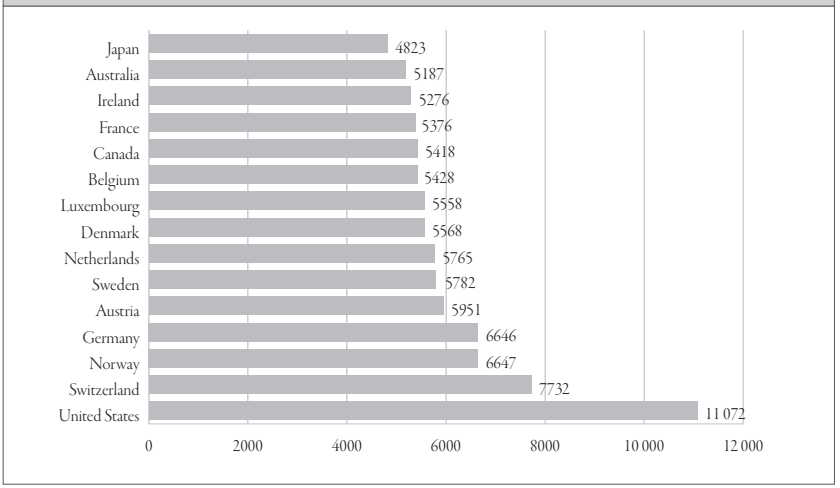
3 This issue is still being debated. In 2018, the First Committee of the U.N. General Assembly said that global military spending and the acquisition and modernization of nuclear weapons would not produce winners in any confrontation involving nuclear weapons, and that these resources would therefore be better spent if allocated to the achieving of vital development goals. See U.N. General Assembly, "Making Economic Case for Disarmament, First Committee Delegates Issue Calls to Trim Soaring Military Budgets, Reinvest Funds in Vital 2030 Agenda Goals," GA/DIS/3598, October 9, 2018, at *https://www.un.org/press/en/2018/gadis3598.doc.htm* (date of reference: February 12, 2021).

4 Nan Tian, Alexandra Kuimova, Diego Lopes Da Silva, Pieter D. Wezeman and Siemon T. Wezeman, *Trends in World Military Expenditure, 2019,* Stockholm, Stockholm International Peace Research Institute (SIPRI), April 2020, 1, at *https://www.sipri.org/sites/default/files/2020-04/fs_2020_04_milex_0_0.pdf* (date of reference: February 12, 2021).

5 WHO, *Global Spending on Health: A World in Transition*, Geneva, WHO, 2009, ix, at *https://www.who.int/health_financing/documents/health-expenditure-report-2019.pdf* (date of reference: February 12, 2021).

Graph 1. Per Capita Spending on Health in Selected Countries in 2019 (US$)



Source: OECD.

Despite its substantial per capita spending on health, the United States is the global COVID-19 epicenter, with 28 780 950 confirmed cases and 519 064 deaths.[6] Why, then, if it presumably has a well-financed health system,[7] is it facing such a severe crisis because of the pandemic? The numbers can be deceiving. There can be no denying the United States spends a considerable amount on health, but there is a huge equality gap when it comes to access to health services.[8] To date, the country has no uni-

[6] Figures up until March 3, 2021 at 6:24 pm. The first case of COVID-19 in the United States was confirmed on January 20, 2020. On the first anniversary of the arrival of the disease in the United States, President Joe Biden said it could claim as many as 600,000 lives. See "Biden advierte que covid podría dejar hasta 600 mil muertos en Estados Unidos," *El Informador,* January 22, 2021, at *https://www.informador.mx/internacional/Biden-advierte-que-COVID-podria-dejar-hasta-600-mil-muertos-en-EU-20210122-0089.html* (date of reference: February 12, 2021).

[7] In 2017, spending on health represented 17.1% of GDP in the United States.

[8] The United States lacks a health system with minimum coverage, although people can seek assistance at public or private hospitals in an emergency, but only in extraordinary cases. There are mandatory systems for vulnerable sectors of society, including Medicare, Medicaid and the Children's Health Insurance Program (CHIP). These three programs were introduced in 1965,

versal health coverage and the efforts of the Barack Obama administration to rectify this situation have met with countless political hurdles. The Organization for Economic Cooperation and Development (OECD) ranks the United States as the country with the most deficient health system of highly developed nations, confirming that spending more does not mean spending *well*.

The accessibility of health services is a major problem in the United States, an area in which it is bested by many countries listed on Graph 1. The United States currently spends twice as much on health as it did in the 1980s,[9] yet has lower life expectancy and the highest rate of child mortality of all developed nations.[10]

There are several reasons Americans spend so much on health. One of these is physicians' fees, which are among the highest in the world: in the United States a general physician earns an annual salary of US$ 218 173, compared to US$ 154 126 in Germany and US$ 86 607 in Sweden.[11] Then there is the increase in the price of medicines: in 2012, the cost of insulin for a patient with Type 1 diabetes was US$ 2864 a year, but by 2016, the price of the same product had risen to US$ 5705, making it increasingly inaccessible. Also, the cost of virtually every surgical procedure is stratospheric: open heart surgery sets patients back US$ 75 345 in the United States, compared to US$ 36 509 in Switzerland, which explains why more and more Americans are choosing to travel to Mexico, Turkey, Brazil, India, South Korea, Indonesia or Thailand, where they can receive the same treatments at a much

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but underwent major reforms during the administration of Barack Obama with the passing of the Patient Protection and Affordable Care Act (ACA), also known as Obamacare. See María Cristina Rosas, "Estados Unidos y el coronavirus", in etcétera, June 8, 2020, at *https://www.etcetera.com.mx/opinion/estados-unidos-coronavirus-trump-pandemia/* (date of reference: February 12, 2021).

9 Megan Leonhardt, "Americans Now Spend Twice as Much as they Did in the 1980s," in CNBN, October 9, 2019, at *https://www.cnbc.com/2019/10/09/americans-spend-twice-as-much-on-health-care-today-as-in-the-1980s.html* (date of reference: February 12, 2021).

10 J. Andjelic, "Healthcare Spending Statistics: How Much Does America Pay to Stay Healthy?," in Fortunly, August 2, 2019 at *https://fortunly.com/statistics/healthcare-spending-statistics#gref* (date of reference: February 12, 2021).

11 *Idem.*

lower price.[12] Just as onerous are the administrative costs of the paperwork required to claim refunds and payments from insurance companies, which is not only time consuming, but eats up 8% of the country's health budget.[13]

Graph 2 shows military spending as a percentage of GDP. Contrary to what you might think, the United States is not the country with the highest military spending if we measure this in terms of its GDP. This title goes to Saudi Arabia, which spends 8% of its GDP on defense. Paradoxically, Saudi Arabia did an excellent job combatting SARS-CoV-2, reporting 378 333 people infected and 6510 deaths,[14] commendable figures considering it is home to sacred places that attract millions of pilgrims from all over the world and the fact that it imports labor from various countries to meet its production demands.[15]

Graph 2 confirms that, with a handful of exceptions, the countries that have dealt moderately well with the threat posed by SARS-CoV-2 allocate just a small percentage of their GDP to defense—1.3% in the case of Canada and Germany compared to 3.4% in the case of the United States. In fact, one of the arguments of the administration of then-President Donald Trump was that his allies should spend more on defense because, according to him, it was unfair that the United States had to take on the responsibility of "protecting/defending them" from… Russia? Iran? China? Terrorism? North Korea? Clearly the allies of the United States view threats to international security differently and while they sanction Russia and Iran, combat terrorism and condemn North Korea's nuclear program, they would appear to have a broader understanding of global vulnerabilities, risks and threats.

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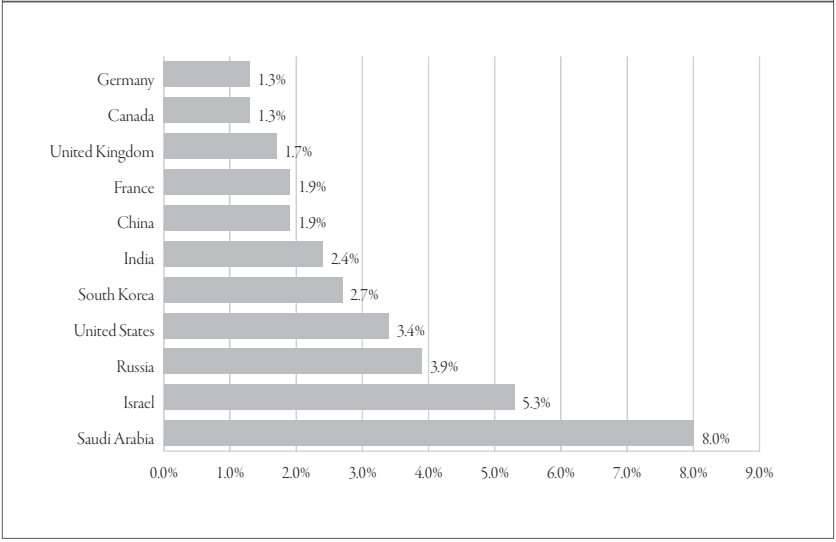
12 *Idem.* See also Patients Beyond Borders, "Patients Beyond Borders Announces Top 10 Cities for Medical Tourists in 2020," in Newswise, January 21, 2021, at *https://www.newswise.com/articles/patients-beyond-borders-announces-top-10-best-cities-for-medical-tourists-in-2020* (date of reference: February 12, 2021).

13 *Idem*.

14 Up until March 3, 2021 at 6:24 pm.

15 Saudi Arabia also benefited from the experience gained during the 2012 Middle East Respiratory Syndrome (MERS-CoV) epidemic. Endemic to Saudi Arabia, MERS-CoV is one of the seven known coronavirus variants and is extremely lethal. The challenges posed by MERS-CoV better prepared the Riyadh authorities to respond to epidemics and pandemics. See M. C. Rosas, "Arabia Saudita y el coronavirus," in etcétera, December 2, 2020, at *https://www.etcetera.com.mx/opinion/arabia-saudita-y-el-coronavirus/* (date of reference: February 12, 2021).

Graph 2. Global Military Spending as a Percentage of GDP in 2019



Source: SIPRI

Nevertheless, it should be remembered that military spending includes a budget allocated to health services for members of the armed forces and their families, not forgetting that military specialists have historically made landmark contributions to the health of their societies and the world at large. For example, military research programs have made major breakthroughs in medicine and vaccination. In 1880, the French military doctor Alphonse Laveran identified the protozoan that causes malaria, while William C. Gorgas, an American military physician, discovered that good sanitation, including public water and drainage systems and the use of mosquito nets, effectively reduced the incidence of yellow fever and malaria—something that helped save lives during the building of the inter-oceanic Panama Canal. Also noteworthy are Santiago Ramón y Cajal of Spain, who became the first army physician to receive the Nobel Prize for Medicine in 1906 for his studies on neurons, and Francisco Javier Balmis, a military doctor and physician to King Charles IV, who is remembered for leading the early nineteenth-century expeditions to take the smallpox vaccine developed by England's Edward Jenner to Spanish

America and Asia to immunize their populations, especially children.[16] An analysis of the role of Mexico's military doctors during the French intervention in Mexico reveals that this community can be credited with the first discoveries in cardioangiology in the country.[17] Later, in 1933, when the Mexican Academy of Surgery was founded, of its 60 founding physicians, nine were military surgeons.[18] Subsequently, the disarmament-development equation needs to take into account the contributions the armed forces have made—and continue to make—to medicine.

Notwithstanding, the argument that reducing global spending on defense would free up resources that could be channeled into development, for example, the SDGs, should not be dismissed. A study based on global military spending in 2015, estimated at US$ 1.68 trillion, found that SDGs 1 and 3, eradication of poverty and hunger, could be achieved with 13% of this figure; SDG 2, agriculture and food security, with 4%; SDG 3, health, with 5%; SDG 4, education, with 12%; and SDGs 6 and 7, water and sanitation and energy, with 3% and 11%, respectively, etc.[19]

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16 Laura Tardón, "Médicos militares que han marcado la profesión sanitaria," *El Mundo*, June 10, 2014, at *https://www.elmundo.es/salud/2014/06/10/5395fafee2704e65438b459b.html* (date of reference: February 12, 2021).

17 Alfredo de Micheli, "Los inicios de la cardioangiología mexicana en los albores de la Academia Nacional de Medicina," in *Archivos de Cardiología de México*, vol. 86, no. 3, July-September 2016, 276-281, in *http://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S1405-99402016000300276* (date of reference: February 12, 2021).

18 From 1933 to date, 65 military surgeons have been members of the Mexican Academy of Surgery: five warrant officers, four graduates of the Escuela Práctica Médico Militar and 56 graduates of the Escuela Médico Militar. See Antonio Moreno Guzmán and Héctor Noyola Villalobos, "Los médicos militares mexicanos y la Academia Mexicana de Cirugía y la Academia Nacional de Medicina de México," in *Revista de Sanidad Militar*, vol. 73, no. 1, January-February 2019, 73-80, in *https://www.medigraphic.com/pdfs/sanmil/sm-2019/sm191m.pdf* (date of reference: February 12, 2021).

19 Sam Perlo-Freeman, "The Opportunity Cost of World Military Spending," in SIPRI, April 6, 2016, in *https://www.sipri.org/commentary/blog/2016/opportunity-cost-world-military-spending* (date of reference: February 12, 2021). Another study by Milante and Sullivan explains why properly financing the SDGs can reduce vulnerabilities and better prepare societies to weather difficult circumstances. See Gary Milante and Kate Sullivan, Against all Odds: Using the Sustainable Development Goals to Overcome Fragility, in *SIPRI, April 25, 2016, at https://www.sipri.org/commentary/essay/2016/against-all-odds-using-sustainable-development-goals-overcome-fragility* (date of reference: February 12, 2021).

This is why disarmament has some fervent development advocates, although it certainly does not come cheap. In the case of the United States, the cost of complying with the disarmament and inspection provisions of the Strategic Arms Reduction Treaty (START) entered into with the USSR is estimated at between US$ 410 million and US$ 1.8 billion or between US$ 136 and US$ 200 million a year in the first five years following ratification of the treaty (in 1990 current dollars). Additionally, it was calculated that the inspections required on Russian territory would cost another US$ 100 to US$ 390 million a year.[20] But ridding the world of weapons of mass destruction is not the only costly undertaking. In Colombia, for example, the authorities estimate it would take between 0.67% and 0.89% of domestic GDP (in 2002 current dollars) to eliminate all the antipersonnel mines in the country.[21] It is therefore essential to weigh up the costs of disarmament against the potential development benefits. Clearly, the dismantling of arsenals of weapons of mass destruction, such as chemical, biological and nuclear weapons, and conventional weapons, too, like antipersonnel mines and cluster munitions, is positive for the development of nations—and unquestionably their health—,[22] but it entails financial costs that are not always taken into consideration.

Health, security and protection

Health is not merely the absence of disease, illness or ailments, at least not according to the WHO, which defines it as "a state of complete phys-

[20] Susan Willet, *Costs of Disarmament – Disarming the Costs. Nuclear Arms Control and Nuclear Rearmament*, Geneva, United Nations Institute for Disarmament Research, 2003, 25-26, at *https://www.unidir.org/files/publications/pdfs/costs-of-disarmament-disarming-the-costs-nuclear-arms-control-and-nuclear-rearmament-306.pdf* (date of reference: February 12, 2021).

[21] Yilberto Lahuerta Percipiano, "Impactos económicos generados por el uso de minas antipersonal en Colombia," in *Planeación & Desarrollo*, vol. XXXV, no. 2, July-December 2004, 603-604, at *https://colaboracion.dnp.gov.co/CDT/RevistaPD/2004/pd_vXXXV_n2_2004_art.6.pdf* (date of reference: February 12, 2021).

[22] Disarmament, both of weapons of mass destruction and conventional weapons, could potentially benefit societies by reducing the risk of death and injury, radioactive poisoning, traumatisms, amputations and psychological effects, among others.

ical, mental and social well-being and not merely the absence of disease or infirmity".[23] Hence, health can be *negative*—as defined by the mere absence of disease—or *positive—i.e.* focused on its causes. The WHO definition of positive health is clearly ambitious and has been the subject of recurring studies over the years, with some extoling its virtues and others claiming its tenets are impossible to translate into public policies and suggesting we concentrate exclusively on n*egative health.*

That said, it should be stressed that the concept of health is more closely linked to development than to security, although the relationship between both is recognized, especially in terms like *health security* (*seguridad en salud* in Spanish and *sécurité de la santé* in French) and *health safety* (*protección en salud* in Spanish and *surêté de la santé* in French. Unlike English and French, Spanish makes no distinction between security/sécurité and safety/surêté, both of which translate as *seguridad.* In order to make this distinction, *protección* has come to be an accepted Spanish translation of *safety/surêté.*

The difference between *safety-surêté-protección* and *security-sécurité-seguridad* is particularly important. The former is more "social," more development-oriented, while the latter is more "political", closer to the traditional "hard" concept of security.

In 2007, the WHO published its *Informe sobre la salud en el mundo 2007. Un porvenir más seguro. Protección de la salud pública mundial en el siglo XXI.* In the Spanish title, the term *seguro* is used as an adjective and *protección* as a noun, which can be misleading to readers. The English title of the report is *The World Health Report 2007. A Safer Future. Global Public Health Security in the 21st Century.* In this instance, *safer* appears as an adjective and *security* as a noun. Even more confusing, in the French title, *Rapport sur la santé dans le monde 2007. Un avenir plus sûr: la sécurité sanitaire mondiale au XXIe siècle*, *sûr* is used as an adjective and *sécurité* as a noun.[24]

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[23] WHO, "Preguntas más frecuentes: ¿Cómo define la OMS la salud?", in *https://www.who.int/es/about/who-we-are/frequently-asked-questions* (date of reference: February 12, 2021).

[24] WHO, *Informe sobre la salud en el mundo 2007. Un porvenir más seguro. Protección de la salud pública mundial en el siglo XXI,* Geneva, WHO, 2007, at *https://www.who.int/whr/2007/07_report_es.pdf* (date of reference: February 12, 2021); WHO, Rapport sur la santé dans le monde 2007. Un ave-

The difference between terms like *safety-surêté-protección* and *security-sécurité-seguridad* goes beyond mere semantics. In health, as can be inferred by simply reading the title of one of the most important reports published by the WHO to explain the bearing of health on security—and vice versa—, different countries interpret these terms differently depending on their specific instrumental interests.[25]

To begin with, there is a thin line between safety and security. For example, was the intentional release of anthrax spores in the United States via letters delivered by mail a safety issue or a security issue? As a matter of fact, it was both. As you may remember, between September 18 and October 9, 2001, letters infected with anthrax spores were mailed from New Jersey to media offices and the U.S. Congress. The spores were found in Florida, New York, New Jersey, Connecticut and the U.S. capital. A total of 22 people were infected and five died. The Federal Bureau of Investigation (FBI) and the Health and Human Services Department (HHS) confirmed that it was a terrorist—or rather, a bioterrorist—attack intended to cause harm.[26] However, questions still remain as to the motives behind these attacks and the statement they aimed to make.

Clearly, an atmosphere of fear and uncertainty reigned in the wake of the terrorist attacks executed using hijacked commercial aircraft that were deliberately crashed into the twin towers of the World Trade Center in New York, the Pentagon in Washington D. C. and Pennsylvania. The Al Qaeda terrorist organization later claimed responsibility for the attacks and the American public was left feeling vulnerable. It was in this context that the anthrax episode occurred. The authorities labeled it an act intended to cause harm and initially attributed it

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nir plus sûr: la sécurité sanitaire mondiale au XXIe siècle, Geneva, WHO, 2007, at *https://www.who.int/whr/2007/07_report_fr.pdf* (date of reference: February 12, 2021); WHO, The World Health Report 2007. A Safer Future: Global Public Health Security in the 21st Century, Geneva, WHO, 2007, at *https://www.who.int/whr/2007/whr07_en.pdf* (date of reference: February 12, 2021).

25 M. C. Rosas, "La seguridad humana sostenible: ¿paradigma para la seguridad nacional de México en el siglo XXI?" in M. C. Rosas (coord.), *La seguridad extraviada: apuntes sobre la seguridad nacional de México en el siglo XXI,* Mexico, Universidad Nacional Autónoma de México/Centro de Análisis e Investigación sobre Paz, Seguridad y Desarrollo Olof Palme A.C., 2019, 62-63.

26 Patricia Matey, "Diez años después del ataque de ántrax," *El Mundo*, October 3, 2011, at *https://www.elmundo.es/elmundosalud/2011/10/03/biociencia/1317666082.html* (date of reference: February 12, 2021).

to Al Qaeda, although it was later discovered that the spores could have been deliberately released by the reputed American virologist Bruce Edwars Ivins, who worked for 18 years at the United States Army Medical Research Institute of Infectious Diseases, in an attempt to test the vaccine he was working on on humans. Ivins committed suicide by taking a lethal dose of codeine and paracetamol on July 29, 2008. At the time, he was the main suspect in the attacks and was under investigation by the FBI.[27] This episode resulted in viruses, bacteria and toxins being decisively linked to terrorism/bioterrorism—and, by extension, "hard" security—and less to health as an issue on the development agenda. Nor was it considered that naturally occurring diseases might be as lethal as those caused by the deliberate release of pathogens. And so health became a biosecurity issue under the banner of the war on terrorism, with health safety (*protección, surêté*) being largely neglected.

The first wake-up call as to the risk of ignoring the threat posed by naturally occurring diseases came in 2002-2003, when the severe acute respiratory syndrome (SARS-CoV) strain of the coronavirus emerged in China, from where it proceeded to spread to other parts of the world.[28] SARS-CoV first appeared in Foshan, a city southwest of Guangzhou, in the province of Guangdong, in November 2002. At the time, China's health system was extremely centralized, little was known about treating infectious diseases and there was no effective strategy in place for communicating with or informing the public. The central government also had a hard time getting local authorities to assume responsibility for dealing with the health crisis.[29]

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[27] David Alandete, "Muere el terrorista de las cartas con ántrax," *El País*, August 1, 2008, at *https://elpais.com/diario/2008/08/02/internacional/1217628001_850215.html* (date of reference: February 12, 2021).

[28] To date, seven variants of coronavirus have been identified: four of them (HCoV-229E, HCoV-OC43, HCoV-NL63 and HCoV-HKU1) are very common and some are present in the common cold along with other pathogens like rhinoviruses, reason why a very high percentage of the population is believed to have developed immunity. In addition to these four coronaviruses, another three have emerged more recently, the most notorious of which is SARS-CoV-2, although its sisters—SARS-CoV and the Middle East Respiratory Syndrome (MERS-CoV)—also made an appearance in this century, setting off alarm bells among the scientific community due to their incidence and varying degrees of fatality.

[29] M. C. Rosas, "China y el coronavirus," in etcétera, December 21, 2020, at *https://www.etcetera.com.mx/opinion/china-coronavirus-pandemia/* (date of reference: February 12, 2021).

The virus spread quickly, reaching Hong Kong in February 2003 and making the leap from there to Singapore, Canada—especially Toronto—and the United States. Meanwhile, the Chinese authorities concealed the spread of the disease, disclosed false information and claimed they had the situation under control. Lack of information caused the Chinese public to panic and, faced with a rising death toll and international pressure, the Beijing government finally acknowledged it had a crisis on its hands. The Chinese capital was hit particularly hard by the disease and both the mayor and health minister were removed from office. The Chinese economy nevertheless took a severe beating and the country's GDP fell by between 1 and 2 percentage points in 2003 because of the epidemic.

SARS-CoV affected mainly the families of patients and health workers. By February 2003, the disease had spread to other countries, with outbreaks being reported in Hong Kong and Vietnam at the end of that month. On March 10, 18 staff members at the Hospital Wales in Hong Kong reported cases of SARS-CoV and a few days later, more than 50 people, including doctors and nurses, had been infected. By mid-March, people with SARS-CoV had been identified in Singapore and Canada, which was when the WHO decided to issue a health alert. A total of 32 countries and regions of the world subsequently reported cases confirmed by laboratory tests. From November 2002 through August 2003, 8422 cases and 916 deaths were reported. The average mortality rate of confirmed cases was 9.3%, but this varied considerably depending on the patient's age. For example, in over-65s, the mortality rate was 50% and the disease tended to affect men more than it did women.[30] Of the total number of deaths reported, 349 occurred in China and 299 in Hong Kong.[31]

Following the SARS-CoV epidemic of 2002-2003 and the anthrax attacks of 2001, the WHO began drawing up new international health regulations to respond to public health emergencies caused by both the deliberate intention to do harm and the emergence of new diseases or the reemergence

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30 *Idem.*

31 David Stanway, "La sombra del SARS: China aprendió por las malas cómo lidiar con una pandemia," in Reuters, January 22, 2020, at *https://www.reuters.com/article/china-salud-sars-idESKBN1ZL1PJ* (date of reference: February 12, 2021).

of others deemed extinct or under control. These new regulations were approved by the World Health Assembly in 2005, but would not come into force until two years later.

The International Health Regulations of 2005 and the relationship between health and security

Unlike the health regulations of 1969, pursuant to which States were only required to notify the international community of outbreaks of cholera, plague and yellow fever, the new ones that came into force on June 15, 2007 are an ambitious set of protocols built on two pillars: global health security—alert and response to epidemics and pandemics—and the global public health response to the natural occurrence, accidental release or deliberate use of biological and/or chemical agents, radioactive, nuclear or similar materials that affect health.[32]

It is not just its different terminology that sets the new international health regulations (IHR) apart from their predecessors, but the change in paradigm: while the old regulations considered only a handful of diseases, the new ones cover all possible threats to public health, and instead of taking preconceived or predefined measures, responses now have to be tailored to the risk. Equally important is the shift from border controls to local containment, *i.e.* in the place in which the disease originates.[33]

The IHR state that the WHO must be notified of all events that could constitute a public health emergency of international concern, which, in turn, depends on the circumstances in which the event takes place and whether or not it is a serious event that affects public health; whether it is an unusual or unexpected situation; whether or not there is the risk the disease will spread internationally; and whether or not there is the possibility of or need to take measures that restrict

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[32] Miguel Mínguez Gonzalo, "El nuevo reglamento sanitario internacional (RSI) 2005", in *Revista Española de Salud Pública*, vol. 81, no. 3, May-June 2007, 239-246, at *http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1135-57272007000300001* (date of reference: February 12, 2021).

[33] María Begoña Adiego Sancho, *El reglamento sanitario internacional*, Zaragoza, Instituto Aragonés de Ciencias de la Salud, 2014, 3, at *http://www.ics-aragon.com/cursos/salud-publica/2014/pdf/M3T07.pdf* (date of reference: February 12, 2021).

travel and international trade. "To comprehensively meet the early warning and alert requirements of the IHR, there is a need to strengthen and develop both routine, or indicator-based, surveillance and event-based surveillance".[34]

In this regard, the IHR of 2005 propose a broad, comprehensive approach that includes "diseases or unknown, unusual or unexpected patterns of disease of all origins (*i.e.* biological, chemical, radioactive, nuclear), as well as threats that could entail a risk to human health, like heatwaves, natural phenomena or contaminated foodstuffs".[35]

Needless to say, to comply with the provisions of the IHR, all 194 WHO members would have to completely restructure their public health surveillance systems, while continuing to cooperate amongst themselves. Given the increasingly transnational and global nature of public health threats and risks, close collaboration among the world's nations is essential, but oftentimes it is hampered by the predominance of biosecurity over public health issues. Sharing epidemiological information like the IHR propose could potentially expose weaknesses that other States and non-state entities, like terrorists, organized crime and lone wolves could exploit to do harm.

Related to this are the crises facing institutions and the reluctance of countries to be monitored by agencies, agreements or regulations at a time when, for example, multilateralism has been vilified and the credibility of the WHO called into question. Furthermore, the IHR of 2005 propose heading off the "event" on a local level. Emphasis is placed on local containment, *i.e.* in the place where the disease originates, whereas previously, nations responded mainly by implementing quarantine and isolation measures anywhere necessary, generally when the disease had already spread to other environments.

Two difficulties remain: how to deal with an outbreak of disease, an accident of anthropic origin or a natural phenomenon if it occurs in a place

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[34] WHO, *Protocol for Assessing National Surveillance and Response Capacities for the International Health Regulations (2005) in Accordance with Annex 1 of the IHR: A Guide for Assessment Teams*, Geneva, WHO, December 2010, 10, at *https://www.who.int/ihr/publications/who_hse_ihr_201007_en.pdf* (date of reference: February 12, 2021).

[35] Pan American Health Organization and WHO, *Detección temprana, evaluación y respuesta ante eventos agudos de salud pública: puesta en marcha de un mecanismo de alerta temprana y respuesta con énfasis en la vigilancia basada en eventos. Versión provisional*, Washington D.C., PAHO/WHO, 2014, 7, at *https://www.who.int/ihr/publications/WHO_HSE_GCR_LYO_2014.4es.pdf* (date of reference: February 12, 2021).

that does not have the necessary clinical assessment infrastructure or the capacity to respond in the event of an emergency. We cannot simply turn a blind eye to the fact that many places in the world do not have even the most basic services and would be hard pressed to implement containment measures like the ones stipulated in the IHR.

Furthermore, a North-South bias can be perceived in the IHR of 2005. This has been a bone of contention, since the interests of more developed nations seem to take precedence over those of the world's poorest countries. For example, the IHR recommend that material and human resources be channeled into events of international concern, but this would compromise the capacity of developing countries to combat diseases like HIV/AIDS, malaria and tuberculosis, which are a lot higher up on their public health agendas.[36] The SARS-CoV-2 pandemic illustrates this reality: the new coronavirus has been given priority and we have lost sight of the need to continue treating other diseases and ailments. In mid-2020, no less than 24 countries announced that they were running out of the antiretroviral drugs they so desperately need to combat HIV/AIDS. Just recently, the Democratic Republic of the Congo reported a new case of Ebola in the province of North Kivu, where the disease had been declared extinct in June 2020. In Guinea, in mid-February of this year, there were also reports of another outbreak of this much-feared disease.[37] The pandemic has caused delays in the transportation of medicines by land, sea and air, while suppliers have encountered sourcing problems and cuts have been made to health services for the treatment of diseases and ailments other than SARS-CoV-2.[38]

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[36] Kumana Wilson, Sam Halabi and Lawrence O. Gostin, "The International Health Regulations (2005), the Threat of Populism and the COVID-19 Pandemic," in *Globalization and Health*, vol. 16, no. 70, July 28, 2020, at *https://doi.org/10.1186/s12992-020-00600-4* (date of reference: February 12, 2021).

[37] WHO, "Resurgence of Ebola in North Kivu in the Democratic Republic of the Congo," *February* 7, 2021, at *https://www.afro.who.int/news/resurgence-ebola-north-kivu-democratic-republic-congo* (date of reference: February 12, 2021); DW, "Ébola, el eterno retorno de la peor pesadilla," February 15, 2021, at *https://www.dw.com/es/%C3%A9bola-el-eterno-retorno-de-la-peor-pesadilla/g-56576481* (date of reference: March 3, 2021).

[38] WHO, "OMS: el acceso a los medicamentos para el VIH está gravemente afectado por el covid-19 y la respuesta al sida se estanca," press release, July 6, 2020, at *https://www.who.int/es/news/item/06-07-2020-who-access-to-hiv-medicines-severely-impacted-by-covid-19-as-aids-response-stalls* (date of reference: February 12, 2021).

But the North-South inequalities exacerbated by the current health crisis do not end here: access to SARS-CoV-2 vaccines is concentrated in a handful of highly developed countries, painting a catastrophic picture not just for our most vulnerable nations and societies, but for the world at large.[39] This is why some believe that addressing a public health emergency of international concern like SARS-CoV-2 is creating other public health crises, but of diseases that were once being combated with relative success. Measles and polio are two other diseases that are reemerging with striking vigor and that, unlike HIV/AIDS, can be prevented with vaccination. In short, it would seem that development issues like health only make their way onto the security agenda when they have a disruptive capacity, especially when it is the more developed countries that are disrupted.[40] As of today, COVID-19 has spread to 192 countries or territories, but as illustrated by the terrorist attacks of September 11, 2001, an issue is more likely to influence the architecture of global security when the affected parties are the dominant country or countries, which explains why health now has a more prominent position on the international security agenda.

The Global Health Security Index

Published in 2019, the Global Health Security (GHS) Index was compiled by the Center for Health Security at the Johns Hopkins University, the Nuclear Threat Imitative and The Economist Intelligence Unit.[41]

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[39] The WHO has harshly criticized certain countries for hoarding vaccines. For example, Canada acquired five times more doses that it needs. See Verónica Mondragón, "OMS pide acceso equitativo a vacuna; advierte riesgo países pobres", *Excélsior*, January 19, 2021, at *https://www.excelsior.com.mx/nacional/oms-pide-acceso-equitativo-a-vacuna-advierte-riesgo-paises-pobres/1427824* (date of reference: February 12, 2021).

[40] As of February 6, 2021 at 10:21 pm, behind the United States in terms of confirmed cases of SARS-CoV-2 are India, Brazil, the United Kingdom, Russia, France, Spain, Italy, Turkey and Germany, all members of the G20, which brings together the world's leading economies.

[41] Philanthropic organizations like the Bill & Melinda Gates Foundation helped compile the report. See Center for Health Security (CHS), Nuclear Threat Initiative (NTI), The Economist Intelligence Unit (EIU), *GHS Index. Global Health Security Index: Building Collective Action and Accountability,* Baltimore/Washington, D. C./London, CHS/NTI/EIU, October 2019, at *https://*

It ranks 195 countries in terms of their health security capabilities, based on an assessment of their ability to prevent, detect, report and respond to outbreaks of diseases, and, depending on the solidity of their health systems, comply with international standards. It also rates countries in terms of their capacity to weigh up the risk of biological threats. This index is in synch with the IHR of 2005 and replicates its biases.

One of these biases is the way it lumps several health scourges together, something to which, as we have already mentioned, objection has been raised, especially by developing nations. The report opens with the assertion that biological threats—be they natural, intentional or accidental—pose a risk to global security, international security and the world economy.[42] It is hard to disagree with this statement, but, for purposes of public policy, it would be prudent to classify biological threats according to the level of risk they represent: natural ones tend to be more disruptive than intentional or accidental ones, which also tend to occur less frequently, while in the case of new, naturally occurring diseases and the reemergence of existing ones, the WHO says that one or more new pathogens have been identified every year since the 1970s, meaning that there are some 40 diseases that were unknown to us just a generation ago and that have a tendency to spread quickly.[43]

This is not to say we should ignore bioterrorism or accidents like Chernobyl and Fukushima, but as SARS-CoV-2 has shown us, such events should not be prevented at the expense of those that have the potential to escalate into global catastrophes, due, among other reasons, to the social and economic makeup of today's world, characterized as it is by changes in the food industry, obesogenic lifestyles, increased meat consumption—which contributes to a higher incidence of diseases like cysticercoids, bovine spongiform encephalopathy, etc.—, human behavior, armed conflicts, global warming, transformations in the medical and pharmaceutical industries, trade, tourism and travel in an increasingly globalized world, and changes in land use and urbanization, all of which create conditions conducive to the spread of diseases.

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www.ghsindex.org/wp-content/uploads/2020/04/2019-Global-Health-Security-Index.pdf (date of reference: February 12, 2021).

42 *Ibid*., 5.

43 WHO, *Informe sobre la salud en el mundo 2007...*, x.

Table 1. Global Health Security Index *vs.* Confirmed Cases and Deaths Caused by SARS-CoV-2

Country	Ranking on the Global Health Security Index	Global Ranking in terms of Confirmed Cases of SARS-CoV-2	Global Ranking in terms of Deaths Caused by SARS-CoV-2
United States	1	1 (28 780 950)	1 (519 064)
United Kingdom	2	5 (4 207 119)	5 (124 117)
Netherlands	3	21 (1 116 365)	27 (15 823)
Australia	4	114 (29 007)	105 (909)
Canada	5	22 (880 835)	21 (22 105)
Thailand	6	116 (26 108)	159 (84)
Sweden	7	29 (675 292)	31(12 964)
Denmark	8	58 (213 486)	72 (2371)
South Korea	9	85 (90 816)	83 (1612)
Finland	10	100 (59 442)	107 (759)
France	11	6 (3 843 241)	7 (87 695)
Slovenia	12	63 (192 266)	57 (3874)
Switzerland	13	32 (559 845)	36 (10 014)
Germany	14	10 (2 472 896)	9 (71 073)
Spain	15	7 (3 136 321)	10 (70 247)

Source: Compiled by the author based on information from CHS, NTI and EIU, *op. cit.,* 20; and Johns Hopkins University, "Coronavirus Resource Center," at *https://coronavirus.jhu.edu/map.html* (date of reference: March 3, 2021 at 6:24 pm).

Table 1 compares the Global Health Security Index assessment with available information on confirmed cases and deaths caused by SARS-CoV-2. This exercise reveals that, while the United States is ranked as the country with the best health security capabilities, paradoxically, it is the one with the most COVID-19 cases and deaths. The United Kingdom, which is ranked second on the GHS Index, is fourth and fifth worldwide in terms of confirmed cases and deaths, respectively. The correlation between health security and confirmed cases of COVID-19 and deaths in the 15 countries listed would seem to contradict the GHS Index. If it hit the mark at all, it was possibly in the case of Thailand (ranked sixth in global health security), which has reported 23 371 cases and 79 deaths. In the rest of the countries ranked as having the best indices, confirmed cases are in the thousands, sometimes millions, while deaths range from hundreds to hundreds of thousands.

This comparison prompts us to ask what exactly it is that health security indices are measuring. The GHS Index revealed that no country is fully prepared for an epidemic or pandemic and rates the world with 40.2 out of a possible 100 points, which, by all accounts, is a fail in its book.[44]

Of particular note is that, according to this report, despite the aforementioned deficiencies of its health system, the United States is ranked as the country with the best health security capabilities of the 195 countries assessed, with a score of 85.3 out of a possible 100 points. This may be true when it comes to threats such as bioterrorism—following the events of 2001, it would seem that its strategy to prevent viruses, bacteria and toxins being used to harm Americans has considerably reduced this type of threat—, but it is not, however, the case with naturally occurring diseases that have arrived in the country in this century, like SARS, AH1N1 influenza, Ebola, Zika, Chykungunya and, unquestionably, SARS-CoV-2. History, it seems, is repeating itself: Woodrow Wilson, knowing full well that there had been an outbreak of flu among his troops at Fort Riley, Kansas, decided to send them to Europe to fight in World War I regardless, thereby contributing to the spread of what would erroneously come

[44] CHS, NTI, EIU, *op. cit.*, 18.

to be known as the Spanish flu.[45] Evidently the United States has not excelled in the management of epidemics or pandemics, either in the twentieth century or this one.[46]

One country that contrasts with the United States is New Zealand, which is ranked 35 on the GHS Index, even further down than Mexico, which is ranked 28. Notwithstanding, it is one of the countries that is deemed to have best managed the SARS-CoV-2 pandemic, reporting 2384 cases and 26 deaths, which puts it in position 164 worldwide in terms of confirmed cases and 175 in terms of deaths. The key to New Zealand's success lies in its prioritization of health and social well-being as the foundation of national security. This decision has put the country on the world map, inciting curiosity, but also respect and admiration. In the particular case of New Zealand, there is one important event that, once again, underscores the relationship between security and development.

On March 15, 2019, a "lone wolf" attacked two mosques in the city of Christchurch, killing 51 people—45 at the Al Noor mosque and seven at the Linwood mosque. The shootings shook New Zealand to the core. The author of the attacks, an Australian with ties to the extreme right, opened fire on men, women and children and broadcast the killings live on Facebook, having previously released a manifesto littered with racist and white supremacist Nazi-like slogans.[47] Although Prime Minister Jacinda Ardern labeled it a terrorist attack, she managed the crisis respectfully, earning her the recognition and support of New Zealanders and the international community. Whereas in other parts of the world, like the United States, Spain, Great Britain, France, etc., the issue of terrorism has taken center stage, overshadowing other vulnerabilities, risks and threats, on

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45 Wilson himself caught the flu while in Europe negotiating peace terms for a defeated Germany with France and the United Kingdom. Initially, he was against imposing a costly peace on the Germans as France was demanding, but his illness caused him to accept. These onerous peace terms would set the stage for World War II.

46 M. C. Rosas, "Wilson, Eisenhower, Ford, Reagan and Obama: cómo gestionar una epidemia," in Globalitika, May 11, 2020, at *https://af6f3f45-e49c-4ab5-8df6-e08f3f8d962c.usrfiles.com/ugd/af6f3f_0b8e569807dc42a4b57f48bdea4dff70.pdf* (date of reference: February 12, 2021).

47 "Christchurch Shootings: 49 Dead in New Zealand Mosque Attacks," in BBC News, March 15, 2019, at *https://www.bbc.com/news/world-asia-47578798* (date of reference: February 12, 2021).

May 2019, just weeks after the tragedy, Ardern announced the largest social well-being budget in the history of the planet, equivalent to a third of government spending.

It is not often that authorities respond to an act of terrorism by attacking the structural shortcomings at the root of the problem. In the case of New Zealand, this strategy has paid off. Unlike other nations that cannot see the forest for the trees, New Zealand sees the big picture, which is why social well-being, along with health and education, account for 60% of its expenditure budget. Additionally, Prime Minister Ardern won the trust of society by responding rapidly and intelligently to the terrorist attacks, and because she also came through on her campaign promises. So when she announced drastic measures to contain the SARS-CoV2 virus, New Zealanders lent her their support.[48] Ardern and her labor party went on to win the October 2020 general elections with a crushing victory, enabling her to form a government without having to enter into coalitions with other parties.[49]

It should be remembered that New Zealand has a reputation for championing social well-being. Its debt to the Maoris and its discriminatory policies against the Chinese community aside, it was the first country in the world to guarantee women the right to vote in 1893 and in 1898 it introduced pensions for senior citizens. It later granted pensions to widows (1911), miners (1915) and the blind (1924).[50] The country's emphasis on the social security—and development—agenda goes back a long way, which would seem to confirm that a society with foundations such as these is in a better position to construct and coordinate its security agenda.

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48 M. C. Rosas, "Nueva Zelanda y el coronavirus," in etcétera, May 1, 2020, at *https://www.etcetera.com.mx/opinion/nueva-zelanda-coronavirus-jacinta-ardern/* (date of reference: February 12, 2021)

49 Redacción BBC News Mundo, "Jacinda Ardern y su partido ganan con mayoría absoluta en las elecciones de 2020," in BBC News, October 27, 2020, at *https://www.bbc.com/mundo/noticias-internacional-54582378* (date of reference: February 12, 2021). By way of contrast, in the presidential elections of November 2020, Donald Trump was defeated despite getting more popular votes than in 2016. It is reasonable to assume his poor management of the SARS-CoV-2 pandemic took its toll on this controversial figure.

50 M. C. Rosas, "Nueva Zelanda y el coronavirus."

Final considerations

Although global spending on health quadruples military spending, this in no way means financing for the SDGs or even for SDG 3, which is the theme of this paper, is guaranteed. Nor should we assume this equation cannot change for the better (reduced spending on defense and the shoring up of spending on health) or for the worse (increased military spending and fewer development resources). However, in a world fraught with geopolitical tensions and rivalries, there is a strong temptation to favor security over development.

The SARS-CoV-2 pandemic has called into question the approach the international community—with scant exceptions—has taken to health. The IHR of 2005 and the GHS Index both lack a comprehensive vision of health, as evidenced by their overemphasis on events employing viruses, bacteria and toxins to deliberately cause harm. This is not the first time it has happened: on March 20, 1995, the Aum Supreme Truth sect placed packages containing sarin gas in subway stations in Tokyo, killing 13 people, leaving dozens handicapped and poisoning 6300.[51] Sarin was also used by the government of Bashar al Asad in the Syrian civil war that has been raging since September 2013.[52] The use of polonium-210 to poison Alexander Litvinenko in November 2006[53] and the nerve agent novichok on Russian opposition leader Alexei Navalny, who had to receive medical treatment in Germany, are just a few examples of the use, in this case, of chemical agents to inflict harm.[54] Nor is the world immune to scenarios like that of the Fukushima

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51 Its leader, Shoko Asahara and six other members of the sect were sentenced to death by hanging in 2004. The sentence was executed on July 6, 2018. See "Ejecutado fundador de secta y cerebro de ataque en metro de Tokio," in DW, July 6, 2018, at *https://www.dw.com/es/jap%C3%B3n-ejecutado-fundador-de-secta-y-cerebro-de-ataque-en-metro-de-tokio/a-44548040* (date of reference: February 12, 2021).

52 Nawal al-Mahgafi, "Investigación BBC en Siria: cómo las armas químicas tienen a Bashar al Asad a punto de ganar la Guerra," in BBC News, October 17, 2018, at *https://www.bbc.com/mundo/noticias-internacional-45867618* (date of reference: February 12, 2021).

53 "¿Qué es el polonio 210?", in *El País*, January 21, 2016, at *https://elpais.com/internacional/2016/01/21/actualidad/1453373675_004886.html* (date of reference: February 12, 2021).

54 Redacción BBC News Mundo, "Alexei Navalny: el opositor ruso 'fue envenenado con novichok,' según Alemania," in BBC News, September 2, 2020, at *https://www.bbc.com/mundo/noticias-internacional-54000515* (date of reference: February 12, 2021).

nuclear plant or natural phenomena like earthquakes, volcanoes, floods, hurricanes, droughts, etc., all events that impact the health of societies. What is needed is a vision more focused on development to accompany the issue of security in the management of the global health agenda.

So what can security contribute to the health and development agenda? Security studies are designed to anticipate threats, risks and vulnerabilities that could put the survival of the State and its components—for example, territory, population and government—to the test, so preventive measures can be devised. And prevention strategies save lives, making it possible to maximize the use of existing material and human resources and take decisions without the pressure of consummated fact, whereas emergencies, full-blown crises and poor contingency preparation can all lead to the taking of ill-advised, potentially costly decisions for societies.

Internationally, there is constant tension between the WHO, the U.N. body specialized in health, and the U.N. Security Council, the agency responsible for maintaining international peace and security. This friction can be attributed primarily to the fact that the WHO views health as a development issue, while the Security Council sees it as a biosecurity issue of a political nature.[55] The Council has held sessions to address the HIV/AIDS, Ebola and, more recently, the SARS-CoV-2 crisis. This is not inherently negative if we agree that biosecurity is as important as the development agenda when it comes to health.

This latent tension in the U.N. System is echoed within States. Many countries have used their armed forces to surveil borders, protect hospitals and health workers and assist the population, while military facilities have been reconverted into hospitals and plants for the production of medical supplies. Other countries have decreed curfews and states of emergency in an effort to maintain public order, guarantee the continuance of essential activities and, ultimately, protect human life. We are, however, left with the sensation that coordination between military and health institutions could be improved on, not just in the present crisis, but in the prevention of future ones.

According to Marco José and Rebeca Borgaro:

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[55] M. C. Rosas, "La seguridad humana sostenible...," 68-70.

> The history of diseases must be based essentially on changes in mortality and life expectancy: there are no reliable statistics for disease and suffering, whereas births and deaths can be counted. As such, mortality must necessarily be taken into account when elucidating how diseases were combatted in the past […] the most devastating infectious diseases were combatted not so much due to the discovery of effective treatments, but the discovery of preventive measures. Mortality began visibly declining at the beginning of the nineteenth century, at a time of revolution and reform, and this decline became more pronounced when the cause of many diseases was discovered at the end of the same century. Even in the twentieth century, the most significant achievements can be attributed mainly to preventive measures.[56]

In keeping with José and Borgaro, a balance needs to be struck in the management of security and development, given that both are important and each has a contribution to make to prevention: it is just as important to combat drug trafficking as it is to educate people as to the risks of drug consumption and rehabilitate addicts; just as important to combat the theft of radioactive material as it is to step up security at storage facilities;[57] just as important to build medical and hospital infrastructure as it is to improve health education, which would undoubtedly help people make better-informed decisions.

The SARS-CoV-2 crisis is an invaluable opportunity to rethink the relationship between security and development. Both are important. Social progress depends on both, reason why it is vital we do not let the novel coronavirus take undue precedence over other diseases, resulting in a one-dimensional development and/or security agenda. Today the world is paying the price of blowing the terrorist threat out of proportion. We can only hope we learn from this crisis so we are better equipped to manage the next pandemic.

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[56] Marco José and Rebeca Borgaro, "Historia universal de la mortalidad," in *Salud Pública de México,* vol. 31, no. 1, January-February 1989, 3, at *https://www.saludpublica.mx/index.php/spm/article/download/107/100/163* (date of reference: February 12, 2021).

[57] "El extraño pero constante robo de material radiactivo en México," in Infobae, October 24, 2019, at *https://www.infobae.com/america/mexico/2019/10/24/el-extrano-pero-constante-robo-de-material-radiactivo-en-mexico/* (date of reference: February 12, 2021).