

## HAPSc Policy Briefs Series

Τομ. 2, 2021



### Health and Migration: Health Securitization and Policy-Making Perspectives in the Post-Pandemic Era

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<https://doi.org/10.12681/hapscpbs.27667>

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#### To cite this article:

Kyrgos, Z., & Pantazis, D. (2021). Health and Migration: Health Securitization and Policy-Making Perspectives in the Post-Pandemic Era. *HAPSc Policy Briefs Series*, 2(1), 118-127. doi:<https://doi.org/10.12681/hapscpbs.27667>

## Health and Migration: Health Securitization and Policy-Making Perspectives in the Post-Pandemic Era<sup>1</sup>

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### Abstract

It is not to deny that the up-to-date literature has already discussed the emergence of forced human mobility due to the outbreak of health crises, owing to the latter's adverse socio-political effects on the intrastate or regional systems. However, the ongoing COVID-19 pandemic has been playing a crucial role in enhancing the research upon health crises and health securitization, hence, further recognizing their multidimensional character. Under these circumstances, this text attempts to estimate whether and to what extent the states will reconsider their agendas –in the post-pandemic era– in terms of more successfully managing health crises and associated migration, so as to respectively reduce the potential negative consequences in their internal systems.

**Keywords:** health crisis; diseases; migration; health securitization; future policy-making; post COVID-19 era.

### Introduction

Although modern medical and pharmaceutical sciences have advanced to an extensive degree, health can still be regarded as a main human security issue (Hough, 2015: 254). A variety of factors, such as the environment-human relationship, human mobility, existing human underdevelopment, or even unsanitary practices undeniably have a knock-on effect on the outbreak of major health crises related to communicable diseases (Ellwanger et al., 2021). Furthermore, and in recent years, there has been an increasing interest in issues related to health, as matters that may primarily and in future concern humanity, especially when taking into consideration the increasing globalization and interaction of human societies. Not only this, but the COVID-19 pandemic has –additionally, and inter alia– played a crucial role in re-examining health in security terms. It is, moreover, aptly noted that, in accordance with the latest research trends, scientific publications regarding infectious diseases tend to increase, particularly after a disease outbreak. The most up-to-date commonly cited research concerns coronaviruses, Influenza, Ebola, and Zika viruses, accompanied by an interlinked interest between the emergence per se and health security (The Elsevier Community, 2020).

<sup>1</sup> To cite this paper in APA Style: Kyrgos, Z., & Pantazis, D. (2021). Health and Migration: Health Securitization and Policy-Making Perspectives in the Post-Pandemic Era. *HAPSc Policy Briefs Series*, 2(1): 118-127. DOI: 10.12681/hapscpbs.27667

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Given the above, and taking into account the multi-dimensional impact which a disease outbreak and diffusion might have on intrastate and regional systems, this paper reports on whether, to what extent, and in what terms can health prevention response be regarded as a policy-making parameter in the future, particularly referring to health-related population mobility and the need for states to confront its specific negative aspects. To extract the necessary conclusions, the methods of literature review and multi-leveled analysis are applied throughout this text. To be specific, this essay's rationale is based on contextualization, correlational implications, and variables identification.

This paper is divided into three sections. The first part gives a brief overview of the cause-effect patterns, which disease outbreaks and health crises may have on state systems. In the second part of the research, it is assumed that the aforementioned consequences may lead to health-associated migration processes; hence, further correlational implications reaffirming this supposition are implicated and evaluated. The remaining part of the paper proceeds as follows: it is estimated that host-nations' policy agents stand positive on migration as long as the latter does not affect the security and viability of the state itself. However, policy-makers might seriously take the respective potential negative aspects into account; hence, it is concluded that states may re-define their agendas on intrastate and interstate health crisis management and migration. Consequently, this policy brief refers to potential policy-making perspectives.

### **Diseases and epidemics: generative factors and impacts on systems**

This section briefly reviews the determinants that can lead towards the (re)emergence of diseases and highlights the potential impacts on states. For the needs of this research, it is to be made clear that “an epidemic can be an outbreak of a novel disease or can occur when the number of cases of a known disease exceeds the typical number experienced in that area or region. Endemic diseases are ones that persist in an ecosystem or population” (Johnson, 2011: 16).

Human activity plays a catalytic role in the outbreak of communicable infectious diseases. Mayer (2000: 938) argues that the last-named situation “is as much a matter of social, ecological and geographical change as it is of smaller scale molecular or microbiological phenomena”. He also notes that “the appearance of new pathogens in populations can therefore be due to the following factors (Ibid: 940): 1. Cross-species transfer. 2. Spatial diffusion. 3. Pathogenic evolution, or change in the structure and immunogenicity of earlier pathogens. 4. The new description of a pathogen that had been present in humans for years, but which is ‘newly recognized’. 5. Changes in the human-environment relationship.”

Moreover, and concerning climate change factors, Lafferty (2009: 898) concludes with a correlation between the emergence of infectious diseases with global warming, under the argumentation that “temperature and precipitation affect physiology”; therefore, “climate can affect species distributions”.

In addition, and drawing on Johnson’s (2011) work on health and development, a set of parameters may tangibly or intangibly guide to distinct observations in demographic and epidemiological models in a particular region. The living standards, public health infrastructure and capabilities, medical and technological innovation, existing sanitary culture, access to health, and political initiatives can be considered such motives (Johnson, 2011: 14-21). Tutu & Bursingye (2020: 30) also discuss the interconnection between development and health, by explaining that “low-to middle income” societies suffer more mortality, owing to infectious diseases at a notable high rate (around 80% of total deaths worldwide).

Furthermore, it cannot be disputed that epidemics may have a variety of socio-political impacts. Mortality per se can lead to increased social panic or even guide to further political instability. Menzel (2018: 15-17) discusses that diseases might contribute to societies’ collapse, especially in the cases of weak states, and, thereby, in an increase in violent phenomena, which can drive in “loss of political legitimacy” –as national capacity is being questioned– in turn. Notwithstanding, infectious diseases’ mortality rates can be amplified by existing social underdevelopment; the latter can also trigger political crises.

Regarding the effects of infectious diseases’ emergence on economic processes, Goenka & Liu (2010: 127) argue that communicable diseases can have an impact “through three channels: labor productivity (...), human capital accumulation (...) and population size (...)”. Bloom et al. (2018) analyze that epidemics may lead to increased health system expenditure, trade shrinkage, or even a GDP decrease, due to economic policy-makers’ inability to predict respective risks. Furthermore, in their review on health crises’ impact on agriculture, Zhang et al. (2020: 409-12) note that diseases may even cause both supply chain disturbance and a decrease in demand, due to social panic.

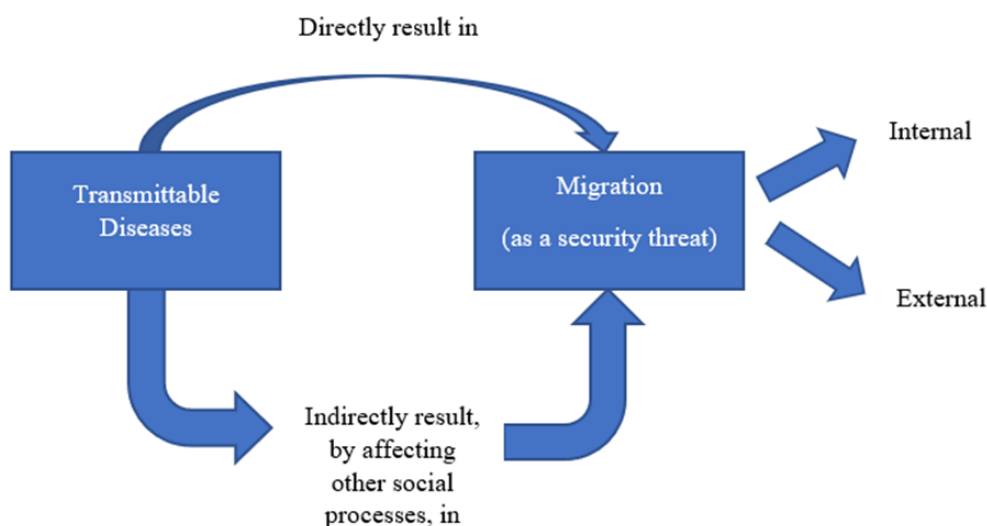
### **Health crises and health-related migration: Correlational implications**

Taking into consideration the above-mentioned formalities, it is possible to attempt defining the causal relation between migration and disease outbreaks under two different –not necessarily distinct– perspectives.

**Sub-process 1**

It is initially assumed that diseases are capable of causing internal displacement or external migration. This may occur (see Diagram 1) either directly –as the afflicted population attempts to flee from a health crisis– or indirectly –by affecting other social processes (see previous section’s implications) in the system suffering a disease outbreak, which in turn urge individuals to flee seeking a better living standard.

**Diagram 1: First proposed migration – diseases correlation (Source: own elaboration)**



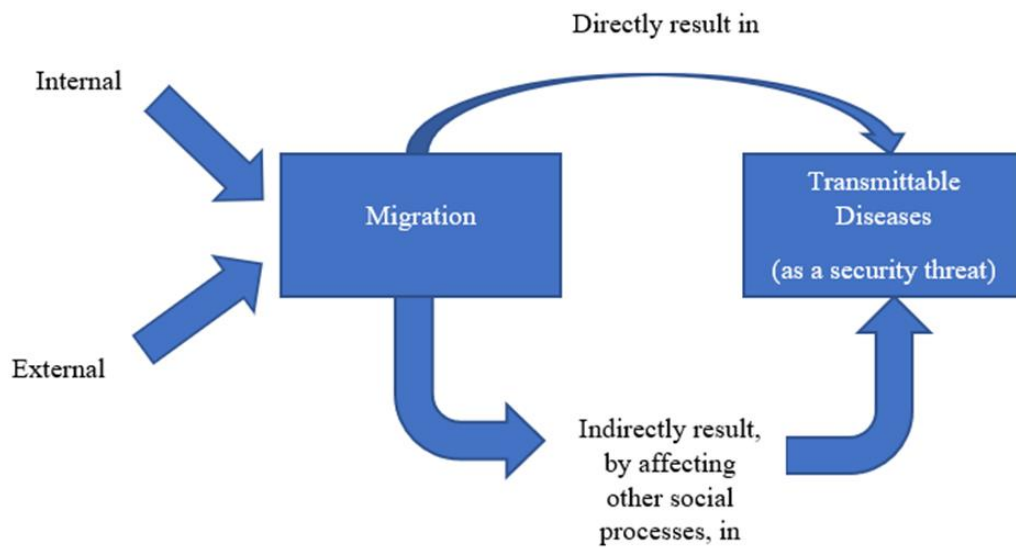
Nevertheless, a disease itself is almost never seen as the sole driving force behind a population’s movement. Especially in the last century, there are only a handful of examples where an infectious disease caused the migration of a population. Such an example can be seen in the Spanish Flu Epidemic of 1918 and 1919, where the high mortality rate of the disease led to several populations moving internally, particularly in the case of the United States of America (Brundage & Shanks, 2008: 1193-9). This could be argued as a result of the societal collapse brought about by the death or otherwise incapacitation of a high percentage of the population affected.

However, it certainly remains a necessity for researchers to fully and synthetically examine the negative societal changes a disease brings to a system, which lead individuals to flee from their country of origin and seek refuge within the borders of another state. Some of these issues were discussed in the previous section.

**Sub-process 2**

The second approach moves the aforementioned sub-process forward (see Diagram 2), outlining that migration is capable of spreading communicable diseases, through normal human interaction among individuals forced to internally or externally move. Furthermore, a disease’s diffusion may be indirectly enhanced by various processes that occur during the migration phase itself (see below).

**Diagram 2: Second proposed migration – diseases correlation (Source: own elaboration).**



Correspondingly, there are many examples of migration bearing the potential threat of directly spreading a disease across borders documented in the relevant literature. For instance, Casteli & Sulis (2017: 283-9) recognize several risk factors regarding the spread of diseases through these processes. Those parameters were divided into different categories, according to the migratory phase they belong to. Therefore, transmission factors can be detected in the pre-departure, travel, interception, destination and return phases, as seen in the following table:

**Table 1: Migration Phase and Indicative co-responding risk factors**

Phase	Factors
Pre-departure	Political and socio-economic circumstances Biological characteristics <b>Pathogen's distribution</b>
Travel	Transports and travel conditions Human trafficking Epidemiological characteristics of transit areas
Interception	Poor living conditions Human rights violations Inadequate medical care
Destination	Socio-economic deprivation Access to care Legal status
Return	Pre-travel advice Poor medical assistance Reduced immunity against local pathogens

Source: Casteli & Sulis, 2017: 283-9

Accordingly, as seen in the case of SARS-CoV-2, the highly infectious nature of the virus resulted in governments deciding to impose restrictions on traveling, in order to mitigate the spread of the disease (Zanin & Papo, 2020). In the case of Australia, the restrictions on travel resulted in the reduction of the imported COVID-19 cases, as well as the delay of the emergence of the disease inside the Australian continent for up to one month more than the original estimations (Adekunle et al., 2020: 257-9). On the other hand, in the case of Greece, along with several other European countries, the first recorded cases of the pandemic were imported from other countries, which had already been affected by the disease (Pappas & Glyptou, 2021).

This observation safely leads to the conclusion that migration, which bears the element of an infectious disease's diffusion, might be perceived as a security threat for the health sector of a state, in the context of health systems' resilience. On that, and although there are contested definitions on the last-named concept per se, Blanchet et al. (2020: 102) mention that in health sciences, resilience is often identified as a system's ability to predict and confront a catastrophic situation. Not only this, but global migration may lead to a series of social transformations. Krämer & Fischer (2019: 14-15), list demographic, epidemiological, healthcare and risk transition, as well as urbanization, among them. The aforementioned could be perceived as indirect state security dangers by policy-makers, forasmuch as existing social schemes, including social cohesion, mass psychology, the economy and political systems' stability, can ultimately be affected by them, as examined in the first part of the research.

### **Health and migration securitization: estimating policy-making paradigm shifts**

Voss et al. (2020: 120) provide a well established definition with respect to securitization of health in the context of forced migration, stating that “rising numbers of migration to high-income countries and events of large-scale migration have triggered concerns related to foreigners and disease. In the public debate, immigrants are frequently perceived, conceptualised, or framed as a threat. Such debates are often dominated by security concerns through health issues, [...] implying that immediate (unexceptional) political action is required to reverse the threat”. Thereby, and following the previous correlational implications, it is safe to assume that host-states are being faced with three distinct courses of action to ensure health security levels –alongside the sub-processes of health-related migration– that are:

6. No reaction to exogenous sub-processes, but intrastate management instead;
7. A reaction based on deterrence, through proactive migration measures;
8. A solid response, through dealing with the causes that generate health-related migration, namely effective health crisis management actions at the source.

By trying to analyze the aforementioned options, and drawing upon previous formalities and a selection of available literature, it is to argue that –as for the first claim– treating refugee populations in the intrastate system can limit host-countries’ available resources, due to increased risks of transmission in camps, enhanced aid requirements, and vulnerability per se (Johnson, 2011: 136-8). Furthermore, host-nations may negatively be affected, as a result of the complex “nature of diseases in the globalized world”, which poses a threat to human societies –directly– or have an influence on “social, political, economic, and military” structures –indirectly– (Rushton, 2011: 782). For instance, Bloom et al. (2020: 2-3) aptly heed that even “tradeoff” measures have a critical macroeconomic effect which policy-makers ought to consider. It is, moreover, noted that mere intrastate reactions require increased initiatives, especially in terms of health management and planning. Although the last-named are essential for health systems’ viability, Mirzoev et al., (2020: 679) contend that policy-makers –still– account for them as non-prospective practices.

The second and third options may be considered similar, due to their resemblance to external actions. Nevertheless, proactive migration policies have generally not proven to be of the effectiveness expected. Therefore, there has been a “shift of interest” from deterrent migration strategies towards operations at the core of the issue, by using “surveillance and emergency response” methods (Rushton, 2011: 758). Besides, modern globalization has led to the supposition that health overlaps



national borders, as it is associated with human rights and ethics (Littlejohn et al., 2020: 75; Gunn, 2005: 166); hence, it requires more systematic and proportional actions.

Given the above, it is not simplistic or illogical to estimate that policy-makers, especially those who are most affected by the issue under consideration, will propose (i) multi-leveled measures, and (ii) at source, namely at the place of a disease or health crisis outbreak. To this end, it is supposed that agents may choose to solely act—definitely a more costly approach—or exploit other mechanisms—in the prism of global health governance. Per Lee (2020: 898), the latter is primarily “characterized by collective action less focused on national borders” and may involve non-state actors, such as NGOs. On that, she (see Ibid: 912) also proposes a series of measures in order for global health governance to be enhanced. Such an option bears more promising and effective results, especially if taking into account the balancing and burden-sharing perspectives. Not only this but there are also a number of publications reviewing health as a foreign policy-making aspect or parameter (McInnes & Lee, 2006; Katz & Singer, 2007; Feldbaum et al., 2010; Labonté & Gagnon, 2010), which can be promoted through global health governance institutions.

## Conclusions

By taking the above reasoning into consideration, it is possible to extract some useful conclusions regarding future health securitization perspectives. At first, the security issues stemming from the correlation of migration and health have been well established, both in the relevant literature and this research. By further analyzing the correlation, it was possible to extract the two probable connections. It is however important to state that this conclusion has been reached through the process of certain research modelling. A different method could potentially bore different results regarding the issue. In addition, from the relevant literature briefly mentioned above, it was made clear that infectious diseases are capable of causing internal displacement, without affecting other parts of a society, as well as external migration, in cases where the disease is capable of altering and damaging societal processes to the extent that a population move is justified.

Correspondingly, it was assessed that it is in a country’s best interest to promote multi-leveled global securitization of health in order to preemptively address respective emergencies, before these being capable of affecting the country itself. In other words, aiding other countries with managing a health crisis could later benefit the countries providing the assistance, by stalling—or completely diverting—the management of a similar crisis inside their borders; something which would have been inevitable, due to the transmitting nature of contagious diseases. Furthermore, it could help mitigate the societal and political destabilization; therefore, preventing a migration crisis that may have negative effects

from occurring. Last, the successful results of such a process can even lead host-states in strengthening their diplomatic capabilities. Further research on the subject could shed more light on the projection of soft power such a policy may have.

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