

Political Engagement

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3 Political Engagement

Patrick F. Walsh and Ausma Bernot

Introduction

This chapter surveys the political and institutional barriers that have constrained ‘Five Eyes’ intelligence agencies in playing consistent and effective roles in managing health security threats and risks, from 9/11 up to and including COVID-19. Building on the fundamental principles discussed in Erik Dahl’s chapter (Chapter 2), we demonstrate that the lack of sustained political attention and coordinated policy action on health security issues since 9/11 has left each of the ‘Five Eyes’ countries, to varying degrees, unprepared to deal with the significant impact of COVID 19. We argue that in most cases this absence of a consistent strategic and operational approach to health security risks, threats and hazards—particularly at the political level—resulted in an equally deficient investment in capabilities within ‘Five Eyes’ intelligence communities. Such shortcomings, as well as the lack of robust centrally coordinated collection and analytical structures on health security intelligence within Five Eyes ICs, limited their ability to fully participate in supporting whole-of-government efforts (including those led by public health agencies) to warn, prepare, mitigate, and manage the impact of COVID-19. The discussion here lays the foundation for Chapter 5 (Bowsher), which outlines how ‘Five Eyes’ intelligence agencies might begin to address these political and institutional barriers post-COVID-19.

Political Engagement and Policy Action

Before assessing the political engagement, institutional and policy action challenges, it is important to contextualise how the terms ‘health security’ and ‘health security intelligence’ have been used since 9/11. As discussed in Dahl’s chapter the notion of what is and isn’t ‘health security’ remains contested. From a contextual perspective, since the 1990s, human security scholars have perceived disease outbreaks in security terms due to their impacts not only on health systems but also their potential to destabilize national economies and disrupt social life (Human Security Centre 2006). We argue that ‘health security’ is an overarching term that may be used to examine the security implications of both the security and public health aspects of health incidents. Not all health security situations will

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involve the same mix of public health, intelligence, and security personnel; nonetheless, however, both dimensions are intertwined (Walsh 2020). Health security intelligence refers to the collection of health security information, utilized before and during the occurrence of the incidents. Health security intelligence prioritizes three types of biosecurity threats—rapidly spreading infectious diseases, bioterrorism, and the potential weaponizing of dual use laboratory research (Walsh 2020). Health security threats are complex issues that require a multi-stakeholder model of work between public health, national security, and intelligence communities to better facilitate and manage emergency warnings and responses. There have been examples of such collaborations between the national security intelligence, public health and scientific communities with the most well-known publicly being the FBI collaboration with the CDC during the ‘Amerithrax’ (Anthrax investigation), which lasted over seven years (The US Department of Justice 2010). However as will be discussed shortly, such collaborations during the period from 9/11 up to and including COVID-19 have not been consistent or optimal in their effectiveness.

The Amerithrax investigation nonetheless established new pathways for IC agencies, public and other scientific personnel to collaborate more effectively with 29 government, university, and commercial labs augmenting the FBI effort to ‘develop the physical, chemical, genetic and forensic profiles of anthrax spores, letters and envelopes used in the attack’ (The US Department of Justice 2010, 5). However, it also exposed difficulties between multi-stakeholder government agencies in working effectively together. For example, the FBI tasked geneticist Paul Keim to identify the Anthrax strain used by the attacker. Keim, in a subsequent interview, discussed the challenges in converting his academic lab into a forensic one, and some of the difficulties with the scientific and investigative communities working together including the natural desire of scientists to share knowledge between peers vs. the security needs of the investigation to restrict information flows. Additional challenges included handling scientific material in a way that preserved the evidence from a law enforcement perspective, different from routine scientific protocols (Bhattacharjee 2009, 1416). We argue that, while operational challenges are to be expected during a multi-disciplinary investigation, they are symptomatic of broader, longer-term political/policy and institutional barriers that have periodically inhibited IC responses to biothreats since the immediate aftermath of 9/11, when Amerithrax occurred, and before COVID-19.

The first section of the chapter will survey briefly the key political/policy barriers to consistent and effective IC responses to health security threats and risks from 9/11 up to COVID-19. The focus is almost exclusively on the US and the UK for two reasons. First, space is limited and providing exhaustive coverage of all ‘Five Eyes’ political and policy activities would not be possible in one chapter. Second, a more significant amount of information is available publicly from the UK and US as successive governments implemented various political and policy initiatives to better manage health security threats and risks.

The second section of the chapter section builds on the analysis by thematically exploring how key policy initiatives may have influenced the ICs’ ability to play

a consistent and coherent role in supporting the management of health security threats and risks from 9/11 up to COVID-19. We cannot fully know the specific impact of all key policy initiatives on the ICs of the UK and US given much of the details are sensitive or classified. However, there is sufficient publicly available evidence to thematically identify how various factors constrained ICs' ability to play a consistently effective role in the national health security strategy. In the forthcoming section, we turn our attention to an analysis of key political and policy initiatives from 9/11 up to COVID-19 for the UK and US respectively.

9/11 to COVID-19: The United Kingdom and the United States Health Security Policy and Practice

United Kingdom Political and Policy Initiatives

The UK government's historic interest in health security threats and risks extends back to the 1930s with concerns that state actors would use a biological bomb in warfare. There were growing concerns that Nazi Germany was developing a bioweapons program. This resulted in policy attention that would support the development of both defensive and offensive bioweapons at Porton Down (Wiltshire) during 1940–45 (Balmer 2002). This research was carried out in closer collaboration with other 'Five Eyes' partners namely the United States and Canada that were developing similar programs (Carus 2017; Regis 1999; Spiers 2010). However, policy-making priorities soon shifted after World War Two to a mainly defensive program from 1955–1960. As the Cold War brought in a key concern in London and other 'Five Eyes' capitals over the Soviet Union's expanding nuclear weapons capacity, interest in biowarfare began to diminish on the policy agenda (Carus 2017; Regis 1999; Spiers 2010).

From this narrow military view of health security threats and risks, i.e. bioweapons used in conventional warfare, in the period leading up to 9/11 successive UK governments gradually expanded their interpretation and attention towards a broader set of health security threats and risks. These reflected a domestic and international concern over infectious diseases, biosecurity, and bioterrorism. In particular, both the 9/11 attacks and the Amerithrax incident in the US served as catalysts for greater political and policy engagement by UK governments in assessing the intent and capability of non-state actor terrorist groups such as Al Qaeda to use bioweapons. Alongside, there was a growing concern that rogue states like Saddam Hussein's Iraq may possess bioweapons, even though the UN weapons inspection team failed to locate them after the Gulf War in 1991.

The growing concern about bioterrorism was in part the reason for the UK government establishing the Health Protection Agency (HPA) in 2004 (Nicoll & Murray 2002, 129–130). Its role was to bring better coordination between national and regional public levels as well as harness the expertise of other 'non-health' groups and stakeholders essential to health protection (Nicoll & Murray 2002, 131). During this early post-9/11 period, the HPA represented the only major institutional change to create greater coordination between civilian public health responses, the

military and the police, and some members of the IC in the event of a bioterrorism attack (Nicoll & Murray 2002, 132). Other than the establishment of the HPA, the post-9/11 policy environment in the UK did not result in any additional significant changes to existing health security response settings within government, including in key areas such as preparedness and emergency response, which contrasts with larger politically driven and more frequent policy changes in the US, as discussed shortly.

Leaving aside the larger population and economy of the US, during the first years after 9/11 and Amerithrax, the UK government also made only modest increases in funding for countering some aspects of health security threats, risks, and hazards. For example, according to the Select Committee of Science and Development, GBP 260 million was allocated in 2003 for bio-release countermeasures in chemical, biological, radiological and nuclear (CBRN) terrorism (Jones 2005). This contrasts with an estimated US government expenditure on civilian biodefense to be around the equivalent of GBP 22 billion for the period 2001–2005, or 18 times the figure spent in 2001 (Jones 2005). Similarly, comparing the two national agencies primarily responsible for health security preparedness (the UK's HPA vs. US CDC), in 2003 the former spent GBP 160 million on bio-release countermeasures compared to the latter's total budget of USD 6.7 billion, of which 1 billion was dedicated to biodefense (Jones 2005, 346). Furthermore, it is evident that in the early post-9/11 period, political and legal concerns in the UK were rising about a lack of an overarching institutional design for addressing health security threats, risks, and hazards. This included the previously discussed 2001–02 UK House of Commons Defence Select Committee (2002) debates about how defense and civilian personnel should work together in the event of terrorist attacks that used bioweapons.

Shortly after 9/11, the policy-making focus pivoted to a wider range of health security scenarios, including the growing belief by the Blair Labour Government that terrorists would use WMDs to attack the UK, and an increasingly greater conviction that rogue states would use bioweapons. In particular, Iraq was endorsed by the UK Cabinet as an immediate threat to the UK and its allies due to its previous documented track record in the production of WMD (Chilcot 2016). Almost immediately from 2002, the principal policy focus on health security was directed at the threat of Iraq, rather than terrorists using bioweapons on UK soil, infectious diseases or biosecurity. This served to reinforce a disjuncture between international and domestic policy preparedness against a broader range of health security threats risks and hazards. It also meant that the UK lacked a comprehensive health security policy describing how all major stakeholders, including public health and national security intelligence agencies, could collaborate on a larger range of health security threats, risks, and hazards. In stock with the US Bush Administrations' policy to initially contain then enact regime change in Iraq through coalition military action, in early 2002, the Blair government in Cabinet endorsed the view that Iraq still had WMDs, including nuclear weapons, and was determined to develop them. Earlier in 2001, the UK's Joint Intelligence Committee had assessed that it was likely Iraq was producing chemical and biological agents and longer-range missiles capable of delivering them (Chilcot 2016,

43). Though as the Report of the Iraq Inquiry led by Lord Chilcott revealed, the extent of evidence and intelligence for Iraq's WMD capability was unclear and 'intelligence and assessments were used to prepare material to be used to support Government statements in a way which conveyed certainty without acknowledging the limitations of the intelligence' (Chilcot 2016, 43).

In the post-Iraq War period, UK governments did start to turn their attention to a broader (non-military) range of health security threats, risks, and hazards including infectious diseases. Sir David Omand a former Director of UK SIGINT agency GCHQ and Intelligence and Security Coordinator during the Blair Government declared in a recent article that after 9/11 in his words 'flu pandemics' 'occupied the top right-hand corner of the strategic notice risk matrix — of all the threats and risks, it posed the most lethal potential combination of impact and probability' (Omand 2020). In the few years before the COVID-19 pandemic, as McMullen notes, 'there was a greater political commitment and resourcing to UK contributions to global health security' and a 'growing centralised role of the National Security Council in health security threats, risk and hazards' targeted both domestically and internationally (McMullen 2020). This broader policy focus on health security was beyond its traditional, more narrowly focused interpretations such as WMD or bio-terrorism and can be seen in a few pre- and early COVID-19 initiatives by the UK government. A key example was the 2018 Biological Security Strategy (Bowsher et al. 2020; Cabinet Office 2018). The Strategy was a significant pre-Covid policy landmark attempting to explain the role all government agencies (public health and security) may play in managing domestic and global health security threats, risks and hazards. It adopted a relatively comprehensive four-pillar approach (understand, prevention, detection, and respond).

While it mentioned the role of intelligence agencies in the collection of information to understand risks and the role of the Ministry of Defence in understanding attribution, the document was largely vague on the general types of mandates the UK IC might play in these areas (Cabinet Office 2018). Other than briefly stating that a 'cross-departmental governance board' will oversee cross-agency activities in the strategy, the document did not explain how inevitable governance tensions will be resolved between activities deemed 'cross-departmental' vs. those which are the responsibility of existing departments and how overlaps might be managed (Cabinet Office 2018). A small qualitative study interviewing 12 senior UK leaders in global health, development, and foreign policy during 2017 reinforced this lack of clarity around the pre-COVID governance of health security in the UK. The interviewees noted the national security council in the Cabinet Office was nominally the lead on the health security agenda; however, there did not appear to be a common strategy or policy to bring cross-sector collaboration between public health, foreign policy, or national security agencies (McMullen 2020). While the rhetoric of 2018 Biological Security Strategy suggested that the UK government was finally going to address a range of health security threats/risks/hazards from a comprehensive health and security perspective, the strategy soon stalled.

A scheduled parliamentary inquiry on biological security was cancelled in 2019 as Brexit and a general election loomed, which as Bowsher et al. (2020, 3) noted

‘resulted in a total arrest of central planning to build on the recommendations of the Biological Security Strategy.’ Policy engagement with health security issues as a priority to be holistically operationalized across the health and security sectors stalled as the UK became mired in leaving the EU and domestic politics. Several political and bureaucratic actions in reaction to the pandemic exacerbated a lack of policy engagement by reinforcing poor historical governance challenges in managing health security and increasing a lack of preparedness. Significant bureaucratic transformation, such as the replacement of Public Health England with the National Institute for Health Protection in 2020, was implemented during a health security crisis. The Joint Biosecurity Centre, which was previously housed in the Institute, was modelled after the intelligence community’s Joint Terrorism Advisory Centre (JTAC), which provides the government with threat-level warnings on terrorism. In the case of the Joint Biosecurity Centre, its function was to provide threat levels on COVID-19. These changes were on top of other stand-up policy advisory groups such as the Scientific Advisory Group for Emergencies (SAGE), which also had a role in providing senior policymakers with advice on managing the pandemic. While it is not the focus of this chapter to provide a detailed analysis of how these ‘on the fly’ policy reforms resulted in a suboptimal response to the pandemic (see, for example, Chapter 5 for further analysis), the renewed policy engagement and subsequent bureaucratic reforms in response to the COVID pandemic were criticized for providing the government with a very narrow ‘epidemiological modelling approach’ to formulate policy responses without a broader consideration (Bowsher et al. 2020). This lack of coherent governance and the government’s policy response in responding to COVID-19 including how UK national security intelligence agencies may most effectively play their role reduced further the preparedness, management, and resilience against COVID-19.

At the time of writing, all ‘Five Eyes’ governments, including in the UK, have moved out of the acute and emergency phase of the pandemic. They are issuing a range of policy declarations, strategies, and statements to learn the lessons of COVID-19, particularly aimed at national preparedness and readiness from threat/risk/hazard detection to recovery. The former Johnson government’s 2021 Integrated Review of Security, Defence, Development and Foreign Policy (herein, the Integrated Review) demonstrates the government’s clear intention to better resilience post-COVID, including health security (Cabinet Office 2021). The Integrated Review says its first goal is to build national resilience, which it argues, ‘is the product of effective and trusted governance, government capabilities, social cohesion and individual and business resilience’ (Cabinet Office 2021, 87). However, previous policy declarations that stalled without delivering results contained similar rhetoric, such as calls to establish ‘a whole of society’ and ‘one health’ approaches to resilience’ and integrate ‘national security with economic health, environmental policy.’ Unsurprisingly, the Integrated Review was short on detail on how effective governance will be implemented to build national resilience in health security (Cabinet Office 2021, 88).

Additionally, the lack of an integrated health security approach has also extended into the UK’s forward-looking efforts evaluating national health security

readiness and response. In December 2022, the UK Government appointed Baroness Heather Hallet to lead an independent inquiry into the UK's response to COVID-19, including its preparedness, interventions, and lessons that should be learnt from past policy-related investigations (Cabinet Office 2022). The Inquiry website does not specifically mention whether Britain's national security and intelligence community will be invited to testify before hearings, which commenced in June 2023 (Cabinet Office 2022). The Hallet Inquiry hearings are ongoing and not expected to be completed until around July 2025. Finally, in June 2023 the UK government launched the new Biological Security strategy which appears to be the government's latest attempt to understand emerging health security threats, risks and hazards, and fuse public health information and national security intelligence to 'enhance situational awareness and to strengthen collective decision-making and improve the effectiveness of decision-making' (Cabinet Office 2023, 23). The new biological security strategy devotes an entire section on 'leadership, governance and coordination' and includes measures such as installing a lead minister and an overall senior responsible officer (most likely the deputy national security advisor) to oversee its implementation (Cabinet Office 2023, 56). The strategy goes much further in describing how various aspects of the UK's IC might be involved in and work with public health and other important stakeholders, but time will tell if it can fully address the many historic governance and leadership challenges underscored in previous pre-COVID political and policy described above. Chapter 5 (Bowsher) will investigate whether the UK and other 'Five Eyes' governments are currently learning the lessons of COVID-19, which, as we suggest in this chapter, are lessons that have *not* been learned cumulatively since 9/11.

United States

Similar to several UK governments from 1945 to the end of the Cold War the primary policy focus of several US administrations was 'state-based biological weapons programmes' with the former Soviet Union's extensive bioweapons program being the primary concern (Walsh 2018, 25). The US had a large bioweapons program that weaponized *Bacillus anthracis*, *Francisella tularensis*, *Brucella suis*, and Venezuelan equine encephalitis virus (VEE), amongst others (Walsh 2018). The US Army's Directorate of Biological Operations at Pine Bluff Arsenal (Arkansas) had a capacity of 86,000 gallons though there also were other large plants at Vigo in Indiana (Regis 1999). The history of the US bioweapons program, as well as its Soviet equivalent, which lasted until the end of the Cold War, is remarkable in that it demonstrates how breakthroughs in post-war microbiology could be rapidly industrialized to develop major bioweapons programs. However, a full examination of these programs is beyond the scope of this chapter. For readers looking for in-depth coverage of these programs, Regis (1999) and Kenneth Alibek's interview with Tucker (1999) provide helpful overviews. By the late 1960s, US President Nixon announced a termination of the offensive American bioweapons program. As discussed above, in the examination of important UK health security policy milestones, policymakers in London and Washington concluded that the increasing

capacity of atomic weapons provided a more reliable offensive option than a bacterial bomb (Balmer 2002).

There was a shift in policy circles in Washington based on a mixture of technical, economic, political, and legal considerations about how immediate a threat state-based biological weapons were (Balmer 2002). While US policymakers may have been scaling back the resources for offensive biological weapons, they began to express similar concerns to their UK counterparts during and up to the end of the Cold War about several rogue states (Iraq, Iran, Syria, and North Korea) that were seeking to develop biological weapons (Koblentz 2009; Spiers 2010). Out of all of these, Iraq seemed to be the one that the US intelligence community knew the most about. Iraq showed an early interest (as far back as 1974) in developing biological weapons for their strategic deterrent value (Koblentz 2009). By 1990, the Hussein regime had tested and weaponized anthrax and botulinum toxin using 400-kilogram aerial bombs and Al Hussein warheads. Though these were thankfully not very efficient at disseminating biological weapons and the regime never produced dried, powder agents, which could have covered greater distances and potentially had more lethality (UNMOVIC 2007). By the end of the first Gulf War in 1991, as UN weapon teams moved into Iraq, the Iraqi regime's offensive BW program was destroyed by inspectors including its bulk supply of biological agents and munitions (Koblentz 2009).

During the mid-1990s, policymakers started to shift their focus again from historical and traditional notions of biothreats (state-sponsored conventional biological weapons programs) to the use of biological agents by non-state actors—primarily terrorists (Koblentz 2009). Several events raised concerns in Washington about the threat from non-state actors using bioweapons. The fall of the Soviet Union and the risk of its former bio-weapons scientists becoming 'guns for hire' to terrorists, the 1995 Aum Shinrikyo subway attack in Tokyo (Leitenberg 2001; Rosenau 2001), the 1993 attack on the World Trade Center in New York and the 1996 terrorist attack in Oklahoma city all made clear to policymakers, Gronvall argues, that the United States was vulnerable to terrorism. The implication is that some groups might use biological weapons (Russell & Gronvall 2012). Further, the 9/11 attacks on the US combined with some senior officials wrongly assuming there was a link between Iraq's Hussein regime and Al Qaeda (with the former even potentially supplying the latter with bioweapons) consolidated the Bush Administrations' threat perception of health security as a narrow band of rogue state-sponsored WMD and bio-terrorism from non-state actors like Al Qaeda. As previously noted, the faulty and politicized intelligence that Iraq still possessed WMD, as well as the scant evidence of US soldiers discovering technical documents and equipment in a 'biological weapons laboratory' under construction near Kandahar, underscored for the Bush Administration Iraq and Al Qaeda had both the intent and likely the increasing capability to develop biological weapons (Pita & Gunaratna 2009; Tenet 2007).

The Bush Administration also expressed concerns publicly that advances in biotechnology and life sciences would result in the creation by adversaries of new novel bioweapons that would require 'new detection methods, preventive measures and treatments' (Spiers 2010, 156). In April 2005, the Administration said:

These trends increase the risk of surprise. Anticipating such threats through intelligence efforts is made more difficult by the dual-use nature of biotechnologies and infrastructure and the likelihood that adversaries will use denial and deception to conceal their illicit activities.

(Spiers 2010, 156)

Even after faulty intelligence on Iraq's WMD possession led to the US-led invasion of Iraq in 2003, other senior US legislators maintained that the threat from biological weapons was growing and that genetic modification techniques would 'allow the creation of even worse biological weapons' (Robb et al. 2005, 34). Another important aspect of this issue is that there were differences of opinion within the US intelligence community and among biodefense experts on how significant the level of threat and capabilities Al Qaeda posed in bioweapons development pre-2001 and post the invasion of Afghanistan (Leitenberg 2005; The Commission on the Intelligence Capabilities of the United States Regarding Weapons of Mass Destruction 2005). Such policy pronouncements during 1999–2009 were not consistently based on 'sophisticated threat assessments' and for many researchers in the field were 'systematically and deliberately being exaggerated' (Leitenberg 2005). In contrast to the low-grade capabilities to weaponize dangerous pathogens by terrorist groups such as Aum Shinrikyo and Al Qaeda, the September/October Anthrax letter attacks allegedly orchestrated by microbiologist Bruce Ivins in 2001 may have vindicated the rhetoric that 'bioterrorism' was a significant threat and needed to be invested in accordingly. However, that attack vector was from a domestic scientist rather than a foreign novice terrorist was likely a surprise to many in the Administration (The US Department of Justice 2010; Walsh 2018). In short, throughout at least the first term of the Bush Administration, the White House was fixing its narrow health security policy in terms of rhetoric around the prism of biodefense against rogue states like Iraq and terrorist groups (Al Qaeda) rather than an integrated one health approach that looked more comprehensively across the one health spectrum.

The policy focus and legislation enacted by the Bush Administration during this time underscore a narrower interpretation of health security threats, risks, and hazards to one marked by domestic biodefense. For example, as noted by Koblentz 'up to 40% (or 23.6 billion) was spent on biodefense (from 2001–2009) for research and development of countermeasures, diagnostics and sensors, and the construction of high containment labs (Koblentz 2012, 136–137). It's clear some US intelligence agencies, including the FBI and DHS, had a role in helping support such biodefense measures (Walsh 2018). For example, the Biowatch Program established in 2003 by the Bush Administration and managed by DHS designed to provide a nationwide aerosol detection system for biothreat agents initially for 30 of the most populous cities in the United States is one of many biodefense measures employed during the Bush years. The effectiveness of Biowatch has been limited however since its initial implementation due to a range of technical, communication, and funding reasons. For a detailed analysis see, for example, Homeland Security (2018); Currie (2016), Government Accountability Office (2014), and Willman (2017).

This domestic biodefense focus was also demonstrated in landmark legislation passed during the Bush Administration. For example, the 2002 Public Health Security and Bioterrorism Preparedness and Response Act set in motion many useful and important planks for protecting and preparing for bioterrorism acts and other health emergencies. These included increased funding for the CDC, security vetting for those with access to select agents and further research to detect biological events of concern. Nonetheless, the new legislation was largely devoid of how the intelligence community would become involved in these and other related activities described in the Act. Section 108 refers to the establishment of a working group on bioterrorism and other public emergencies to work on a series of recommendations across federal, state, and local government to prepare and respond to such threats. The Act mentions the role in such a group by the Director CIA, Secretary of Defence and Energy. All three are heads of IC agencies yet the act remains vague on the specific mandate these and other IC agencies should bring in a broad (unclassified) sense and how they might work with the US Health and Human Services and Department of Agriculture to bring about key recommendations (A to G) listed in the legislation (House of Energy and Commerce 2001).

Increasingly from 9/11, there was another cluster of health security threats risks and hazards which did not sit neatly under existing classifiers of 'biodefense' or 'bioterrorism' but also began to capture the attention of scholars and policymakers post 9/11. 'Bio-crime' was one such area, though novel infectious diseases of global significance grabbed the most focus of policymakers post-9/11 (Walsh 2018). Many of these, such as the 2003 SARS outbreak, the 2009 H1N1 influenza pandemic, the 2014 West African Ebola outbreak and the 2015 expansion of the Zika virus into South America were traditionally viewed as public health emergencies given that they were the result of natural causes and not the intentional or malevolent actions of threat actors (Walsh 2018). Nevertheless, all these cases had wider impacts beyond public health. They showed how the pathogen involved was zoonotic (i.e., could move from one species to another), and each impacted significantly on the global economy and wealth of nations. For example, SARS forced the closure of airports, reduced global travel, and resulted in increased sick days in many countries. In the broadest sense of what 'national security' means, such pandemics, particularly zoonotic ones including COVID-19, can have profound impacts on the political, social, and economic resilience of nations.

As a result of some of these natural pandemics since 9/11, successive US administrations (like other 'Five Eyes governments in Australia, Canada, New Zealand, and the UK) implemented several policy initiatives that included a broader focus and inclusion of other non-bio-terror threats and risks such as pandemics. In the case of the US, biodefense was the main focus during the first term of the Bush Administration and 'initiatives to manage global health issues were kept largely separate... Such policy separation impacted the way the intelligence community was tasked and how it worked with the public health agencies also working on bio-risks and threats' (Walsh 2018, 67).

In contrast to the Bush years, the incoming Obama Administration placed a greater emphasis on linking traditional biodefense threats with global health

security risks such as pandemics and infectious diseases. Obama's National 2009 Strategy for Countering Biological Threats underscored that global health security capacity building, dual-use research, biosafety, WMD, and state-sponsored bioweapons programs should be addressed in tandem by all stakeholders. This meant that there was a role for national security agencies in assisting with global health security issues such as pandemics, as well as the traditional responses to domestic biodefense issues. The Strategy also made clear that there needed to be a significant increase and depth in partnerships including information sharing between health and security communities to achieve its objectives (The White House 2009). Health security threats and risks were already on the IC's radar in various intelligence assessments, for example, Director of National Intelligence (2008). Additionally, in 2007 the DNI established the Biological Sciences Expert Group—a standing panel of non-government biologists to assist in assessing IC research in the life sciences and to review the scientific validity of intelligence assessments (Bhattacharjee 2009). In the same year, the DNI also created a national strategy for public health security (Koblentz 2012).

As early as 2005 the FBI established a program called Science and Technology Outreach (STOP) (later renamed the Biological Sciences Outreach Program) to build trust between the scientific and law enforcement communities (Dvorkin & Lanier 2010; Hummel 2017; Walsh 2018). Over the years the FBI outreach program has sponsored do-it-yourself amateur synthetic biology groups and biohacker events in collaboration with national and local FBI WMD coordinators (Wolinsky 2016). The Obama Strategy for Countering Biological Threats provided a further catalyst for various IC agencies to engage more with public health and scientific communities. The Strategy was accompanied by Presidential Policy Directive 2, which established an inter-agency process (including the DNI) for its implementation and a framework for monitoring its progress (The White House 2009). While the DNI was included, it was less clear what section within it should the DNI take the lead for implementing the Obama Strategy for Countering Biological Threats. What remained unclear was how the agency would identify IC enterprise-wide efforts to implement the Directive, including identifying budgetary and program priorities and the mechanics of coordinating with important stakeholders outside of the IC.

The Trump Administration occupied the White House before the commencement of COVID-19 in December 2019 and was in place throughout most of the pandemic's acute phase, i.e. December 2020. In 2018, two years into the administration Trump enacted a National Biodefense Strategy. The Biodefense Strategy was expected to 'promote a more efficient, coordinated, and accountable biodefense enterprise' by bringing together Defense, Health and Human Services, Homeland Security, and Agriculture to jointly develop a national biodefense strategy and an implementation plan (Homeland Security 2018). In some respects, rhetoric contained within the National Biodefense Strategy seems to go further than the previous US administration's efforts to encourage a whole-of-government approach to biodefense that would include medical, public, animal and plant health, emergency response, scientific and technical, law enforcement, defense,

and security and intelligence. The Strategy sought to address the existing ‘fragmentation throughout the complex inter-agency, intergovernmental and intersectoral biodefense enterprise’ (U.S. Government Accountability Office 2020, 9). It was aimed at (1) assessing enterprise-wide threats, (2) determining optimal biodetection technologies, (3) building and maintaining emerging infectious disease surveillance, (4) establishing situational awareness and data integration, and (5) enhancing lab safety and security (U.S. Government Accountability Office 2020, 9). Several goals were mentioned in the strategy, including Goal 1 Risk Awareness, which made clear that national bio-risk decision-making needed to be informed by intelligence, forecasting, and risk assessment. Goal 1 also required ‘further enhancement of intelligence and analysis activities’ but failed to mention which agencies within the IC should be responsible for these activities or who should take the lead (Homeland Security 2018, 6–9).

The National Biodefense Strategy was accompanied in 2018 by the Presidential Memorandum on the Support for National Biodefense/National Security Presidential Memorandum-14 (NSPM-14): This memorandum was issued to support the National Biodefense Strategy and provided the governance arrangements to implement it. Specifically, the memorandum established two governing bodies—the Biodefense Steering Committee (chaired by the Secretary of Health and Human Services) and included the Secretaries of State, Defense, Agriculture, Veteran Affairs, Homeland Security and the Administrator of the EPA. The Steering Committee’s role was to provide the strategic oversight and leadership of the National Biodefense Strategy. However, it did not include senior leadership from the US IC such as the Director of National Intelligence and their participation was only on an as-required basis, which we argue was a misstep (Homeland Security 2018). The other governance instrument was the Biodefense Coordination Team, which consisted of senior officers from the above-mentioned agencies including some input from the ODNI that provided the day-to-day functions to assist the Biodefense Coordination Team in monitoring the Strategy (Homeland Security 2018).

In a 2020 testimony before the Committee on Oversight and Reform, the Directors of Homeland Security and Justice and Health Care observed that the early implementation of the strategy had three large challenges: (1) difficulties in adopting new procedures, (2) guidance on methods for data analysis, and (3) roles and responsibilities for joint decision-making (U.S. Government Accountability Office 2020). A GAO review report two years into the implementation of the Biodefense Strategy listed similar challenges and many more. Additional challenges included staffing and organizational resources limitations to identify priority strategy areas such as identifying and documenting biodefense programs across government, a lack of capabilities to bring in expertise outside of government (e.g. private sector) where most of the biodefense expertise is located and a lack of agreement on how agencies would jointly identify and support enterprise-wide biodefense priorities rather than those at the agency level (GAO 2020, 20–30). The review report completed by the GAO concluded that the ‘implementation process required attention including from stakeholders outside the Biodefense Steering Committee such as the National Security Council Staff, OMB and the Congress’ (U.S. Government Accountability

Office, 2020, 29). In particular, the GAO review noted how ‘staff turnover within the NSC contributed to a lack of consistent leadership from the White House, which created a lapse in momentum and disrupted the implementation process’ (U.S. Government Accountability Office 2020, 29).

Shortly after the February 2020 GAO report into the implementation of the national biodefense strategy was released COVID-19 reached the US and any ongoing implementation of the Biodefense Strategy was sidelined as the Trump White House confronted the COVID-19 pandemic. The many good ideas contained within the NSPM-14 and the National Biodefense Strategy for creating an enterprise-wide risk management approach to biodefense stalled as a more disorganized and politicized process defined the White House’s response to the pandemic (Alexander et al. 2022; Parker & Stern 2022; Rutledge 2020). On the point of politicization, there are a few key examples that became evident during the Trump Administration. For example, in 2016, the Obama administration developed a response plan based on lessons learnt from Ebola and Zika, a document titled ‘Playbook for Early Response to High-Consequence Emerging Infectious Disease Threats and Biological Incidents.’ The document included risk considerations about novel coronaviruses and offered a plan for a coordinated national response to a potential epidemic; in 2020, the Trump administration dismissed the advice of the outgoing administration, only to blame it once the pandemic swept the US (Yamey & Gonsalves 2020). We also saw how politicized during the Trump Administration the issue of tasking the IC to find the origins of COVID-19 became (Walsh et al. 2023).

In summary, several key initiatives from successive US administrations showed a narrow and somewhat fragmented approach. Biodefense political and policy responses focused almost exclusively on traditional state and non-state actor bio threats. In the Bush years in particular, zoonotic diseases were often cast as requiring public health or biosecurity responses not national security ones and were often running in parallel with policy initiatives in the biodefense domain led by the military or in some cases agencies within the intelligence community. The Obama and later Trump Administration’s strategy around health security do show efforts to bring global health security, biodefense and biosecurity threats, risks, and hazards together. However, the net result of treating some health security threats and risks (e.g., pandemics) as a public health problem only and others (e.g., bioterrorism) as a national security threat reinforced a lack of governance, leadership, and mission integration within and across a range of health security threats, risks, and hazards.

The COVID-19 Health Security Choke Points: Preparedness, Governance, Threat Assessment, Ethics, and International Coordination

We now turn to the second section which assesses the key factors from 9/11 to the start of the COVID-19 pandemic that impacted both the UK and US ICs ability to play a consistent and coherent role in supporting the management of health security threats, risks, and hazards during this period. As noted earlier the analysis here

relies on secondary data sources. A more comprehensive study of constraining political, policy, and institutional factors would only be possible with detailed interviews of a significant sample of IC personnel who have had responsibility in managing health security threats, risks, and hazards during this timeframe. This may be possible in the future and would be desirable to test the weighting we put on the significance of various factors discussed here. Currently, however, such a study is beyond the logistical possibilities of the authors. Nonetheless, there are sufficient, detailed, and quality secondary data sources in which to assess factors that were consistently at play from 9/11 up to COVID-19 that constrained both political decision-making and IC leadership's ability to develop capabilities to support the management of health security threats, risks, and hazards more effectively during this time frame.

Preparedness

COVID-19 was a large-scale test of decades of planning and preparation for such events. While all pandemic events are unique, the lessons to be learnt often fall into the same categories of prevention, preparedness, mitigation, and response. We argued above that COVID just amplified a range of legacy factors that had not been sufficiently dealt with historically in the policy, political, and institutional responses to a range of health security threats, risks, and hazards from 9/11 to the COVID pandemic.

The brief overview of both UK and US political and policy initiatives discussed above underscores that neither political rhetoric nor even preparedness equals action. This point is well illustrated by the paradox between global health preparedness and an actual response to the Covid-19 crisis. The 2019 Global Health Security Index published by the Nuclear Threat Initiative and Johns Hopkins Centre for Health Security evaluated the United States as the top country in its preparedness for prevention of the emergence or release of pathogens, early detection and reporting for epidemics of potential international concern and rapid response and mitigation of the spread of an epidemic, while noting that no country was fully prepared for an epidemic (GHS Index 2021). Other 'Five Eyes' countries were in the top five overall well-prepared scores in the index though interestingly New Zealand was ranked thirty-fifth (GHS Index 2021).

While the United States was rated as no. 1 on the Global Health Security Index, it performed worse than many other countries, including New Zealand, as noted which had been rated thirty-fifth in the world on the same index for preparedness. The Trump Administration dismissed previous preparedness plans, delayed national response, and engaged in blame rhetoric (Parker & Stern 2022; Schismenos et al. 2021; Yamey & Gonsalves 2020). In 2021, the Center for Disease Control and Prevention (CDC) reviewed its response to the COVID-19 pandemic and officially admitted that its response to both COVID-19 and monkeypox 'did not reliably meet expectations' despite the '75 years CDC and public health have been preparing for COVID-19,' triggering a major restructure (Sun & Diamond 2022).

The COVID-19 response miscoordination in the US resulted in 21% of the global infections and deaths attributed to COVID-19 (Muellbauer, Aron, Janine 2020). In contrast, New Zealand's government, despite being ranked lower in pandemic response preparedness, adopted a swift pandemic response initially focused on eliminating COVID-19 and later adopted graduated risk-informed suppression measures (Jefferies et al. 2020). These measures helped New Zealand achieve low levels of population illness disparities, a low relative disease burden, and the initial effectiveness of COVID-19 eradication (Jefferies et al. 2020). The unexpected variations in national responses highlight the importance not only of public health preparedness to contain disease, but also the importance of political and institutional coordination.

Governance

The history of political and institutional coordination of health security threats, risks, and hazards from 9/11 to COVID-19 demonstrates that the effectiveness of preparedness, mitigation, and response measures is dependent on a variety of elements, the most important of which is undoubtedly robust governance. Governance also influences other themes we have discovered having an impact on health security preparedness, such as resolving legal and ethical challenges, strategic vs. operational planning, risk, threat/hazard methodologies and institutional cultures. Good governance means public health, national security agencies, and other stakeholders all know what their mission, mandates, and accountability points are in large bureaucratic environments at national, regional, and local levels.

Governance in the intelligence context has an external and an internal component. External governance relates to how well governments understand health security, threat risks and hazards, and the extent to which they can fund and sustain the development of evidence-based (less politicized) policy outcomes to improve preparedness, mitigation, and response (Walsh 2011). Internal governance relates to how senior leaders of public health and national security intelligence agencies can prosecute the development of strategic and operational capabilities to identify, prevent, mitigate, and respond to health security threats, risks, and hazards (Walsh 2011). Our analysis suggests that both poor internal and external governance has contributed to the inconsistent whole-of-government approaches taken to health security issues from 9/11 to the present.

While administrations in both the UK and the US have evolved in the development of strategic health security planning that includes the right kind of rhetoric of being 'one-health' or 'multi-disciplinary,' these frameworks have often failed to develop into integrated political and institutional responses to health security over time. The net result of this has contributed to a lack of preparedness to optimally manage health security threats, risks, and hazards during the period focused on in this chapter, including COVID-19. From an external governance or political standpoint, it is clear that political interests in health security-related threats, risks, and hazards have not been consistent in both the UK and the US, especially in the

earlier post-9/11 period when viewed through a narrower health security prism such as ‘biodefense’ or ‘bioterrorism.’

There are a few other factors that are related to governance which have also impacted the extent to which policymakers and ICs have engaged effectively with health security threats, risks, and hazards in recent decades. These include political-cultural differences even between the UK and the US and other ‘Five Eyes’ countries. COVID-19, putting aside the influences of politicization, also underscored differences between how each ‘Five Eyes’ country adopted public health intervention policies within the confines of their political systems. One could argue the more fractured, ‘tribal,’ and innate mistrust of centralized power baked into the US federal political system would not allow the same kind of federal and state cooperation seen in Australia or New Zealand when it came to prosecuting various public health orders that restricted the liberties of citizens in the earlier stages of the pandemic. In other words, the art of what is ‘politically doable’ in both a legislative and political sense must also be understood in the existing nation’s political culture which historically may or may not facilitate rapid emergency policy measures in some liberal democratic states as was seen during COVID-19.

Narrow and sometimes fragmented policy perspectives contributed to a less holistic understanding and warning of the range of health security issues governments ideally should know about. In turn, a narrower political focus on what might be seen as more ‘traditional’ biothreats (e.g., WMD/CBRN and terrorism or rogue actor’s use of bio-weapons) also influences how the IC leadership views the collection, analytical, and operational priorities within their agencies of health security threats, risks, and hazards. Equally, a specific narrower focus on one threat actor group (e.g., WMD by state actors) does not necessarily equip IC agencies with the relevant threat and risk methodologies to understand let alone collect relevant intelligence on CBRN terrorism, biohackers, or pandemics. This in turn compounds the ability of ICs to effectively warn decision-makers of other potentially emerging health security, threats, and risks. Both policy and IC group think can also lead to insufficient intelligence collection and assessment, which in turn leads to intelligence and policy failure either/or at the tactical and strategic levels.

The understanding and operationalizing of what constitutes a legitimate national security threat like pandemics have of course been evolving within ICs from 9/11 to COVID-19. Comments made by former distinguished IC leaders show how national security implications of once less traditional bread and butter issues for them like pandemics have now increasingly been understood as well as the role IC agencies should play in supporting government to manage them.

For example, as noted earlier, former distinguished UK IC leader Sir David Omand in a 2021 article written during COVID-19 argues that during his time in government flu pandemics were considered high-priority risks with presumably all the resource allocation that such a designation brings (Omand 2021). In the same article Omand made some suggestions on how ICs can play a greater role in health security, including building a greater capability to do so (Omand 2021).

Yet in an earlier article he had suggested that the ‘assessment of disease outbreak is not the business of the intelligence community, though he said governments need warnings on these things which need to be a robust combination of intelligence and scientific assessments’ (Omand 2020). Omand’s 2020 comment seems to reflect a more traditional perspective on what role ICs should play in pandemics—one that some IC leaders may still share in the current post-COVID period (Walsh et al. 2023). COVID-19 will likely continue to challenge at least to some extent the longstanding organizational cultures of ICs—a culture that for decades has been built around responding to threat actors, not more amorphous risks and hazards like pandemics or climate change (Walsh et al. 2023). It is clear, however, that Omand’s 2020 perspective has evolved like many IC leaders after COVID-19. Omand’s earlier 2020 statement about the ‘assessment of disease outbreaks’ somehow not being in the lane also of national security intelligence agencies we argue is somewhat contradictory because to provide robust intelligence warning one needs IC staff who understand well both the scientific, health, and intelligence on health security and how it relates to the national security intelligence information, particularly if you are trying to build better warning systems post-COVID.

Just how many people in the IC need to have this knowledge and where located will require careful consideration post-COVID-19 by all governments and particularly the IC leadership. These issues are taken up in Chapter 8 by Vogel. It will be in part determined by budgets, IC leadership and governance, and whether political leadership expects to see more IC health security products that are multidisciplinary in nature.

Ethics

In addition to any political legal and constitutional challenges faced by political leaders in the management of health security crises like COVID-19, the history of political and policy responses to these issues also shows a series of ethical dilemmas for policymakers and ICs in what is the appropriate level of intrusion into citizen’s privacy (medical history and identity-related data) and their liberty in implementing various public health orders and other non-pharmaceutical interventions.

What is clear from our survey of policy action from 9/11 to COVID-19 is that greater integration and collaboration needs to occur between public health and national security agencies particularly ways to share more rapidly data sources of relevance to the mission of both sectors. However, also as seen during the period examined in this chapter, institutionalizing cooperation between health and security agencies implies potentially a securitization of the public health area. The intended goal of linking health with security data sources is to rapidly identify and disrupt the spread of infectious diseases with the least loss of life and negative impacts on social and economic life. However, overt securitization might have unintended consequences, such as restricting the work of public health scientists (Vines 2018). Political pushes towards more securitization without clear accountability

mechanisms in place might lead to populist purposes of ‘political policy’, where more securitization might not be required. It is therefore key that decision-makers deploy ethical considerations before melting barriers to information sharing across government jurisdictions.

Ethical practices in the expansion of increased integration continue to be a contested area. Walsh and Miller (2015), Miller et al. 2022 amongst others, for example Henschke et al. 2024, contend that intelligence studies literature has been slow in identifying ethical aspects of intelligence practice, but also critiques anti-intelligence activism that does not offer pathways to ensure national security. They argue that policy guidelines should not necessarily provide “specific ‘one size fits all’ policy prescriptions, but rather develop generic standards, purposes and parameters that could apply to different contexts” and propose that they should consider (1) methods, (2) context, and (3) targets of intelligence gathering (Walsh & Miller 2015, 348–349). Miller and Blackler (2005) expand those ideas by detailing six ethical principles that should follow:

- 1 Surveillance and interception are in themselves an infringement of the individual’s right to privacy and should therefore be only overridden by other moral considerations, such as preserving the right to life during wartime.
- 2 Benefits of surveillance must intercept the costs.
- 3 Surveillance must be deployed only for serious crimes.
- 4 Reasonable suspicion/belief that a crime and/or probable cause that the individual under surveillance is intending to commit a crime.
- 5 No alternative feasible method should be available to obtain the information required.
- 6 Law enforcement must be subject to strict accountability requirements.
- 7 Individuals under surveillance must be informed about surveillance at the earliest time following the completion of the investigation.

Despite the complex issues surrounding the ethical expansion of public health intelligence, scholarly literature has identified some best practices in evaluating the need for intelligence and surveillance as well as their evaluation. Additionally, proactive measures of public consultation have also been engaged by some governments: in 2019, New Zealand announced an overhaul of the country’s Biosecurity Act and included a formalized consultation process with Māori, industry partners, environmental groups, among other groups, as well as a plan for a period for formal public consultation (MPI 2019). Although scholars have called for increasing accountability requirements (Walsh & Miller 2015), significant concerns (e.g., the effectiveness of expanded security rights) remain unaddressed. Seumas Miller’s contribution (Chapter 7) explores these issues in detail particularly how post COVID-19 the many ethical risks emerging from the use of public health data during the pandemic and the conditions under which national security agencies may have access to it in any future health security emergencies is unresolved.

International Health Security Coordination

A final dimension to how policymakers and ICs engaged with health security threats, risks and hazards relates to the extent ‘Five Eyes’ states have participated in various international and multilateral health initiatives during the period studied in this chapter. While the chapter focus has been on how domestic policy initiatives in the UK and the US have impacted IC’s ability to support health security, the role of international health institutions and initiatives no doubt has also impacted ‘Five Eyes’ countries’ ability to receive, timely and accurate global health data useful to providing early warning and decision maker support. Historically, international utilization of health security intelligence faces an even larger number of challenges in working together to counter health security threats. Even when health intelligence is collected, numerous barriers exist to effectively communicating that information. For instance, during the early months of the 2014–2016 Western Africa Ebola outbreak, several factors contributed to health intelligence failure, including the Guinean government’s inadequate capacity to handle the crisis, the government’s inaccurate assessments of the crisis, the US embassy’s failure to contextualize the risk information appropriately, and the US embassy’s readiness to accept the Guinean government’s assessment without question (Ostergard 2021).

At the international level, rapidly spreading infectious diseases are monitored by the Global Outbreak Alert and Response Network (GOARN), which was formed in 2000 and places the World Health Organization (WHO) at the center of network coordination. GOARN is a network of more than 250 global institutions and networks that can help respond to and deploy staff and resources (Global Outbreak Alert and Response Network, n.d.). After the 2002–2003 SARS outbreak, GOARN was linked at the international and national level: national systems were to monitor disease outbreaks national and report their data to the WHO, which could then monitor and report outbreaks as well as liaise with countries affected (Wark 2021). Equipped with the International Health Regulations that mandated outbreak reporting, GOARN was to rely on transparent national reporting and the WHO’s capabilities to aggregate information internationally. To add to the information in case some countries were unable or unwilling to report outbreak data, the WHO included additional reporting from non-state sources. One of those sources was the Canadian Global Public Health Intelligence Network (GPHIN) (Government of Canada n.d.). In 2019 and 2020, however, the GPHIN failed to report on COVID-19, for reasons that were later uncovered via investigative journalism including: Canadian officials’ focus redirection away from global to North American health monitoring, technological issues, budget shortfalls, restraints on internal scientific reporting, mismanagement, cessation of reporting to global instruments (Wark 2021; Government of Canada 2023). The review of GOARN is still underway (Global Outbreak Alert and Response Network, n.d.), which will determine how international health intelligence will be coordinated across the interconnected national and international levels. A broader review of the WHO’s early warning capabilities has also taken place along with a range of other

multi-lateral measures including potentially an international health treaty aimed at mandating greater transparency on disease outbreaks of concern by member states. These post-COVID international measures are discussed by Lentzos in Chapter 9.

Conclusion

Barriers to effective political engagement at both the domestic policy and IC institutional levels as noted above have been many and accumulated over several decades from 9/11 up to including the COVID-19 pandemic. The solutions to addressing such constraints are not straightforward both at the political, policy and IC institutional levels. The remaining chapters will pick up many of the themes identified here and examine how they might begin to be addressed. There is again, as in the past, a small window to keep policy maker's attention on health security threats, risks, and hazards in the wake of COVID-19 before it seems the inevitable disengagement on these issues begins again.

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