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I have had a lot of trouble over the years wrapping my mind around this human security idea. I will admit that I have found it to be flaky. It is a little bit of everything. It is everything we aspire to: a better world, a happier world, a safer world, and a less combative world. Don't we all want all of that? In trying to grapple with what this concept really could mean, and how it could serve as a framework in our evolving transnational thinking, I have to give great credit to Keizo Takemi for his insights, and, as always, once again I am indebted to Lincoln Chen for bringing clarity into the middle of my foggy brain.

I think that there are two ways to look at where we stand right now with global health in the world. One is global health viewed as an acute intervention issue, and the other might be global health as viewed through the framework of human security.

The acute is what we do well, and it is what most of the billions of dollars sent for global health are used for. We like it because it involves application of technology, the targets are usually very clear, the outcomes are usually measurable, it is possible to do cost analysis in advance and have some idea how much money will save how many lives, and so we like this. We like child vaccine campaigns; we like flu vaccine campaigns in the midst of a pandemic. We get very anxious with all other aspects of pandemic control that are not amenable to quick fix technological issues. We like HIV as a treatment issue because that is an applicable technology with a set of ancillary technologies. We are incredibly uncomfortable with HIV as a behavioral issue. We like TB once we have the patient in the room, and we can throw the antibiotics at them. We are very uncomfortable with why it is that we cannot get those patients in the room in the first place. We like handing out malaria bed nets—that is a technology. We throw it out and then we come back and we report to the donors, “We gave away 800 million bed nets.” It makes us all feel very good. We do not want to know that they got used as curtains, they got used as fishing nets, they got sold on the black market, and the children continue to get bitten by mosquitoes.

We also actually have a capacity to mobilize for acute challenges. Whether it is Cyclone Nargis hitting Burma, or a tsunami hitting Aceh, Indonesia, that sort of mobilization is—perhaps in a poor choice of words on my part—in a “comfort zone” for the UN system. The system knows how to respond, and many donor nations know how to respond: they know what place to position themselves in. In the case of Haiti, it was immediately apparent, as was the case also with Aceh, from the point of view of the US government, that the key respondent was the United States Navy. And that is a very well organized machine.

So global health targets are attractive because they can be measured, because we have systems in place, and frankly also because they involve short-term engagement by the partners. “Safari science” is the phrase often thrown at this sort of thing, or “safari medicine.” It is a comfort zone that many in the developed world enjoy. You feel good because you flew to a country and did open heart surgery for two weeks and then flew home or the rough equivalent thereof. It creates a mechanism that works for the donors quite well.

And over the last decade as a result, we have seen an astonishing increase in the amount of money poured into global health. We have gone from roughly hundreds of millions of dollars in 2000 to now well over \$20 billion dollars collectively donated in 2009 for global health. It is unprecedented—no other field or endeavor of human collective action on the global plane can boast such an extraordinary increase in funding support over such a short period of time. Again, it is because it fits in with a set of very old models.

In fact, this notion of the wealthy world mobilizing to use its technology to better the lives of those in the poor world goes back to the 1950s, the moment we started to have the vaccine revolution—the introduction of the polio vaccine, measles vaccine, and so on—and the moment we had the introduction of the chloroquine and DDT revolutions and the possibility of controlling vector-borne disease. This basic modality that we are in right now that we are calling global health is actually about five decades old and has not substantially changed except to fine tune the tool kit and put more money into it. The focus for that money has been the G7, later the G8, in a giant global guilt trip. And every year, we rev up the global guilt trip, go to whatever country is going to be the host, and

start making them feel really lousy unless they commit billions of dollars, then scream and yell at the actual meeting, and billions get committed, some percentage of which actually materializes down the road to enable us to carry out this old paradigm of global health.

What is wrong with this paradigm? It is not in the least bit sustainable, it is entirely dependant on external funding, and nations rarely come up to the plate and meet the financial and technological demands of this approach on their own without external support. Look today—China, India, and Brazil, which collectively are the three biggest booming economies on the planet and one of which controls most of the global debt, are still dependent on the Global Fund to donate money for their HIV treatment programs, for their malaria bed net programs, and for their tuberculosis programs. They may be booming economies, and they may be the G20 leaders, but they expect handouts still from the G7. We are about to lose the G7/G8 as a process—Ottawa I will predict will be the last even marginally significant G8 Summit—and the G20 is taking over. Now, you tell me, is South Africa going to be the donor for Malawi? Russia has never donated any of its committed dollars. Are we imagining that China is suddenly going to become the donor that raises all boats in southern Asia? Is India, which still cannot meet the health needs of its own people, suddenly going to be supplying the human security financial needs of the rest of southern Asia? I do not think so. If you are thinking that way, you are smoking something.

So, what is our second paradigm and how do we shift to it? And, how can we make this assessment moment as we look to five years from now: where will we be in the MDGs and our various targets? Well, first, I think we have to be very clear, and I am grateful to Lincoln Chen for raising this, that the notion of security has clouded this conversation. In Washington, you say the word “security” and it has nothing to do with human security, and it probably never will. It is not the way we look at it, nor is it the way London looks at it, or Berlin looks at it, or Beijing looks at it. What does it mean? Security is a term that has been used for hundreds of years defined in a nation-state context referring to the existential status of the state and threats that could fundamentally bring down the state. Historically, that meant it was about an intelligence apparatus, a

diplomatic apparatus, a military apparatus, and to some degree related to economic development and trade.

Human security is an entirely separate concept. It sees security in the notion of the individuals within the state, and the state itself may be the primary threat to human security. A huge leap of thinking about what we are trying to accomplish on a transnational level is recognition of that. Since I am not part of the UN, I can actually name states—let's just say, Zimbabwe. Has the state itself been the primary existential threat to the people of Zimbabwe for the last 10 years? Yes. If you talk human security and you talk state security, they are opposing phenomenon—one threatening the very existence of the other.

Getting away from the notion of state security to the notion of human security, how can we use this as a new framework going forward for global health and get out of being locked in to this acute orientation? One big criticism of the acute model is its emphasis on the outsider as the intervener, the outsider as the funder, the outsider as the implementer, the outsider as the very designer of the program and the one that sets and measures the outcomes of said program. A human security model would at least in theory shift that, so that the concept, the expression of need, and the execution comes from the people themselves within a country. It would put a greater focus on behavior and the ecological context of a challenge. It would take us away from the quick fix mentality to normative shifts that fundamentally transform the way people live within their societies.

Let's take the example of South Africa—again, I am not part of the UN, I can name countries. South Africa is now embarking on a bold initiative to actually provide universal access to antiretroviral therapy to its people after years of denying the very existence of the epidemic—probably, according to Harvard University, at the cost of some 360,000 lives. Yet, the US Census Bureau estimates that South Africa will, from this year onward, still lose 830,000 people a year to AIDS. It is fundamentally witnessing the reshaping of the whole concept of family, of villages, and of the cultural context of leadership within the village structure and within the community structure. The hidden economic burdens are going to be longstanding, will go on for generations, and we have only begun to truly recognize them. Nothing any external funders are doing, and not

much that the state itself is doing, address that scale and those dimensions of the human security problem for South Africa just in the face of one disease: HIV/AIDs.

If we look at New Orleans, a city I love dearly and have for most of my life, now threatened by a giant oil slick—the result of a massive accident in the Gulf of Mexico. This is a community that has yet to recover from a 2005 Category 5 hurricane. While that Category 5 hurricane was not an existential threat to the national security of the United States or an existential threat to the state of Louisiana, it clearly was an existential and human security threat to the people of Louisiana, to the people of New Orleans, and continues to be an unresolved set of threats that we have not, as a country—the United States of America—figured out how to resolve or what mechanisms in our old fashioned toolkit of governance can address it.

If we look at Haiti—many of you may not be aware because it has not yet been published—but the National Weather Service and our United States Navy forecasts are that this summer will be the worst hurricane season in the Caribbean, Gulf of Mexico, and our part of the Atlantic experienced in at least two decades. They are predicting a minimum of 16 named tropical storms and anywhere from 8 to 14 Category 3 and above hurricanes. What happens to Port au Prince in a Category 5 hurricane when nearly two million people are living in tents? We can look at this very clear human security threat and start talking about a variety of problems with trying to move the people up the mountains fast enough and this and that, or we can look at countries in the region that have historically had very low death rates even when slammed by Category 4 and 5 hurricanes and ask why: what is the difference? Cuba was hit by two Category 5 hurricanes in 2008—total loss of life in Cuba that year was three people. Why? It is not a rich country; in fact, it is a desperately poor one. It is because of social mobilization and the empowerment of people: they knew what to do, they had warning systems, and they knew who looked out for whom—this is human security. It does not have a technological quick fix, but it requires massive mobilization and intervention in advance of the event. Why isn't this happening right now? I think if we look at human security in the big picture, how do we move toward a global health paradigm that draws on the classic old term of pediatrics: failure to thrive? How do we move to a world that no longer fails to thrive and bring in that pediatric concept of the thriving reality?

The issue of aging was raised earlier in today's discussions. Again, this notion of the acute approach of global health has to begin to fade away as we look at the rise of the emerging market societies. Whether you are looking at China, Brazil, Mexico, Indonesia—whatever country it might be—you are seeing an ever increasing percentage of the population that is now aging and also an ever increasing percentage that is subject to chronic diseases, with infectious diseases retreating. China now has 10 percent of its adult population at risk for diabetes, or, frankly, diagnosed with diabetes. They have seen a 27 percent decrease in infant mortality over the last 50 years but a 30 percent increase in cardiovascular disease deaths. Right now it might have 11 percent plus GDP growth every year, but it has not yet been able to figure out this new paradigm of human health security needs for its population. That is the challenge going forward. I would argue—as I have in the *Lancet* with Mushtaque Chowdhury and Ariel Pablos-Méndez in a piece we did a few months ago—that the shift has to be toward looking for universal health coverage and creating a vast marketplace of health consumers with sufficient influence, power, clout, and financing to be able to demand of their health systems, whether they be public or private, and pay for services that supply at least that level of health security and human security.