BMJ Global Health

Is it about the 'where' or the 'how'? Comment on *Defining global health as public health somewhere else*

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To cite: Fischer SE, Patil P, Zielinski C, *et al*. Is it about the 'where' or the 'how'? Comment on *Defining global health as public health somewhere else*. *BMJ Global Health* 2020;**5**:e002567. doi:10.1136/bmjgh-2020-002567

Received 1 April 2020
Accepted 6 April 2020

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Summary box

- The original commentary by King and Koski makes many important points, but we feel that the definition they provide, suggesting that the field is distinguished by the geographical relationship between practitioners and recipients, is too limiting.
- We propose an alternative definition of global health as public health *everywhere*, which takes into account the 'how' as well as the 'where', and we urge readers to emphasise equity in addition to geography.
- In our global health ecosystem, health problems, and the people who experience, prevent, solve and study them, are interconnected and cross national boundaries.
- Good governance, increasing use of local expertise, locally appropriate sustainable technologies and knowledge exchange programmes across countries and communities can all play an important role in delivering public health everywhere.

INTRODUCTION

A recent commentary by King and Koski[1] proffers a parsimonious definition of global health: as 'public health *somewhere else*' (emphasis in original). The authors describe how this definition highlights the underlying assumptions and normative issues that emerge when considering the practice of public health outside one's home community. While we agree with many of the points made by the authors, we feel as though this was a missed opportunity to push the definition of global health forward applying systems thinking. This commentary first addresses the points of convergence and divergence with the original article's main arguments. We then suggest why the definition presented does not do justice to the dynamism of global health. Finally, we conclude with a revised definition and discussion on what such a definition should encompass.

WHY PRACTISE SOMEWHERE ELSE?

The authors raise relevant and justifiable concerns regarding some common assumptions among global health practitioners. First, we agree that the oft-assumed 'expertise gradient' is problematic and maintains an ill-conceived notion of the foreign expert. This presumes that global health is practised by foreign experts in distant lands, flowing directionally from high-income experts to low-income recipients.[2] While we reject this notion, we acknowledge the importance of exchanging knowledge and sharing experiences. In fact, health problems are often shared, transcend geographical boundaries, and can be better addressed by working together across various cultural, social or political perspectives. Moreover, highlighting the assumption that those from outside have more valuable knowledge suggests that the authors have not adequately acknowledged the increasing trend to work in partnership with governments and local organisations, placing local and foreign expertise on at least the same level.[3] Thus, *how* global health is practised is, in our view, just as important as *where* it is practised.

Second, working *somewhere else* may result in someone having less cultural proficiency or professional regulation—rendering them less accountable to their intended beneficiaries—than when working at home. While this is certainly a problem when it occurs abroad, it is important to note that accountability issues can also arise at home. Marginalised, vulnerable or at-risk populations, including those within high-income countries, are intervened

on without the same ability to demand accountability of the person or organisation delivering the intervention.[4] Furthermore, emerging trends in global health rely increasingly on a country-level or regional-level expertise, rather than bringing advisors from further afield who may lack contextual understanding. We therefore contend that, once again, the *how* is just as important as the *where* in this context.

Third, the global health industry often preserves its idealistic desire to 'help' at the expense of efficiency. It is certainly important to consider how resources are being consumed, particularly in resource-constrained areas. Yet we should also consider how resource constraint is a direct result of historical events such as slavery, colonisation and the development of the neoliberal economic order, the resultant moral obligation of which should account for at least some of the justification of global health interventions.[5] Thus, global health practitioners should be sensitive to such histories and work towards redressing these structural ills, for example, through systems advocacy and strengthening.

Overall, we stand firmly behind the authors' efforts to push towards the decolonisation of the field of global health. Colonialism remains the original sin of global health and we believe that asking ourselves, 'why practise somewhere else?' is worthwhile. Likewise, the examination of our underlying assumptions and normative concerns is imperative in order to move the study and practice of global health towards delivering health equitably for all, everywhere. That is to say, the focus of global health should revolve around concerns of equity, social determinants, power and holistic well-being.[6] Nevertheless, the authors suggest that the field is distinguished by the geographical relationship between practitioners and recipients, and we feel that this definition is too limiting and does not do justice to the otherwise strong arguments made in the paper.

WHY ONLY *SOMEWHERE ELSE*?

The definition provided by the authors—that global health is 'public health somewhere else'—ignores the fact that threats to human health do not respect borders. Take, for example, the recent COVID-19 pandemic. Are we to assume that public health practitioners responding to the outbreak or creating preparedness plans at home are not engaged in an exercise of significance to global health? Our interconnected global health ecosystem is in direct contradiction to the definition offered by King and Koski. Suggesting such a non-chalant distinction between *here* and *somewhere else* belies the highly interactive relationship between health and globalisation.

Beyond global epidemics (an obvious example that could easily be used as a red herring), we should consider the fundamental attribute of globalisation: that people, along with their languages, and cultural and social norms, cross borders.[7] The existence of large diasporas and the emergence of globalisation disrupt national geographical continuities, and there is increasing support between countries within the same region (what is often termed 'South-South' cooperation).[8] Alternatively, an app for family planning designed in Silicon Valley, or the promotion of carbonated soft drinks worldwide can have profound effects on public health both within and across borders. Students from across the world train elsewhere and bring learning and practices back home.[9] Country nationals working in UN agencies, for example, can also be said to be engaged in the practice of global health.

Furthermore, technology plays an important part in global health, for example, through telemedicine or transcontinental academic or clinical collaborations.[10] With technology providing instant access to people, information and products worldwide, the practice of global health no longer necessitates travelling somewhere else, yet the outcome of these collaborations have applicability both within our own communities as well as elsewhere. Thus, we feel that the definition provided by King and Koski is at variance with the transnational practice of global health that has narrowed the remoteness of public health interventions.

We have argued that health is not confined within country borders, but we also feel that defining global health solely as taking place *somewhere else* is dismissive of what global health *should* entail. Rather than focusing solely on the *where*, we feel that focus should also be placed on the *how*. The authors' definition seems to disregard the emphasis on equity and overall well-being that a good definition of global health necessitates. We should begin by using the concept of 'health' as the parameter that we apply anywhere we practise, whether within or outside of our own communities. We suggest that, following the formula in WHO Constitution,[11] healthy individuals should be able to maximally participate and thrive in their community and daily life, with minimal barriers. Thus, emphasising *somewhere else* does not do justice to the principles of equity, quality and access that we believe should be core elements of any definition of either public or global health.

PUBLIC HEALTH EVERYWHERE

Given our objections to the definition provided in the original article, we believe it should be amended to 'public health *everywhere*'. This definition does not narrow our thinking to any particular geographical boundary or group of people, as does the definition of public health *somewhere else*. Global health should be more about the applicability of a health solution in the global context rather than where it has been piloted. The delivery of public health anywhere in the world should strive to design approaches that use the best health information to provide affordable, accessible, quality health and well-being services equitably to all people everywhere. This encompasses many of the normative considerations of public health: that of universal health coverage; planetary health; sustainable development; and accessible

health information. It should simultaneously encompass issues of disease, prevention, well-being, conflict, migration, systems, sustainability and human capital, as well as varying layers of society, from the individual to the population at large, and finally forming a collective attempt to create good health worldwide.

CONCLUSION

King and Koski's article offered a simple and thought-provoking new definition of global health, as public health *somewhere else*. In this response, we have argued that while we agree with many of the authors' points, we do not believe that their definition does justice to these concerns. We have offered a modified definition, as public health everywhere, and believe this better encapsulates the core operating principles of public health practised anywhere in the world. This debate offers a healthy opportunity to re-examine our own assumptions, and we believe that our definition better addresses these concerns. We understand that although the roots of allopathic health lie in the developing world, global health has historically moved from higher to lower income countries. Therefore, we do not wish to diminish the importance of always interrogating the issues of power, politics, history, structural violence and other such issues. Instead, we wish to use this decolonising approach when defining global health.

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Acknowledgements The authors are all members of the HIFA global health discussion forum (Healthcare Information For All, www.hifa.org), where this topic has been discussed among 20 000 global health professionals in 180 countries. They would like to thank the HIFA forum, and particularly Neil Pakenham-Walsh, for sharing the original article and encouraging debate, as well as Peter Jones and Anna Schmaus-Klughammer for their insights and comments. They invite you to also join HIFA: www.hifa.org/joinhifa.

Contributors SEF drafted the initial response based on discussion and input from the group. All authors made substantial intellectual contributions and revisions. All authors have agreed upon the final version to be published.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement There are no data in this work.

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