

'Global health': meaning what?

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'Global health' is emerging as an increasingly widely invoked and powerful discursive construct. But what does it mean? It is described as a metaphor, a conceptual framing, a set of legal norms, and as a distinct field of practice;^{1,2} as an emerging science, an area of policy and research and as a formative disciplinary field of study.³ But the precise dimensions of the idea remain unclear.^{4,5}

While we have yet to clarify what we mean by global health, we should circumspect as to what it is *allowed* to mean. Too often, discourse appears to point in one direction, while reality runs rapidly in quite another. The appearance of an agreed language may obscure and suppress important differences in philosophy, strategy and priority.⁶ Global health may well be invoked to support and enable policies and actions with genuinely universal and equitable benefit. But it may also be used to justify measures that are neither progressive nor just.

We should not assume that a harmonious interpretation will, over time, emerge. Rather, we should expect an emergent global health paradigm to be characterised by potentially fierce contest. We should encourage that contest, played out through transparent, honest and evidence-based debate. The quality of that debate, from the health perspective, will depend on an ability to understand, engage with and draw on insights from a wide field of intellectual traditions and disciplines.

If global health is to be an organising framework for thinking and action, we should ask: what does it imply, what does it endorse? For proponents of a global health vision characterised by health as an intrinsic social goal, and by health equitably generated within and across populations, understanding how the concept is framed from other political perspectives, based on other disciplinary values, will require a polymathic capability—to engage with heterogeneous concepts in macro, micro and behavioural economics; in sociology, political science, international relations and public policy and in anthropology and institutional ethnography. It will require going beyond advocacy simply rooted

in 'health', to understand what health means from other intellectual and political standpoints, and to engage and challenge where such standpoints traduce the values we seek in global health.

EPIDEMIOLOGICAL CONVERGENCE?

From an epidemiological perspective, global health may be characterised as health issues whose causes or redress lie outside the capability of any one nation state—a growing homogeneity of challenges common across countries at all levels of socioeconomic development. This draws on the dramatic reduction in some health inequalities between rich and poor countries under the Millennium Development Goals (MDGs), between 1990 and 2015, which itself underpins optimism about the possibility of a 'grand convergence' through which countries across the world see a levelling of major health issues, largely in the fields of infectious disease, maternal and child mortality, by 2035.⁷ As traditional infectious and perinatal drivers of poor-world mortality are reduced to comparable global lows, a new world of predominantly non-communicable conditions—many with common determinant elements and solutions—emerges. This is a positive vision of global health, but one that should be approached cautiously. Improvement in parity between countries in health outcomes may be allowed to distract attention from structural—and deepening—inequality within them.

Convergence is predicated on significant improvement in basic universal healthcare.⁸ Yet, we know that even the most narrowly deliverable universal services, such as immunisation, remain characterised by deep inequality in access and uptake. In Nigeria, full immunisation ranges from 51.5% in the South-South to 9.5% in the North-West.⁹ For other forms of healthcare requiring more complex health system functions, genuinely equitable population coverage remains abysmally low.¹⁰ In fact, between 1990 and 2011, coverage inequalities for reproductive, newborn and child health services increased in almost a third of 64 developing countries. In a quarter of



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those countries, coverage among the bottom four deciles actually fell, and in a little under half of them, inequality in health status rose.¹¹ Income inequality has been increasing in both developed and developing countries in recent decades.¹² Socioeconomic inequality in adolescent health rose in 34 surveyed North American and European countries between 2002 and 2010.¹³ If global health asserts a benign convergence between countries, it risks obscuring growing inequity within them.¹⁴ That inequity is associated with underlying political and economic factors within countries and increasingly at global level under processes of globalisation—processes which will, ineluctably, shape the meaning of global health.^{15 16}

GLOBALISATION, ECONOMIC NORMS AND HEALTH

We know that the impact of globalisation on health can be stated positively, with increased opportunity for individual, communal, national and regional participation in the accelerating circulation of knowledge and technological skills, systems of production and trade and increasing institutional and political space for collective action and problem-solving. We know too though that, founded in anterior inequalities in capability and power between countries and social groups, such opportunities frequently translate into inequitable distributions of benefit and risk.^{17–19} Fundamental neoliberal norms that underpin contemporary economic globalisation—in particular, the imperative of growth, and the meaning of inequality and poverty—present profound challenges to what global health entails.

Growth is viewed as the principal marker of a country's success according to the prevailing paradigm of economic development. In this view, health is constituted as an input to growth—an important one, without doubt, but in essence subsidiary. Construed as an investment, rather than an intrinsic goal of social development in its own right, 'health' may be confined to those investments and outcomes that have the greatest direct influence on productivity, limiting significantly the scale of a more holistic health vision.

Neoliberal economic orthodoxy has, until recently, taken inequality as an acceptable, inevitable or even, at the limit, desirable feature of growth.^{20–22} Only more recently has economic research started to acknowledge that inequality may be bad for growth—or that the idea that inequality is a necessary trade-off in order to secure greater economic efficiency is empirically questionable.²³ Inequality—or rather inequity—in health, by contrast, is axiomatically unacceptable—pointing to the need to clarify interdisciplinary thinking on the relative meanings of inequality and inequity.

Poverty reduction sits at the epicentre of socioeconomic development thinking and at the roots of action to improve health. In a neoliberal economic framing, though, poverty is constituted as a 'residual' problem—the absolutely poor as an unfortunate but technically resolvable effect of the growth process. An alternative,

sociologically derived analysis views poverty as 'relational'—produced by the forms of social organisation we generate to enhance productivity and growth. In this view, poverty is not a side effect but a direct consequence of the way societies are organised.^{24 25} The relational view of poverty bears striking similarity to the social gradient in health.²⁶ The implications of both are that technical fixes at the bottom of the distribution are as inadequate in addressing social inequality as they are in addressing inequitable health. How we understand poverty—and poverty-related health—has significant consequences for what we do about it. Moreover, analysis of the MDGs process suggests that increase in household income does not automatically translate into improvements in household health, causing us to question whether an economic interpretation of poverty is adequate in considering wider sociodevelopmental goals.²⁷

Neoliberalism views social agency as axiomatically individual. The value of collective agency is viewed much more ambivalently. Again this has distinct consequences for health. An individualist model of social action emphasises personal responsibility for health; hence, behaviour change as the primary focus of intervention, with lesser attention to structural interventions—in particular, where these involve state intrusion, through tax and regulation, on people's sovereign consumption choices.¹⁴

Foundational policy norms, flowing from economic globalisation, will increasingly shape health actions in coming decades. A global health vision needs to clarify how it engages with these norms—the primacy of growth, a tolerance for inequality, the constitution of poverty as a technical problem and the pre-eminence of individual over collective action in social and health policy and action — to accede to their authority or hone the analytical skills required to challenge them.

GLOBAL DISCOURSE, NATIONAL INTEREST

As much as globalisation influences countries' policy-making, countries continue to influence—or try to influence—global policy processes, including in relation to health. Understanding global health requires a nuanced understanding of domestic policymaking within national government systems, understanding where health intersects with foreign, trade, development and security agendas and drawing on international relations theory, public policy, political science and institutional ethnography.²⁸ We can illustrate this through the examples of aid, security and the global distribution of human resources for health.

Aid has been a significant feature of international development financing, including for health, since the end of the Second World War. It has also been viewed, more or less explicitly, as a medium for leveraging national, economic and foreign policy objectives.²⁹ Under the MDGs, global aid allocations to health massively favoured a small set of disease-specific interventions—most notably HIV/AIDS, tuberculosis and malaria.^{30 31} By contrast, between

2000 and 2015, investment in structural aspects of health system development (basic health infrastructure, health personnel and health education) constituted around 4% of total health aid financing.³² Preferences in the way aid is used remain closely informed by the domestic politics of donor countries and deeply contested ideologically and empirically—from effective interventions in disease prevention, to modes of financing for equitable health-care.³³ Global health must offer a credible space within which competing and contesting fiscal and programmatic approaches can be tested against agreed standards of evidence and basic values.

Health as a matter of global security arose in the 1990s as the potential impact of infectious diseases on trade, foreign affairs, social stability and insecurity was recognised.^{34–36} But it remains unclear, whether ‘global health security’ legitimises individual countries to act internationally when they perceive their domestic interests to be at risk, and to do so through militarised means where deemed necessary, or whether it demands a stronger collective global decision-making facility to determine, beyond the current International Health Regulations, a more progressive route to enhancing common health security through shared action on the transnational drivers of health risk.^{37–39}

The worldwide shortage of human resources for health is now constituted as a global crisis—affecting countries at all levels of wealth, though in distinctly different ways.⁴⁰ In poorer regions and countries, there is a simple—and often critical—dearth of trained workforce numbers; in richer countries, with shifting demographic and epidemiological demands, the requirement for healthcare workers, in particular in nursing and social care, increasingly outstrips domestic ability or fiscal willingness to recruit, train and employ.⁴¹ A global health vision needs to be clear whether ‘globality’ now implies a marketplace through which countries at all levels of development may freely exchange, compete for or actively source health workers (accepting the gravitational pull of higher-income offers), or if it reflects a continuing commitment to redress the massive distortion in skilled health workers constituting perhaps the greatest barrier to progress among the poorest states.^{42 43}

GLOBAL HEALTH, GLOBAL GOVERNANCE

‘Global health’ is not a new science, though it may become one. It is not—yet—an emerging field of practice. Right now, global health is a new terrain on which older contests—contests of ideological interpretation, geopolitical interest, empirical method—are played out. In its best form, global health offers real opportunities for more collective, equitable health thinking and action. But without adequate agreed definition, global health may be used as discursive cover for a range of policies, by individual states or through multilateral institutions, which are distinctly inequitable or poorly aligned to agreed common global interests.

Arriving at a clearer sense of what a global health paradigm entails—whether in the form of consensus or, at a minimum, agreeing the terms of debate—requires assembling and interrogating evidence and argument from multiple intellectual and disciplinary traditions. That process of assembly and interrogation requires an arbiter—an institution at global level with a reasonable claim to technical competence and ideological impartiality. It may be argued that the only institution coming close to that definition is WHO. And herein lies an interesting paradox.

As the emergence of ‘global health’ as a powerful new framing for policy and practice has illuminated the need for arbitration as to what it means—what it implies and endorses—the one mandated institution to mediate at the global level appears to be losing authority and influence.^{5 44} Perhaps, though, this is not a paradox. In the absence of a single global actor authorised to mediate global health, ‘global health’ may be shaped to whatever the most powerful global actors determine it to be.⁴⁵ Just as, under the ascendant influence of liberal free-market economics in the 1980s, we saw the emergence of the language of ‘governance’ displace and marginalise the traditional centrality of government as sovereign actor in citizen health, replacing it with a fragmented galaxy of ‘stakeholders’, is it possible that, in a similar fashion, the rise of a poorly defined ‘global health’ paradigm fits rather well with the diminution and marginalisation of WHO’s centrality, empowering a more diffuse field in which vested interests may more easily navigate.

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