DOI: https://doi.org/10.2298/GEI2103531B
UDK 008:159.938.363.6:39
Review article

Stuart Blume

Department of Anthropology, University of Amsterdam
S.S.Blume@uva.nl

Goodbye Global Health?

Over the past 20 or 30 years vast sums of money have gone into 'global health'. The money has funded vast initiatives largely focused on infectious disease control, as well as university centres and research projects. The numerous and varied definitions of global health share a normative element. Global health implies an egalitarian approach, treating everyone's health needs equally, irrespective of citizenship, ethnicity or gender. If we look at what the concept does in practice, other than lubricate the flow of funds, the picture becomes more complex. This essay argues that despite its normative connotations, global health is closely associated with globalization. It became an arena for engaging in contests for economic and strategic advantage under cover of its normative connotations. This 'underside' of global health was invisible to all but a few critics. I argue that responses to the Covid-19 pandemic have made it visible to all. Perhaps, recognizing what the concept really does, it should be used with caution, or avoided entirely.

Key words: global health, globalization, vaccine nationalism, strategic interests, equity

Због ом, глобално здравље?

У протеклих двадесет-тридесет година огромне суме новца уложене су у „глобално здравље". Тим средствима финансиране су широке иницијативе претежно усмерене на контролу заразних болести, као и универзитетски центри и истраживачки пројекти. Бројне и различите дефиниције глобалног здравља деле нормативни елемент. Глобално здравље подразумева егалитарни приступ: једнако третирање здравствених потреба свих, без обзира на држављанство, етничку, полну и родну припадност. Ако погледамо како концепт функционише у пракси, најпре ћемо уочити да омогућава проток средстава, а даља анализа даје сложенију слику. Теза овог есеја јесте да је глобално здравље, упркос нормативним значењима, блиско повезано са глобализацијом. Оно је постало поље надметања за економску и стратешку предност под покрићем његових нормативних конотација. Ово „наличје" глобалног здравља је било невидљиво за све осим за неколико критичара. Тврдим да су га одговори на пандемију ковида 19 учинили видљивим свима. С обзиром на то како концепт заиста функционише, предлажем да би га требало или опрезно користити или потпуно избегавати.

Кључне речи: глобално здравље, глобализација, вакцинални национализам, стратешки интереси, једнакост

Introduction

The Wikipedia entry for 'Global Health' starts with a definition. 'Global health', it states**,** 'is the health of populations in the global context. It has been defined as "the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide".[1] "Global health," the text continues, "is about worldwide health improvement (including mental health), reduction of disparities, and protection against global threats that disregard national borders." Global health, in other words, respects neither the boundary between research and practice, nor the boundaries between nation states. Since it aims at achieving health equity, at reducing disparities between peoples and populations, it clearly has a normative dimension. In this it differs from the obviously related term 'globalization'. This too refers to cross-border movement: to flows not of pathogens but of ideas, people, goods, and above all capital. But globalization has inspired not only social protests, but also theoretical critique. Many social theorists regard it with suspicion.

> "Globalization is certainly a source of anxiety in the U.S. academic world. And the sources of this anxiety are many: Social scientists (especially economists) worry about whether markets and deregulation produce greater wealth at the price of increased inequality. Political scientists worry that their field might vanish along with their favourite object, the nation-state, if globalization truly creates a 'world without borders'. Cultural theorists, especially cultural Marxists, worry that in spite of its conformity with everything they already knew about capital, there may be some embarrassing new possibilities for equity hidden in its workings... And everyone in the academy is anxious to avoid seeming to be a mere publicist of the gigantic corporate machineries that celebrate globalization" (Appadurai 2001, 1).

Whether one shares these anxieties or not, the notion of globalization is open to critique in a way that 'global health' appears not to be. What possible objection could there be to reducing health disparities and improving the health of people everywhere? In this essay I argue that the Covid-19 pandemic exposes interconnections between the two concepts which were previously invisible to most people and consciously ignored by the few. Another way of putting this is to say that the assemblage of meanings hidden in the notion of global health is being broken open.

Thirty or forty years ago no one spoke of 'global health'. There was 'public health', with roots far back in the 19th century, and which referred to actions taken in the interest of the health of a community or a state. And there was 'international health', derived from 19th century health regulations designed to prevent the spread of contagion. The focus here was mainly on international approaches to reducing mortality and morbidity in poor countries. So before turning to what has changed in

[1] Global health. Wikipedia. https://en.wikipedia.org/wiki/Global_health (Accessed April 10, 2021).

the past 12 months, we should first take a step back. Where does the concept of global health come from? When and why was it introduced?

The origins of the concept of global health

In the 1980s the World Health Organization (WHO) was in crisis. Its regular budget was going down, and Western governments – that contributed most of the money – were becoming increasingly critical of the way WHO worked and of its resistance to the neoliberal policies that dominated western politics. It was faced with the growing authority of the Washington-based World Bank, which was making grants for health-related development projects. Not only was the Bank very much in tune with neoliberal policies, it had far greater resources than the WHO. By 1990 the Bank's loans for health were greater than the WHO's total budget. The Bank's approach was based on the idea that better health would lead to faster economic growth. As the Bank began to lend money for health services it insisted on privatization, deregulation, decentralization, and a reduced role for governments. People would have to pay for their health care! The Bank's policies not only conflicted with the values of many WHO staff-members, they threatened to erode the Organization's influence still further. This is the background to WHO's attempt to refashion itself. Historians have suggested that the idea that health should be considered a global issue is tied up with WHO's response to its difficult situation (Brown, Cueto & Fee 2006). If health has to be dealt with as a global phenomenon, working at the country level – on whatever scale – could never be adequate. Since the World Bank works through loans to individual countries it would not be in a position to provide the necessary global coordination and leadership.

However, if the WHO could claim initial ownership of the concept, it was not in a position to control or shape its further use. The literature on global health contains many definitions. Though they all have something in common with the Wikipedia extract with which I began, they differ in what they emphasize. It's the diversity, the differences in emphasis, which I want to stress here. This diversity in definitions indexes the flexibility and the ambiguity of the concept.

Definitions and beyond

In terms of numbers of citations, the most influential definition is that given a decade ago by a group of professors representing the 'Consortium of Universities for Global Health'. Insisting on the need for an agreed definition of global health, they try to provide one.

> "Global health can be thought of as a notion (the current state of global health), an objective (a world of healthy people, a condition of global health), or a mix of scholarship, research, and practice (with many questions, issues, skills, and competencies" (Koplan et al. 2009, 1993).

These authors want to make a sharp distinction between global health and both public health and international health. Global health goes far beyond the control of epidemic infectious diseases. It should also address injury prevention, obesity, the health of migrant workers, and much more.

> "Thus – like public health but unlike international health – global health can focus on domestic health disparities as well as cross-border issues" (Koplan et al. 2009, 1994).

Moreover, it acknowledges that

> "the developed world does not have a monopoly on good ideas and search across cultures for better approaches to the prevention and treatment of common diseases, healthy environments, and more efficient food production and distribution" (Koplan et al. 2009, 1994).

The authors explain why they prefer the term 'global health' to the older terminology. It is because they see global health as based on an attitude, a philosophy, different from that which underpinned earlier health practices. Global health, they write, "emphasizes the mutuality of real partnership, a pooling of experience and knowledge, and a two-way flow between developed and developing countries. Global health thus uses the resources, knowledge, and experience of diverse societies to address health challenges throughout the world" (Koplan et al. 2009, 1994).

Responding, a year later, a group representing a consortium of schools of public health in the US, argued that there is no difference between global health and public health. That some people see it differently is due to a misunderstanding. The general tendency is still to think in terms of "international aid, technologies, and interventions flowing from the wealthier countries of the global north to the poorer countries of the global south". Like Koplan et al. these authors too stress the need to acknowledge interdependences and "the many contributions of both resource-rich and resource scarce nations". Their preferred term is 'global public health', which they see as "a public good, benefiting all members of every society, even though local applications must be contextually appropriate" (Fried et al. 2010, 536).

On the other hand, Beaglehole and Bonita, epidemiologists and public health physicians from New Zealand, link their definition to the notion of 'health for all'. Inextricably bound up with the 1978 Alma Ata Declaration, this was soon rejected as idealistic and impractical by influential public health experts from the global north.

> "Our proposed definition for global health is collaborative transnational research and action for promoting health for all. This definition is based on Koplan et al. but has the advantage of being shorter and sharper, emphasizes the critical need for collaboration, and is action orientated" (Beaglehole & Bonita 2010, 5142).

Whilst agreeing that global health rejects the privileging of some people's health needs over other people's, historians Brown, Cueto and Fee emphasize the growing complexity of the field.

> "'Global health' in general, implies consideration of the health needs of the people of the whole planet above the concerns of particular nations. The term 'global' is also associated with the growing importance of actors beyond governmental or intergovernmental organizations and agencies – for example, the media, internationally influential foundations, nongovernmental organizations, and transnational corporations" (Brown, Cueto & Fee 2006, 62).

Finally, anthropologists Janes and Corbett define global health in a way which will resonate with many anthropologists, though leaving most public health doctors scratching their heads!

> "Global health is an area of research and practice that endeavours to link health, broadly conceived as a dynamic state that is an essential resource for life and well-being, to assemblages of global processes, recognizing that these assemblages are complex, diverse, temporally unstable, contingent, and often contested or resisted at different social scales" (Janes & Corbett 2009, 169).

In most of these definitions the normative aspect of global health is clear. It is an approach to studying and doing health which takes each person's health and well-being as of equal importance, irrespective of nationality, gender or ethnicity. It is an approach which transcends and rejects any assumption of (Northern) epistemological or technical privilege. Though differently referenced and conceptualized, these assumptions underpin each definition. Still, the plurality of definitions suggests that Koplan et al. were wrong. Perhaps the success of the concept rests precisely on its ambiguity. Loosely defined concepts enable diverse actors to proceed on the assumption they are talking about the same thing (Davis 2008). The 'interpretative flexibility' of the concept is essential to the job it is intended to do. What does it do? Put differently: 'what is being done in the name of global health?' It is here, not with definitions, that an interrogation of global health must start.

'Global health' has undoubtedly drawn in an increasingly diverse range of funding agencies, and led to a vast increase in funding for global/public health. Beyond national development aid agencies and multilateral institutions (including the World Bank and various United Nations organisations), private foundations (including the Gates Foundation), NGOs (such as Doctors without Borders) and the private sector played increasingly important roles. Where did the money go? There is evidence that not only are politically stable countries favoured, but that expenditures on health issues in poor countries does not correlate with disease burden in those countries (Esser & Bench 2010). A large share of these resources goes directly to any one of a (sometimes very large) number of NGOs working in a country, rather than to the national government. This should mean that funds are used more effectively in meeting the health needs of communities, and very likely it does. But there is also a downside to this expansion in numbers of donors and of NGOs. Because they all have their own priorities and programmes, often without any coordination, it becomes difficult for countries to control their own planning and priority setting (Pfeiffer 2003).

In research and in teaching as well as in practical interventions, 'global health' has enjoyed spectacular growth over the past ten or fifteen years. A bibliographic search for scientific articles with 'global health' in the title points to approximately 900 published annually for the last 2-3 years. For comparison, in 2000 there were 78 and in 1990 only 14! Of more than 10,000 articles which had appeared, as of early 2021, 700 were classified as 'social science'.

Anthropology in/for/of global health

The enormous scale of many global health initiatives means they usually operate according to a standard protocol. These programmes offer little scope for respecting the local meanings, practices, and values central to anthropological approaches. Nevertheless, there is no doubt that universities, including departments of social science, have benefited from the extra attention which 'global health' has drawn. Countless universities have established a 'Centre for Global Health' in the last decade. Anthropologists have found homes in many of these centres. What do they do there? Much global health-related anthropological research seeks to "link wider social, economic, and political forces to local experiences of sickness and suffering" (Janes & Corbett 2009, 171). There are clear parallels with the 'horizontal' approach to health and illness formulated most clearly in the Alma Ata declaration, (though largely abandoned thereafter).

Anthropologists try to specify the links between local life worlds and global forces. They try to expose the scope, the scale, and the differential impacts of exploitation and structural violence which may mark even global health initiatives. Paul Greenough's classic study of the violence with which the goal of smallpox eradication was achieved is exemplary (Greenough 1995). Janes and Corbett touch on the dilemma which anthropologists can scarcely avoid in working in and on global health.

> "We argue that a central ethical problem for anthropologists, as for scholars of global health more generally, is … whether their work contributes to social justice and the remediation of structural violence where it is the most severe. This problem provokes two questions: Are the products of anthropological scholarship in global health – conceptually, theoretically, methodologically, and pragmatically – relevant to those broadly interdisciplinary efforts to improve health and well-being? And, is anthropology, principally an academic discipline, prepared in the context of global health to engage in what we refer to here as principled engagement and intervention" (Janes & Corbett 2009, 176).

Given the shape and the structure of the global health field in practice, can anthropology reconcile its disciplinary goals and values with 'making a difference' in practice? If not, what is the alternative? Anthropologist Betsey Brada has offered one:

> "Anthropology's great strength lies in criticizing the taken-for-granted in asking what makes 'global health' so self-evident, and so genera-

> tive, and what ways of imagining and acting in the world it eclipses or forecloses… Uncritical approaches to 'global health' obscure the highly unequal power relations that are revealed when we examine competitions over its terms. While the seductiveness of 'global health' lies in its vanishing horizon, at once totalizing and elusive, this flexibility also makes possible the naturalization of politics, the making of a 'global' that erases the conditions of its own production" (Brada 2011, 307).

From this perspective global health should be seen less as a fund of resources and opportunities but rather as a phenomenon in need of critical interrogation.

Co-optation of the field before Covid-19

I referred to 'the shape and the structure of the global health field in practice'. What is this, beyond the rhetoric and beyond the funds and employment it provides? It has had other consequences. From the 1980s onwards pharmaceutical companies focussed increasingly on serving global markets with standardized products. The notion of health being 'global' helped legitimate their activities. In the vaccines field specifically local producers serving distinct national markets largely disappeared, displaced by global corporations. Their focus was on profitable markets, with little attention for diseases (such as parasitic diseases) affecting poor countries almost exclusively. Global vaccination initiatives and global vaccine action plans were launched. New initiatives (advance market commitments, public-private partnerships) aimed to bridge the growing gulf between industry's priorities and those of public health.

Geographer and political scientist Matthew Sparke, looking back (from 2017), argues similarly that global health is (and always has been) fundamentally imbued with the tenets of neoliberalism. "From the eclipse of Alma Ata by structural adjustment and Washington Consensus reforms in the 1980s and 1990s" onwards. Creating structural violence, vulnerability, and ill-health in one turn, it has also gone on to be twisted into the conceptualisation and advocacy of idealized solutions in the next turn. Through all of these twists and turns, neo-liberalism has clearly bound and led global health governance, globally, nationally, and personally" (Sparke 2020, 52).

Much of the money flowing into global health is motivated neither by commercial interests nor by the health needs of neglected populations. It is motivated by security issues. Fear of bioterrorism is the most obvious instance, but it goes much further. Public health officials have eagerly endorsed the security connection in order to capture the interest of political leaders and push health higher up the political agenda. As political scientist Simon Rushton puts it: "It is not always clear where public health ends and security begins" (Rushton 2020, 133–134).

Two decades ago, HIV/AIDS appeared within a security context, particularly in relation to national and regional stability. This was highlighted by the 2000

UN Security Council special session on the HIV/AIDS threat to Africa. It was followed by a Security Council resolution which noted that if nothing were done to check the HIV/AIDS pandemic, it would threaten the Continent's stability and security. Concerns raised in the security context included the disproportionate HIV infection rate among security forces, the economic burden caused by the disease, increased social fragmentation, reluctance to send or receive peacekeepers due to the risk of infection, and even its use as a weapon of war, principally through rape.

The shared agenda was dominated by the concerns of foreign and security policy, not those of global public health. The relationship between the two policy communities was unidirectional, emphasizing how health issues may create risks for (inter)national security or political stability. The agenda was not about how foreign and security policy might promote global public health. Australia's then Foreign Minister Alexander Downer noted in 2003 that global health could no longer be left to health ministries, but must also be the concern of foreign ministries. What was driving the relationship was foreign policy concerns for protecting the national interest, not a concern for improving global public health (Altman 2008, 17).

The attention to infectious disease as a 'security risk' focused on infections that had (or have) the potential to move from the developing to the industrialized world. Prior to the current pandemic a list of such diseases included West Nile virus, Ebola, SARS, and monkey pox. By constructing the link between infectious disease and security in this manner, the global health agenda was clearly privileging the interests of certain populations over others.

From a security perspective a focus on infectious diseases made sense. They posed identifiable risks to domestic populations, regional stability and economic growth. But from the perspective of 'the health of people everywhere' the focus was (and remains) inadequate for many reasons. The broader determinants of health, including all the manifestations of forced migrations and poverty, are set aside as intractable. The focus on the spread of infectious disease tended to obscure dangers from non-communicable diseases including those related to tobacco and other addictions. It obscured the damage caused by over-consumption of nutrient-poor foodstuffs marketed so profitably by western conglomerates. Emphasis on the spread of infectious disease reflected more the concerns of Western foreign (including economic) and security policy than it did the concerns of global public health. No matter that the health risks to populations in the industrialized world pale by comparison with those in much of the Global South.

Prior to the current pandemic all of this, what might be called the 'underside of global health', was largely invisible. It was publicly acknowledged only by a few critical commentators. That has now changed. The pandemic has shone a harsh new light on what 'global health' means in practice.

'Global health' and Covid-19

Early in the pandemic China, Russia, and the US were competing in a race to produce the first effective vaccine. By the end of 2020, as the first vaccines be-

came available, the competition was as fierce as ever but the goal had changed. It continued to evolve, in a field visibly dominated by competing strategic and economic interests.

To control the pandemic and return to anything like 'normal life', it would not be enough to vaccinate the whole populations of a few rich countries. However, it soon became known that the rich countries had reserved most of the initial supply of 'promising' vaccines well in advance. They signed confidential advance purchase agreements with leading western manufacturers, reserving millions of doses for themselves. This was the first sign of what was soon labelled 'vaccine nationalism'. Focused on their popularity or a forthcoming election, politicians tried to convince their electorate that its well-being, the health of citizens, was their only concern. No matter the needs of vulnerable populations in distant countries. Elsewhere, political leaders sought to use the crisis to advance their countries' international interests. Regulatory authorities in China and Russia moved rapidly in approving locally developed vaccines for domestic use. The subsequent offer of providing poor countries with much-needed vaccines, in exchange for privileged access to markets or raw materials, came to be known as 'vaccine diplomacy'.

In April 2020, the international community began to formulate a mechanism of its own for ensuring poor countries' access to vaccine supply. The mechanism they came up with does seem to reflect the practical and moral commitment implied by global health. An important element of the mechanism was the Covid-19 Global Access Facility, COVAX. Co-led by GAVI, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI) and the WHO, COVAX was established to "guarantee rapid, fair and equitable access to Covid-19 vaccines worldwide", and "regardless of their wealth".[2] COVAX was supposed to mitigate the impact of bilateral agreements by encouraging rich countries to cooperate and to support low-income countries as well. Rich countries would commit to investing in support of vaccine production and to acquiring part of their supply through the facility. The European Union has been a major source of support, whilst the USA began to support COVAX after the installation of the Biden Administration. COVAX aimed to have 2 billion doses to distribute by the end of 2021: enough to help countries vaccinate all of the highest priority populations. As of December 2020, COVAX involved 190 participating and eligible economies. 92 low-income countries would receive their shipments of vaccine without charge. Deals or Memoranda of Understanding were struck with a number of manufacturers, including the Serum Institute of India, the world's largest manufacturer of vaccines. 1.3 billion shots were to be reserved for the 92 eligible middle- and low-income countries, whose participation was supported by a fund-raising mechanism.

COVAX is a multilateral initiative which contrasts sharply with the pursuit of economic and strategic interests indexed by 'vaccine nationalism' and 'vaccine diplomacy'. COVAX is surely about equalization, about overcoming inequalities,

[2] Gavi. The Vaccine Alliance. COVAX explained. https://www.gavi.org/vaccineswork/covax-explained (Accessed April 10, 2021).

about social justice. Does it then rebut my claim that 'global health' has lost its commitment to 'health for all', to transcending privilege? Alas, a recent report suggests otherwise. In a complex assessment its author concludes that COVAX's obscure multi-stakeholder structure weakens the United Nations system, and that lines of responsibility have been made obscure. Adopting a market-based approach, it undermines

> "public acceptability of health as a global public good. It implies that only those who have access to purchasing power – or who have non-state bodies attempting to have purchasing power on their behalf – are eligible for access to the medical services to mitigate the impact of COVID or other epidemics. COVAX's focus on protecting commercial markets is also reflected in its granting of 'stakeholder' status to Big Pharma but not to those in need of health services or those who might advocate for an alternative public sector response" (Gleckman 2021, 11).

If 'global health' has been (re)fashioned as a subterfuge, a moral camouflage for vested economic and political interests, isn't it now time to attach a 'use with care' label to the concept? Or perhaps, sadly (though I hope temporarily)... to say: Goodbye Global Health?

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Примљено / Received: 11. 05. 2021.
Прихваћено / Accepted: 15. 11. 2021.