

UNDERSTANDING THE CONTEXT OF GLOBAL HEALTH POLICIES

Their Post-Colonial Legacies and Impacts on Health Service Systems

Kasturi Sen, Imrana Qadeer and Eduardo Missoni



Kasturi Sen (*left*), PhD, is a Social and Political Scientist based at the Wolfson College (CR), University of Oxford. She is a founding member of the South Asia Research Cluster. Email: kas.sen@wolfson.ox.ac.uk

Imrana Qadeer (*right*), MD, worked at the Centre of Social Medicine and Community Health, School of Social Sciences of the Jawaharlal Nehru University, India. Email: imranaqadeer@gmail.com

Eduardo Missoni, MD, teaches Global Health at the School of Management, Bocconi University. Email: eduardomissoni@gmail.com



Abstract: The systemic inadequacies of models of health systems propagated by the advocates of global health policies (GHPs) have fragmented health service systems, particularly in middle- and lower-income countries. GHPs are underpinned by economic interests and the need for control by the global elite, irrespective of people's health needs. The COVID-19 pandemic challenged the advocates of GHPs, leading to calls for a movement for “decolonisation” of global health. Much of this narrative on the “decolonisation” of GHPs critiques its northern knowledge base, and the power derived from it at individual, institutional and national levels. This, it argues, has led to an unequal exchange of knowledge, making it impossible to end decades of oppressive hegemony and to prevent inappropriate decision-making on GHPs. Despite these legitimate concerns, little in the literature on the decolonisation of GHPs extends beyond epistemological critiques. This article offers a radically different perspective. It is based on an understanding of the role of transnational capital in extracting wealth from the economies of low- and middle-income countries resulting in influencing and shaping public health policy and practice, including interactions between the environment and health. It mobilises historical evidence of distorted priorities underpinning GHPs and the damaging consequences for health services throughout the world.

Key words: global health policies; debate; decolonisation

Introduction

The complexities of public health, which often have a history steeped in intellectual and material appropriation, are increasingly being simplified into workable interventions, but in the name of philanthropy and without threatening the interests of the powerful. This may not benefit the majority of people in the places where these interventions are occurring, but it maintains the status quo of power relations. One such example has been the transformation since the late 1970s of comprehensive primary healthcare (CPHC) into selective primary healthcare (SPHC), and in another example we are currently seeing global health (GH) being obscured by global health policies (GHPs). Here the proclaimed objective is to achieve health equity and improvement for all people worldwide, and to address issues such as pandemics that transcend national boundaries and thus require global cooperation and global governance (Beaglehole and Bonita 2010). The glaring inequalities highlighted by the COVID-19 pandemic, however, have brought anger to the surface at the power and privilege that until now have been entrenched in GHPs. This frustration has been expressed by a section of the public health intelligentsia in many published pieces on GH, originating in both the Global South and North and accompanied by a rallying cry for the “decolonisation” of global health policies (Abimbola et al. 2021; Kentikelinis and Rochford 2019; Rasheed 2021; Shiffman 2015; Topp et al. 2018; Gore and Parker 2019; Moon 2019).

The disquiet has drawn largely upon the impact to date of unequal intellectual exchange between North and South, which according to this view has resulted in the embedding of structural inequity and racism, said to permeate global institutions, research and policymaking (Abimbola et al. 2021; Moon 2019; Rasheed 2021).

This concern is pertinent, but the perspective involved misses the fact that such transitions are deeply rooted in the world’s changing political economy. Seeking the decolonisation of knowledge and power alone ignores the fact that the world has moved on from colonial control to a fast-moving finance that exercises command by decamping from locations where its interests are not directly served. This has left behind the previous mechanisms of control, such as occupation, control over production, philanthropy, and militarisation, under the sway of imperialism. The only remnant of colonialism is the occupation of minds and the seeding of ideas. This is critical but not sufficient for understanding how unequal global relations are maintained, and how they are actually destructive for lower- and middle-income countries (LMICs) (Horton 2021).

The focus of this paper is on the historical legacy left behind by decades of neoliberal global health policies and on the fallout in terms of poverty, inequality

and lack of access to adequate health care that is part of the lived experience of a majority in the LMICs. In the calls for the decolonisation of global health and the policies informing it, these phenomena cannot be excluded as abstractions. Neoliberal global health policies use a framework steeped in a biomedical paradigm, underpinned largely by considerations of power, by economic interests, by foreign policy and by the need for control and security, in the areas of both finance and health (Moon 2019; Stuckler and McKee 2008). We discuss these issues in their historical context, with a focus on the growing economic and political domination of LMICs by the West, and explore how they have been thrust further into the forefront by the COVID-19 pandemic. The questions involved here include the growing inequalities in wealth and opportunity within and across nations over the past three decades, despite an ongoing GHP agenda framed ostensibly in terms of equality and rights.

We highlight the blatant use of the pandemic as an opportunity for financial gain through promotion of the business model for health care in many regions, most notably in India (Ghosh 2021; Guerterras 2020). Yet another consideration is the environmental challenges triggered by climate change and zoonotic diseases. Both of these factors contribute to the current “One World” thesis in the GHP field, and are shaped yet again by the unequal exchange that underpins GHPs (Cunningham, Scoones, and Wood 2017).

This article also touches on the intense human suffering and economic devastation that the COVID-19 pandemic has inflicted across the world. These impacts are being felt not just in the effects of the disease/pandemic, but still more in the systemic failure and inadequacy of the models of health service systems promulgated for the past three decades by particular advocates of GHPs. The article thus explores the approaches to global health and its evolution; changing global health policies; their political economy and protective role for the rich; and most significantly, their impact on health service systems. It then knits the exploration into a concluding section.

Approaches to the Study of Global Health

According to Khan et al. (2021), the push to “decolonise global health” has evolved into a movement that will challenge the systems of power and dominance arising from the unequal exchange that has become ingrained in global health policy.

Others have argued that many of the intelligentsia from the Global South who have been trained in the North have internalised privilege and patrimony, and mimic the values of the northern hegemony (Abimbola and Pai 2020; Rasheed 2021). These authors suggest that the first step is to unlearn this training, and then

to evolve a theoretical basis for understanding power asymmetries and practices at individual, institutional, national and international levels, in order to address global health challenges (Abimbola and Pai 2020; Abimbola et al. 2021). This is particularly relevant in view of the epistemic hegemony that has a deleterious impact on GHPs. Several articles published in *The Lancet* series on “What Is Wrong with Global Health” deal mainly with the imposition of values, underpinned by unequal exchange through its associated power and subsequent imposition at the personal level, and with policy outputs that are inimical to national and local needs. These values and policies, it is argued, reinforce political and cultural hegemony (Abimbola and Pai 2020; Moon 2019; Bhakuni and Abimbola 2021; Naidu 2021).

Debates about the role of ingrained power in determining the parameters of global health and GHPs have also been triggered by challenges from anthropologists and ethnographers to the concept of a global health. These scholars argue from an empirical standpoint that in order to address inequities in health and society one must focus on the local and not on the “global” alone. In this view, ever-increasing global “connectedness” and the recognition of global political, economic, social, cultural and environmental determinants of health are key to understanding human health. Hence one cannot dispense with the need to understand local context, local need and power dynamics in the making of relevant policies, and the notion that one size fits all is rendered meaningless. This is well illustrated by Artega-Cruz and Cuvi in a critique of the exclusionary capitalistic logic of GHPs where health systems development is concerned. According to these scholars, GHPs neglect indigenous world-views and their possible contributions to the practice of medicine (Artega-Cruz and Cuvi 2021).

In ethnographic studies the “local” is not a romantic or abstract notion, nor one defined by geographical boundaries alone, but rather describes any small-scale arena where social meaning and relationships are “informed and adjusted” (Janes and Corbett 2009; Lee and Goodman 2002). Similarly, local experience and action need to inform and inspire global policies and governance if health is to be effectively promoted (Missoni, Pacileo, and Tediosi 2019).

The lack of scrutiny of the relevant power dynamics has been viewed as a major failing in the understanding of how GHPs operate at the global level. This critique as it stands has been adopted by a number of analysts of GHPs, with some using Bourdieu’s notion of cultural and symbolic power as a premise. This approach is viewed as highly meaningful, and as essential for addressing the power of non-economic assets such as education and, in particular, of global social networks that strengthen and reinforce power and agency even where finance is not directly involved (Hanefeld and Walt 2015; Shiffman 2018; Walt

and Gilson 1994). Such a framework, these authors suggest, cannot be excluded from the study of GHPs, a field where “science” devoid of its politics and power has taken centre stage. In this case, the science concerned is premised on the supremacy of “method” and of the evidence it produces through the extensive collection of data, as well as on utilising this to create a normative order that is then viewed as universal objective truth. Critics argue that this data-driven framework is often devoid of context. The global burden of disease (GBD) project is a case in point (Adams 2016).

For some decades, the GBD has acted as the gospel truth and as the evidence base for GHPs at national and international levels. Those who favour its methodology describe the GBD as one of the most comprehensive assessments of disease across the world. Currently, it includes the metrics for 369 diseases and injuries covering 204 countries and territories, and by 2019 had identified some 87 relevant risk factors (The Lancet Commission: GBD 2019 Diseases and Injuries Collaborators 2020). As we highlight, however, such a framework has serious limitations.

According to Adams (2016), such metrics cannot solve global health problems that are steeped in politico-economic phenomena (inequality, poverty and social relations, among others) that are pertinent to each context under study. Young, Roberts and Holden (2017) have argued that in the real world of primary care, for example, policies can never be formed on the basis of GBD metrics alone. This is due to the unique, context-specific nature of patient care in public health. These authors describe primary care in practice as a complex adaptive system where priorities are focused on quality management, including patient-centred reporting, and on quality goals that are not based on rigid targets, but that are focused on the patients and their socio-economic environment. When data-driven evidence in primary care focuses on “better outcomes” and “lower costs” as part of the GBD, there is less focus on the patient but more on avoiding costs, including days of avoidable disability.

In an overview of the GBD, Shiffman and Shawar (2020) claim that it has helped significantly in identifying patterns of disease across countries and has been used extensively for evidence-based GH policy. However, they agree that its shortcomings as identified by its critics need to be addressed. Foremost among its dangers, they accept, is that it has the potential to be used to dictate local policies due to its control over data. This may occur without due consideration of local expertise and concerns, leading to the charge of lack of accountability (Odjidja 2021). The data, according to critics, often generate flaws due to opaque techniques, divergence from local context and statistics that are not adjudicated. Most crucially, according to this view, a data-driven approach neglects the important unquantifiable dimensions of illness, such as perceptions, beliefs and

circumstances, that are often key to poor health (Artega-Cruz and Cuvi 2021; Shiffman and Shawar 2020). Despite such concerns raised over the years, the global dataset is here to stay. It is continuously updated and continues to inform GHPs at national and international levels, with some arguing that it has shifted from its pure metrics and now attempts to gauge the socio-demographic context of ill health and disease (The Lancet Commission: GBD 2019 Diseases and Injuries Collaborators 2020).

In short, the GBD approach of the discrete enumeration of diseases at the cost of their interconnectedness with each other and with the environment (lack of food security, infections, environmental pollution levels and respiratory diseases, occupational diseases, etc.) inevitably helps veil the social determinants of ill health, leading to distorted priorities for health policy (Adams 2016; Unger et al. 2010b). It is only now that country-level analysis and association with developmental milestones are being recognised as vital (*The Lancet* 2020).

Also, as part of the debate on the implicit and explicit power of existing GHPs, many researchers continue to challenge the notion of the objectivity of the scientific knowledge base of GHPs. Historically, this has been used as a means for exerting power and making decisions over the lives of others. Some scholars have even viewed this approach as a basis for the continuity of empire (Janes and Corbett 2009; Ludden 2012; Walt and Gilson 1994).

Despite the pertinence of such debates on the different manifestations of power and on its impact on epistemic hegemony and practice, we believe that the “decolonisation of GH and GHP debate” needs to be addressed from yet another angle; one that looks beyond its empirical base and control of knowledge, that is, a historical perspective that focuses on unequal exchange and examines its consequences for policy and practice.

In the view of the authors of this article, to grasp this power asymmetry fully it is important to realise that GH has a history in the course of which it has ceased to be merely a repository of knowledge, and has acquired a language of power and privilege in its new avatar as GHP. Much of the debate on decolonisation, however, still projects GH as a knowledge repository, while the truth is that it has moved beyond, into the political arena.

A Brief Overview of the Evolution of Global Health

While the concept of GH appeared in health literature as early as the 1940s, it remained a dormant force until the 1990s. Only a few scholars took up its various manifestations and discussed its theoretical basis, operating within a liberal framework. This framework viewed the state of health as integral to autonomous and equitable development, free from conditionality. As a part of public health, it

focused primarily on medical and health issues with global impacts that could be addressed effectively through global solutions. During this period, the WHO contributed to GH science and research (Chen, Hao, and Lucero-Prisno 2020).

The idea of health “beyond” national boundaries (as in the case of GH now) was also put forward by the Dag Hammarskjöld Foundation in 1975 in the context of its demands for a new world order. Here, there is a full understanding that health is a political issue, and the Foundation argued for redefining “development” itself as including health as an important component. Development was now to be regarded as:

[...] the development of every man and woman, of the whole man and woman and not just the growth of things, which are merely means. Development geared to the satisfaction of needs beginning with the basic needs of the poor who constitute the world’s majority, and at the same time, development to ensure the humanisation of man by the satisfaction of his needs for expression, creativity, conviviality and for deciding his own destiny. (Dag Hammarskjöld Foundation 1975)

In the context of the “basic needs approach,” the WHO shifted towards strategies more attentive to the development of basic health services, community participation and the immediate health needs of the population, reflected in the Declaration of Alma-Ata of 1978 and the “Health for all by the year 2000” goal adopted by the World Health Assembly in 1977. However, only one year later US-led bilateral and multilateral agencies engendered the “Selective Primary Health Care” approach, which resulted in the reorganisation of health systems into “vertical programmes” and a complete detachment from the comprehensive intersectorial approach envisaged at Alma-Ata (Missoni, Pacileo, and Tediosi 2019).

By the early 1980s, however, nearly all liberal thought had been marginalised by Structural Adjustment Policies (SAPs). These had been preceded by oil debt, and by multiple economic crises due to rising debt in countries such as Argentina, Chile and Uruguay in the late 1970s, and in Brazil, South Africa and various countries of Asia during the 1980s. With the growing dominance of international funding agencies, and the push to liberalise the movement of capital so as to open up local financial systems and force competition in open markets, the economic crisis that had initially arisen out of the developing world’s indebtedness to these funding bodies deepened further (Haggard and Maxfield 1996). The liberal approach lost its power. The main global players at this stage became the IMF and the World Bank, imposing a “one size fits all” Health Sector Reform (HSR) as part of SAPs in most developing countries.

The expansion of health reforms was to have devastating consequences for most low- and middle-income countries (Qadeer, Sen, and Nayar 2001; Sen 2003a; Unger

et al. 2010a). The underlying shift from the liberal policies of welfare capitalism to the HSRs of the neoliberal era—initiated by the World Bank, and beginning between 1970 and 1980—became self-evident. Thus the term HSR was retained and nurtured, acquiring a new meaning as an instrument of developed-nation foreign policy and signifying international transfers of knowledge, technology, skills, expertise and above all funds (Qadeer, Sen, and Nayar 2001; Sen 2003b).

Over the following two decades, GHPs became integral to US foreign policy, security and trade agenda, along with collaboration between countries to deal with challenging medical and health issues. This collaboration was implemented through federal funding, development aid, capacity building, education, scientific research, policymaking and implementation of health projects with WHO participation (Chen, Hao, and Lucero-Prisno 2020). According to Stuckler and McKee (2008), for the new administration that took office in the United States in 2009 GHPs functioned as “metaphors” that developed into policy and strategy.

The metaphors included global health as US foreign policy, viewed as integral to US security; global health as charity; global health as investment; and global health as public health. Of these, the metaphor of GH as foreign and security policy would take precedence over the other “strategies” for action (see Table 1 below) (Stuckler and McKee 2008). An army of experts was assembled from the Global North and South to implement this strategy, which in addition to receiving backing from international financial institutions such as the World Bank and the IMF, was greatly reinforced by support from US-based philanthropic organisations such as the Gates Foundation. The combined effect was to systematically undermine the funding, purpose and function of the WHO as a global multilateral agency (Birn and Nervi 2020). The autonomy of the WHO was progressively reduced through increasing dependence on earmarked contributions (up to 80 per cent), with the remarkable influence of the Gates Foundation, which became the second largest contributor to the WHO after the United States (Missoni, Pacileo, and Tediosi 2019).

While much of this knowledge/power dynamic is recognised in the “decolonisation of global health and global health policies” debate, there remain major caveats in the general understanding and acceptance of the impact of GHPs, in particular on LMICs.

The literature on global health became indeterminate due to a hesitation to acknowledge the presence of two opposing streams in how reality was perceived. Both of these streams were ideologically motivated, one geared towards disease control and backed by the financial power of the promoters of HSR, and the other—inspired by the comprehensive public health approach of the Alma-Ata Declaration of 1978—people-centred and inclusive of socio-economic determinants. It was, however, up to national governments to decide whether to adopt the

Table 1. Five Leading Metaphors in Global Health Policy

<i>Principle</i>	<i>Selected Goals</i>	<i>Key Institutions</i>
Global health as foreign policy	Trade, alliances, democracy, economic growth; foster reputation; stabilise or destabilise countries	US State Department, USAID, President's Emergency Plan for AIDS Relief
Global health as security	Combat bioterror, infectious diseases and drug resistance	US Centres for Disease Control and Prevention
Global health with focus on charity	Fight absolute poverty, fight diseases, influence policies	Bill and Melinda Gates Foundation, Rockefeller Foundation, other philanthropic bodies
Global health as investment	Maximise economic development	World Bank and International Monetary Fund, International Labour Organisation, World Trade Organisation, private sector
Global health as investment	Maximise health effects, define global strategies and policies	WHO, global public-private partnerships (e.g., GAVI, GFATM, CEPI)

Source: Adapted from Stuckler and McKee (2008).

latter approach to the extent possible, and the issue therefore remained clouded, as the LMICs were heavily indebted to their global funders (Qadeer, Sen, and Nayar 2001; Sen 2003a; Unger et al. 2010a).

Under the influence of the World Bank's "Financing Health Services in Developing Countries: An Agenda for Reform" (The World Bank 1987) and its *World Development Report* (The World Bank 1993), the literature began focusing on how best to resolve the health problems of the LMICs through "investing in health," "progressive universalism of universal health coverage" and "convergence of financial and technological capabilities" so as to reduce infections and mortality (The World Bank 1993; WHO Macro Economic Commission on Health 2001). While extending financial help and encouraging benevolent acts with a view to increasing capabilities, knowledge and expertise became a central concern, the fact that the national health systems of the LMICs were shaped differently was ignored. These differences resulted from the historical evolution of the local political economies, and from the power relations and dynamics between emerging global institutions, national governments and civil societies. However, even the liberal authors of these policies were confident that they had the financial and technical capacity to achieve all this "in their lifetime" (The Lancet Commission for Global Health 2013). In the process, the World Bank with its links to the WHO emerged as a lead player in the area of GHPs.

Origins of the Ever-Changing Face of Global Health Policies

Carrying forward the tradition of tropical medicine and international health, and despite the claims of adopting a rights-based approach to public health and of addressing inequality, power asymmetry and the universality of health needs (Beaglehole and Bonita 2010), the GHPs of this period remained captive to the vision of supremacy of the North. Like their predecessors, they focused on programmatic interventions in health issues in poor southern countries, mostly previous colonies. Increasingly, the implementation of GHPs was accompanied by the aggressive violation of national boundaries by finance capital as globalisation transformed global governance at the turn of the 21st century and initiated global crises (Patnaik 2020).

This neoliberal globalisation weakens nation states, controls their policies and forces adjustments upon them, making them adjuncts to the global financial system. The result is growing inequalities between and within states that can no longer be independent, due to the power of a finance capital that is delinked from trade and has the ability to impose conditionality or to flee to another country (Patnaik 2020; Shutz 2022).

It was this aspect of globalisation, enforcing SAPs and HSRs, that led to huge transformations in the economies and health systems of nations that accepted it. The safety nets that were devised as part of the SAPs failed, and the HSRs distorted the little that the LMICs had created in the way of public health systems. It was then that the GH concept transformed in the mid-1990s as a “new” field, in which research policy and practice could investigate the interaction between globalisation and health (Missoni, Pacileo, and Tediosi 2019).

In the wider context of global health governance, the intention of hegemonic global actors was to minimise the negative impacts of globalisation through technocentric biomedical interventions that in fact served the purpose of enhancing the financial gains of the international funders while also allowing them to claim credit for philanthropy. GH has today diversified in academic circles into areas such as “One Health” and “Planetary Health.” These approaches focus on the relation between human health, animal health and the ecosystem, without adding substantially to global health studies that by definition are inclusive of “globe/planet.”

One Health visualises living beings (people, animals and pathogens) sharing the same environment and making up a unique dynamic system, in which the health of each component is inextricably interconnected with and dependent on the others. It focuses on animal–human interactions during human activities in given ecological settings. From this interface emerge infectious diseases, especially in rapidly changing ecological settings that give birth to new organisms (Calistri et al. 2013). Planetary Health explores the effects of human activity on the biosphere and its

effects on the environment and human health, focusing on such problems as global warming, new infections, pollution, reduced food availability and so forth.

Both One Health and Planetary Health emphasise interdisciplinary, integrative effort at local, national and global levels to guarantee optimal health status for humans, animals and the environment through collective global action. This is in complete contrast to the processes in the real world, where these concepts might best be seen as areas for study among the powerful and negative impacts of the global political economy, controlled by fast-moving finance capital. One Health and Planetary Health pushed GH in moving away from its roots in political economy and from any critical analysis of GH policies and governance, even when they permit human imagination to expand and explore newer aspects of human health.

In the United States especially, GH has been mediated by its dominant power relations with LMICs in a discourse largely led by highly influential self-defined “global health” organisations and philanthropic bodies, pushing a rising number of global public–private partnerships (PPPs) and multi-stakeholder initiatives. While ostensibly promoting critical health concerns of LMICs, these in practice deny the nature of the scientific enterprises, power dynamics and neo-colonial top-down governance and programming by the Global North (Irfan, Jackson, and Arora 2021; Ugalde and Jackson 1995). This is inherent in the all-pervasive transnational expansion of a neoliberal capitalist economic model that undermines the future of universal health care systems.

Like the 2013–2016 Ebola crisis, the COVID-19 pandemic highlighted the inequalities between and within countries, and still more, the abysmal failures of the GH policy framework that resulted in the mismanagement of health care systems throughout decades of disinvestment in public health provisions. Causing health authorities in LMICs to lose sight of health determinants and social context, the GH framework left the front lines of the pandemic response seriously depleted (Ahmad et al. 2022; *Oxfam* 2022).

Global Health Policies—An Apology for Environmental Degradation by Rich Countries?

Among the countries of an interconnected world, the poorest and most exposed pay the highest price for the health impacts of ecosystem deterioration, the prime responsibility for which lies with the richest polluter countries. The zoonotic diseases that in recent years have triggered the notion of a “One World—One Health” agenda fit this frame well. They have emerged out of rapidly changing ecological settings and climate change due to aggressive human exploitation of natural resources. These activities have contributed to such global health emergencies of the past two decades as Avian Flu, MERS and COVID-19.

Nevertheless, and as Cunningham, Scoones and Wood (2017) have illustrated, policy discussions around these outbreaks have focused on protecting the health security of the richer northern countries, rather than on the actual impact in poorer countries where zoonotic emergencies are a regular occurrence. These countries experience the rapid spread of zoonotic diseases, with limited ability to control their transmission. Cunningham, Scoones and Wood argue that in poorer settings zoonotic diseases, linked to close contact between humans and wild and domestic animals, have done extensive harm to the environment, as well as having damaging consequences for land use in these regions. Together, these factors have destroyed livelihoods and increased poverty and poor health. The focus of “one world,” however, remains on the “security” of the North. The COVID-19 pandemic provides an excellent illustration of this; as the high-income countries (HICs) of the North have rushed to triple vaccinate their populations, in Africa and South Asia the majority remain unprotected or are still waiting for a second dose (Harman et al. 2021; OECD 2021).

The experience with climate change has been similar to that with zoonoses, due to the inequalities that are embedded in the process of addressing it, and that are now compounded by the COVID-19 pandemic. Climate change is linked indissolubly to the dominant production and consumption model, which has an impact on health through multiple interactions and through predictable, potentially catastrophic and irreversible epidemiological transformations (Landrigan et al. 2018). The G20 discussions, however, have tended to focus almost entirely on the reduction of carbon emissions, through technological (and often highly polluting) interventions aligned with the perspective of economic recovery. This can only serve the interests of the richest economies and their transnational corporations.

Resource-intensive agricultural and industrial production is leading more and more rapidly to the inexorable depletion of natural resources and to increased levels of pollution, which is the largest environmental cause of disease and premature death in the world today. Pesticides and chemical fertilisers are promoted on a massive scale and are used with little control, causing contamination of the soil, water and air, posing a direct health hazard for rural workers and their families as potentially dangerous amounts of chemical residues enter the food chain, including drinking water (Willet et al. 2019).

The processing, packaging, transportation, storage and waste that characterise the globalised economy contribute still further to pollution, food contamination and unhealthy consumption, incentivised by aggressive marketing. Worldwide, supermarket shelves are full of harmful foods, alcohol and tobacco, along with other unhealthy or otherwise potentially harmful consumer products (such as those for the home and personal care). All these contribute to the dramatic increase in chronic diseases such as obesity, metabolic diseases (above all diabetes),

respiratory diseases, and cardiovascular, neoplastic and neurodegenerative illnesses. Besides creating greenhouse gas emissions, industrial production diffuses many other dangerous contaminants into the environment, with a direct impact on the health of the population (Landrigan et al. 2017; Willet et al. 2019).

Overall, environmental factors account for between 25 percent and 33 percent of the burden of disease (Willet et al. 2019). A total of 83 percent of deaths are mediated by environmental factors. Carcinogenic chemicals can now be found at every level of the food chain, in soils, groundwater and the air, and are widespread in a myriad of household and personal care products to which people are exposed every day (Haider and Nibb 2017).

In this problematic situation, GHP has been defined and disseminated by a transnational intellectual elite, based mostly though not always in the Global North. The members of this elite have succeeded in marginalising a majority of the voices calling for a better understanding of the power, politics and unequal exchange embodied in the dominant paradigm of GHPs and reflected in the serious critiques made of them. This has been followed by an aggressive targeting and reorganisation of health service systems that has taken little account of the need for access to contextualised quality health care, as embodied in PHC (Qadeer and Baru 2016).

Three decades on, and accompanied by the usual hand-wringing from advocates of these policies, the COVID-19 pandemic has also brought to the fore the failure, where the cost, quality and effectiveness of response and care are concerned, of this globally imposed neoliberal model with its dysfunction, high prices and embedded corruption. The casualties of this model include above all the placing of communities and patient care at centre stage, and the showing of respect for people's rights and their contexts. This is illustrated by the ill-gotten gains of a handful of individuals and capitalist enterprises (Ahmad et al. 2022; Guerterras 2020; *Oxfam* 2022).

Around the globe, the way the pandemic has been dealt with reflects the priorities and ideologies of the governments in power, as well as the power-plays of the global elite. We shall take a few examples. The effects of the lockdowns imposed by China and India were praised initially by the WHO, but the differences in implementation were to become stark over time. Responding to the threat posed by a previously unknown but apparently lethal virus, the Chinese set in place strict lockdowns, while organising the mechanisms needed to supply daily provisions to the families affected at the time of writing.

In India, by contrast, large numbers of men, women and children had to walk for many miles back to their villages, as there was nothing to sustain them in the cities where the adults had worked. The loss of lives, dignity and trust was almost incalculable. The pandemic was handled primarily by the Home Ministry through

the police as a law and order crisis, and only to a limited extent by the health department. In countries such as Germany and New Zealand the governments reached out to people, sharing information, supporting them and making them partners in the anti-pandemic measures.

In developed countries, scientists were rapidly drawn into combating the virus and devising steps to contain its spread. Relief packages were prepared quickly and on an adequate scale. In Germany, the US and Japan the government investments in anti-pandemic measures came to 5, 10 and 20 percent of GDP, respectively. In India the funding was late in coming, and when it came, it was a pittance—less than 1 percent of GDP (Patnaik 2020). In a number of countries the death toll from COVID-19 was high, and a year into the pandemic, 90 percent of the countries that responded to the WHO's second Pulse Survey were reporting disruption of essential health services. This survey covered 135 out of 216 countries, with 81 non-respondents (World Health Organisation 2021).

Despite improvements over the first survey, about 20 percent of the respondent countries also reported disruption of life-saving emergency care. Some 40 percent experienced disruption of measures to prevent or treat malaria, tuberculosis, HIV and hepatitis B and C, as well as having to curtail cancer screening and other services for non-communicable diseases, along with provisions for family planning, contraception and malnutrition prevention. Disruption of immunisation services was reported by 25 to 30 percent of countries, with 66 percent citing workforce-related issues among the causes and 43 percent a lack of finance (World Health Organisation 2021).

Although the survey report does not provide a breakdown of which countries suffered worst from the disruption, other studies show that the LMICs bore the heaviest impacts on their meagre services. Underfunded and weak public health systems lack the capacity to manage a new pandemic. India, for example, has the world's fourth-lowest health budget as a share of government expenditures, and its people pay 60 percent of the cost of their health care from their own pockets. Only half of the Indian population has access to even the most basic healthcare services. Inevitably, health outcomes have deteriorated during the pandemic, and the risk of death has increased.

Recent research also illustrates how corporate businesses have made billions at the cost of the poor as rich nations, representing just 14 percent of the world's population, have financed the development of COVID-19 vaccines and bought up over half the output of leading vaccine suppliers. The pharmaceutical companies concerned have made huge profits during the pandemic (Harman et al. 2021; *Oxfam* 2022), without even being made liable for the possible side effects of their products. The growing concentration of wealth within and across nations has been brought home in a potent fashion during COVID-19, as has been documented by

a number of scholars (Ahmad et al. 2022; *Oxfam* 2022). “Oxfam reports that from March 18 to the end of 2020, global billionaire wealth increased by \$3.9 trillion. By contrast, global workers’ combined earnings fell by \$3.7 trillion.”¹

This reality strips off the veil of universality and equality from the face of GHP. It shows that even during the worst pandemic for generations, GHP has continued to neglect the needs of the people of the South, while protecting the interests of the developed countries and their populations. The LMICs meanwhile have followed the WHO prescriptions, have provided markets for vaccines and other drugs, and have made their populations available for experimental vaccine trials (Correspondent, *BMJ* 2021). The Ebola crisis in Africa and now, as noted by Ghosh, the COVID-19 pandemic as well have expanded and brought to the fore the inequality and unequal exchange between North and South (Ghosh 2021), while causing misery and large numbers of deaths worldwide.

The Impact of Global Health Policies on Health Service System

Over the past three decades the analysis and dissemination of the core ideas of GHP, dominated by economists and clinicians, has led to solutions that are selective, largely reductionist and technology-dependent. An integral part of the process has been a disproportionate focus on specialist care, together with fragmentation into a multiplicity of competing programmes, projects and organisations and the pervasive commercialisation of health care into inadequately regulated systems (Birn, Nervi, and Siquiera 2016). This remains the case as global and national public–private partnerships, despite their disastrous impact on health systems, continue to manage COVID-19 throughout the world (Pegg 2021).

While such long-standing “market failures” in the provisioning of health services were initially rejected by the advocates of neoliberal health reforms, “investing” in health later became a core reform for the health sector. Such investments, though, were not without conditionality, as governments were forced to shift subsidies to the private sector and to open up the health sector to private insurance.

In developing countries where people’s capacity to pay remained limited, state-led insurance offered a solution and led to public–private insurance schemes that on the face of it included both the public and private sectors. However, given the decimated condition of the public sector, and the fact that its state support was linked to performance, the public sector was never given a level playing field to compete with the private sector, which appropriated a large share of the public subsidies for insurance schemes.

The Pradhan Mantri Jan Arogya Yojana (PMJAY), the largest state-funded insurance scheme in India providing tertiary care for the poor (mainly through the private sector), has grown at the cost of key sectors of primary healthcare services,

as is reflected in India's annual budgets. Nevertheless, it is insufficiently funded to care for the 100 million families at which it is targeted (Ghosh and Qadeer 2021). This has led to the privatisation of national health care systems as a profitable venture attractive to global capital investment, aimed ostensibly at removing inequities in health but operating without regard for the epidemiological priorities and socio-economic characteristics of the developing world.

Several studies show how global capital investors are setting up tertiary care institutions across the developing world, at the same time as access to care declined for ordinary citizens (Baru 2003; Chakravarthi, Shukla, and Marathe 2021). Programmes for the control of diseases such as tuberculosis, leprosy and malaria continue to stagger along, since dealing with these illnesses requires addressing not just the therapeutic aspect but also the social determinants of disease control, as is well illustrated by Zurbrigg's historical study of malaria in the Punjab (Zurbrigg 2019). It is not unknown for external funds to play a critical role in influencing public health policies in low-income countries, in such a way that these policies become integrated into the global health planning process and political economy. This process is very much reflected at the national level through distorted health care systems that reflect persistent inequalities in health (Qadeer and Baru 2016). These distortions have once again been highlighted during the COVID-19 pandemic, when the human cost in terms of death, disability and morbidity has been very high (Kakade and Shukla 2021). What has been notable is the role of the WHO in this narrowing of the approach to public health. The WHO came under increasing financial pressure during the 1980s and 1990s, when its regular budget was frozen and its extra-budgetary funding increased, with the additional money taking the form of earmarked contributions from member countries. The organisation's two directors during this period accepted PPPs and multilateral alliances with medical and drug corporations, private financial institutions, international NGOs, governments and UN organisations for global health (Qadeer and Baru 2016).

In the current GHP paradigm, the objective is to reduce the scope of public services supported by state tax revenues, with the solely political aim of promoting the privatisation of services, to the benefit of private capital. This has been described as a veritable "assault on universalism" (McKee and Stuckler 2011). Dependence on out-of-pocket payments (OOPs) for services, together with the introduction of regressive financing mechanisms, constitutes a barrier to access to needed care and generates problems of financial protection. Every year, more than 100 million people throughout the world end up in poverty as a result of direct spending on health care (Haider and Nibb 2017).

The hegemony of the market and the withdrawal by the state have intensified the commodification and commercialisation of such vital social determinants of health as food security, education, water and electricity. Other results of the

dominant economic model include environmental degradation, which also has a heavy impact on working conditions. As a consequence, the burden of chronic diseases together with emerging and re-emerging infectious diseases disproportionately increases the demand for care, especially in low-income countries with already weakened health care systems. Thus, without a dramatic change in the current neoliberal paradigm, the Sustainable Development Goal 3 (SDG3)—“health and wellbeing for all at all ages,” and specifically its “centrepiece” of Universal Health Coverage (UHC), cannot be sustainable (Missoni 2021).

Conclusion

At a special session of the United Nations in 1975, the Mexican President posed the future as a choice between “cooperation and chaos,” while the US President anticipated “a period of extraordinary creativity or a period where international order really came apart, politically, economically and morally” (Dag Hammarskjöld Foundation 1975). These remarks signified that both the rich and poor halves of the world perceived the coming of a global crisis of welfare capitalism. That crisis of shrinking collaboration and welfare during the 1980s and 1990s was countered by implementing the neoliberal reforms prescribed by the IMF and the World Bank, providing markets with major opportunities to expand at the same time as welfare was constrained. With the turn of the century, equity, equality, justice and cooperation—the forerunners of the original concept of global health—receded still further. Our paper is intended to illustrate the purposive choices that GHP made, and that have helped bring global society to its current state.

Multilateral organisations such as the WHO have been overwhelmed by philanthropic-capitalist interests and influence (Birn, Nervi, and Siquiera 2016; Qadeer and Baru 2016). But this assumed philanthropy in the field of global health and its associated political economy features a key contradiction: driven by business models and financial markets, aiming at revenue generation and appropriation, and dependent on knowledge control and the promotion of exclusive technology-based systems, it heightens inequalities at the same time as it lacks accountability to citizens (Erikson 2015; Shiffman and Shawar 2020). It has caused PHC to be sidelined, and moved from Health for All (HFA) to UHC, which in the name of “multi-stakeholderism” usurps state resources for the commercialisation of healthcare, disintegrates service systems and distorts medical education and work culture as well as workforce planning, development and retention. It transforms meaningful concepts of public health and its priorities in the name of “freedom of choice.” This reductionist approach to global health thus tends to appropriate and distort the discipline of public health, which in its long history has through rigorous analysis established the centrality of politics and political

economy in state endeavours to achieve health for the majority (Navarro 1998; Rosen 2015).

This GHP practice not only appropriates the areas of public health it was already engaged with, but also attempts to restrain public health within national boundaries, while claiming to address trans-border issues such as pandemics, patents, climate and environment, global governance and the transnational framework for handling diseases, as well as issues of food security, urbanisation and migration. It makes its claims while failing to acknowledge that the corresponding issues can be handled with fairness and justice only where there are strong welfare-oriented national governments, advocating the interests of their people and acknowledging their needs.

Consequently, making suggestions for corrective actions must not become a trap that requires acceptance of the larger neoliberal framework. Instead, the reality of a more egalitarian vision of global health needs to be “another” development, whereby determinants of health are acknowledged and the right to health reaffirmed. The aim must be to build a genuinely democratic world, and in this context, people’s struggles for better health need to be recognised as crucial elements in the fight for social justice, as well as serving the construction of health systems that transcend the current rhetoric.

Note

1. See <https://inequality.org/facts/global-inequality/#covid-global-inequality>.

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