Schisms & Problems in Global Health

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Dichotomies in global health

1. Globalization – positive vs negative health impact
2. Comprehensive versus selective primary health care
3. Horizontal versus vertical programs for healthcare delivery
4. Addressing social determinants & health systems versus biomedical and technological interventions (i.e. medicalization of global health)
5. Prevention versus care
6. Foreign aid is good versus bad
7. Public versus private provision of care
8. Corporate and entrepreneur involvement is good versus bad (market-based approaches are good versus bad)
9. Engagement of philanthropists is good versus bad
10. Global health security agenda: necessary vs harmful

Globalization – positive vs negative for health

Martens *et al. Globalization and Health* 2010, **6**:16
http://www.globalizationandhealth.com/content/6/1/16

RESEARCH Open Access

Is globalization healthy: a statistical indicator analysis of the impacts of globalization on health

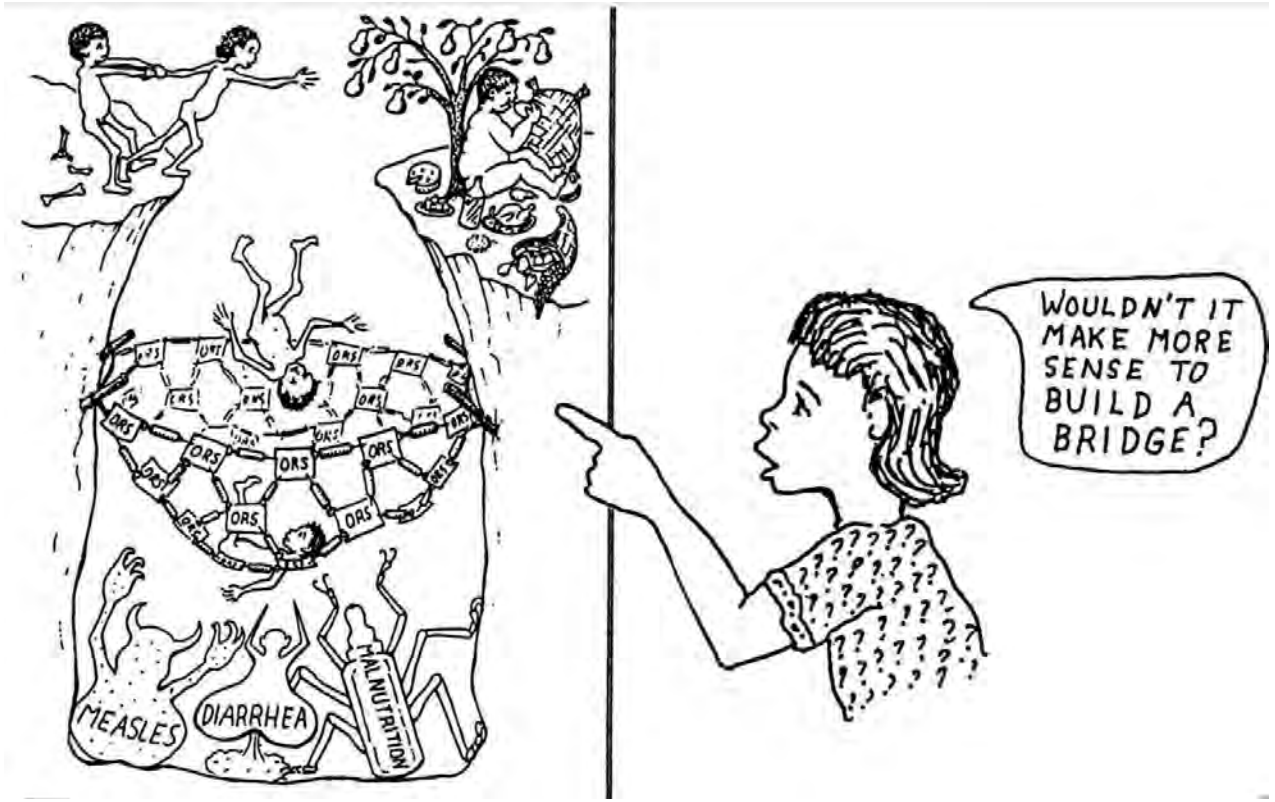
Pim Martens[1,2*], Su-Mia Akin[1], Huynen Maud[1], Raza Mohsin[1]

Table 1 Positive and negative health impacts of globalization: some examples ([8,9]

Positive health impacts	Negative health impacts
-Diffusion of knowledge and technologies, improving health services;	-Spread of infectious diseases due to increased movement of goods and people;
-Diffusion of knowledge and technologies, improving food and water availability (e.g. irrigation technology);	-Spread of unhealthy lifestyles due to, for example, cultural globalization, global trade and marketing;
-Improvements in health care or sanitation due to economic development;	-Brain drain in the health sector;
-Global governance efforts, such as WHO's Framework Convention on Tobacco Control (WHO FCTC) and WHO's Global Outbreak Alert and Response Network;	-Health risks due to global environmental change;
-Increased access to affordable food supplies due to free trade.	-Decreased government spending on public services due to, for example, Structural Adjustment Programmes (SAPs);
	-Inequitable access to food supplies due to asymmetries in the global market.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945333/pdf/1744-8603-6-16.pdf

Comprehensive vs. selective primary health care



The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448553/pdf/0941864.pdf

Horizontal vs. vertical programs

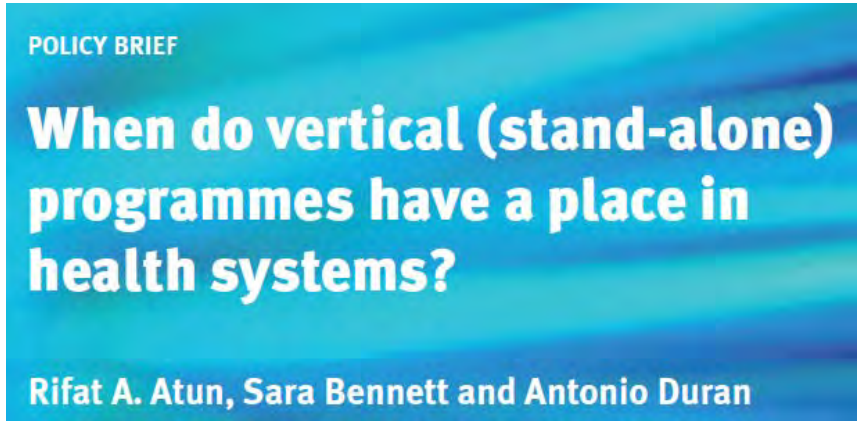


Table 1. Impact of vertical programmes on health systems

Level	Positive impact	Negative impact
Community and household	Programme aimed at eradication of dracunculiasis (Guinea worm) led to community mobilization with a focus on disadvantaged groups and the establishment of a surveillance system *(34)* The Global Polio Eradication Initiative promoted social mobilization in the middle-income countries of Latin America *(35)* and India *(36)*, with increased confidence in health systems and a rise in demand	High dropout rate of volunteers, limited use of community for other health problems and inefficiency due to the use of single-community workers *(36)* Constrained interaction between the Expanded Programme on Immunization and Global Polio Eradication Initiative in Benin and Niger due to lack of social mobilization*(36)* Conflicts between local demand and immunization targets as well as high opportunity costs for communities and health services *(36)*
Health services delivery	Smallpox eradication programme was able to use existing workforce rather than establish a parallel structure *(35)* Geographic mapping and numbering households for regular visiting (from the malaria eradication programme), organizing and delivering effective immunization services establishing active surveillance systems, quality control within laboratory network (from the yaws eradication programme) *(35)* Distribution of vitamin A during national immunization days *(37)*	Inefficient use of health workers who make repeated visits to communities for a single purpose *(36)*
Health sector policy and strategic management	Strengthened managerial, surveillance and laboratory capacity and promoting leadership *(35)* Improved donor coordination *(36)*	Inefficient distribution of resources for routine Expanded Programme on Immunization services and other health services *(37)*

http://www.who.int/management/district/services/WhenDoVerticalProgrammesPlaceHealthSystems.pdf

GLOBAL VIEWS | GLOBAL HEALTH

Opinion: The false dichotomy between ending epidemics and building health systems

*By **Peter Sands** // 12 October 2018*

A health worker takes a blood sample for a malaria test in the Dominican Republic. Photo by: PAHO / CC BY-ND

https://www.devex.com/news/opinion-the-false-dichotomy-between-ending-epidemics-and-building-health-systems-93648

Prevention versus care

- Often rooted in ‘cost-effectiveness’ analyses which discourage LMICs from getting into care
  - E.g. prevent HIV and MDR-TB vs provide ART & second-line Rx
  - E.g. contain outbreak vs provide care to those affected by outbreak
- Prevention is considered more feasible and cheaper

- UHC aims to be more comprehensive and cover both

"The lesson I would take out of the West African Ebola epidemic is that it is important to integrate prevention with care. Because people, when they are sick, are not looking to be sprayed, controlled, counselled, told about bush meat... they are looking to survive, and when they see the quality of care is not good, they are going to flee... Control without care is what amplified the epidemic... I hope the epidemic will be contained, but it does not have to be at the expense of trying to take care of people so that the majority survive.“ Paul Farmer

https://naturemicrobiologycommunity.nature.com/users/20892-madhukar-pai/posts/33379-insights-from-an-inspiring-global-health-leader

Addressing social determinants & health systems versus biomedical and technological interventions

Do the solutions for global health lie in healthcare?

Jocalyn Clark *executive editor*

[1]icddr,b, Dhaka, Bangladesh; [2]Department of Medicine, University of Toronto, Canada

Medicalisation of three global health problems

- *Global mental health*—Current approach emphasises biological disease, links psychiatry with neurology, and reinforces categories of mental health "disorders." It promotes the universality of symptoms, causes, and biomedical diagnoses across cultures, and takes an individualised view, giving priority to biomedical treatment and scale-up of healthcare interventions[2]
- *Non-communicable diseases*—Bias toward individualistic targets that avoid the root causes of the problem; deflect attention from government policies or regulation of the drug, alcohol, and food and drink industries; and create expanded roles for physicians, healthcare workers, drugs, and medical monitoring[3]
- *Universal health coverage*—Campaign conflates health with healthcare, downgrading the social and structural determinants of health and the risk that healthcare may worsen inequities. It focuses on preventive and curative actions delivered at the individual level, and risks the commodification of health[4]

http://www.bmj.com/content/349/bmj.g5457

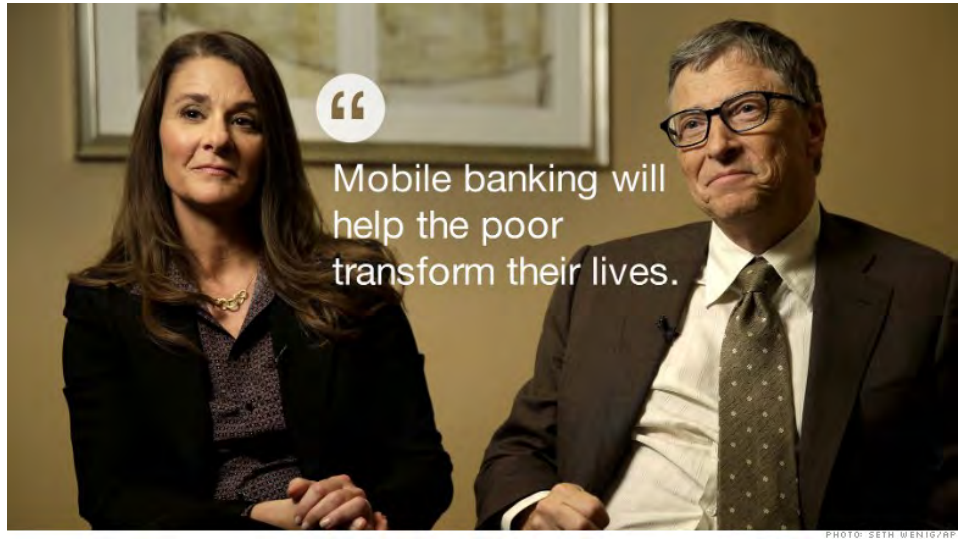


PHOTO: SETH WENIG/AP

DealB%k WITH FOUNDER ANDREW ROSS SORKIN

ESSAY

Cellphones for Women in Developing Nations Aid Ascent From Poverty

By MELINDA GATES APRIL 1, 2015

CONNECTION Ketteline Pierre, a 19-year-old high school student and street vendor, text-messaging in Port-au-Prince, Haiti, months after the 2010 earthquake. Natasha Fillion/Bill & Melinda Gates Foundation

http://www.nytimes.com/2015/04/02/business/dealbook/melinda-gates-cellphones-for-women-aid-ascent-from-poverty.html?_r=0

Addressing social determinants & health systems versus biomedical and technological interventions

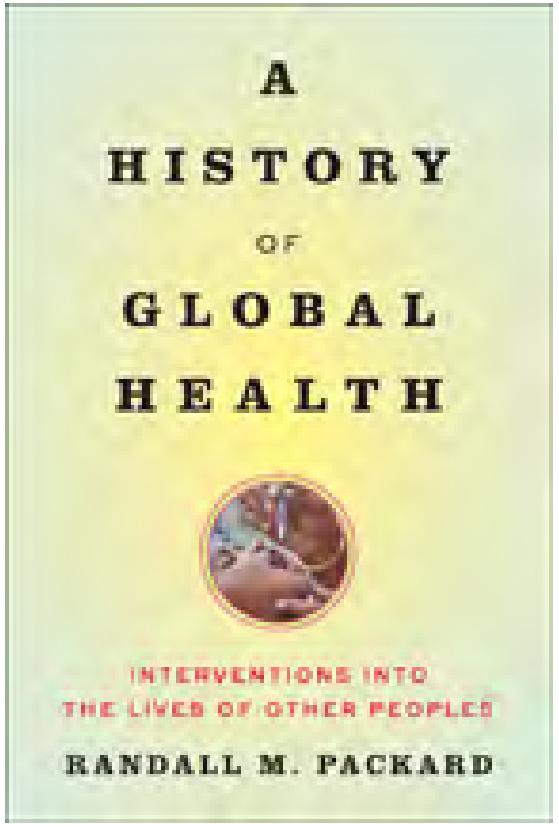
Commentary: False dichotomy hinders global health

Gavin Yamey *evidence to policy initiative lead*

Global Health Group, University of California San Francisco, San Francisco, CA 94105, USA

Downplaying biomedical innovation hinders global health progress. Indeed, developing countries that are early adopters of new health technologies—medicines, vaccines, and diagnostics—see an additional 2% per year decline in their child mortality rate over countries that do not adopt these tools. And the world spends way too little—not too much—on the research and development of health tools for the world's poorest populations. Clark's viewpoint provides a convenient excuse for inaction at a time when we need to be at least doubling our investments in finding new health tools.

http://www.bmj.com/content/349/bmj.g5458

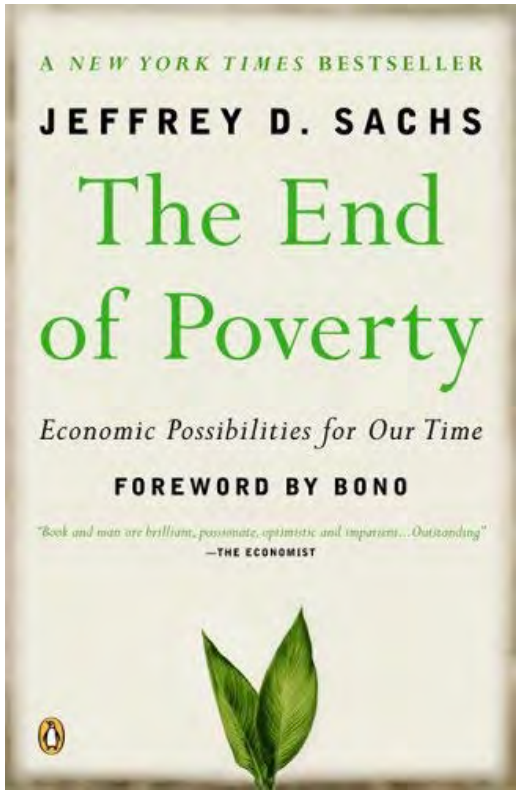


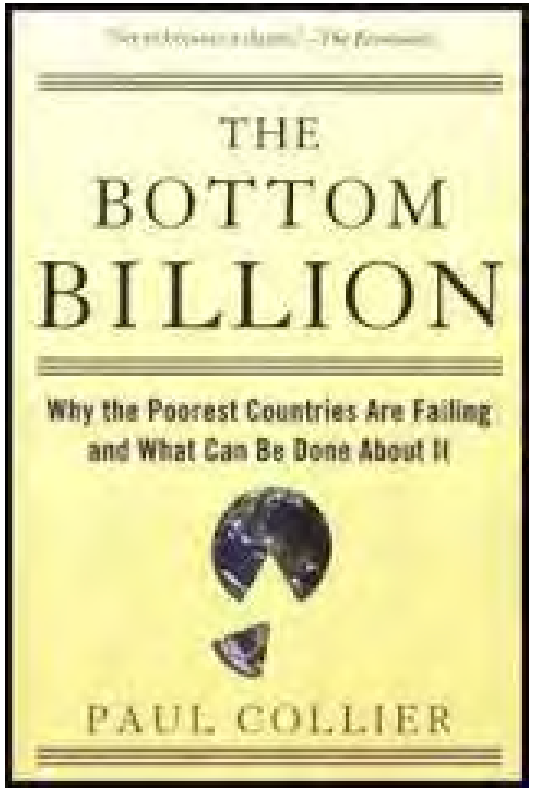
Packard argues that global-health initiatives have saved millions of lives but have had limited impact on the overall health of people living in underdeveloped areas, where health-care workers are poorly paid, infrastructure and basic supplies such as disposable gloves, syringes, and bandages are lacking, and little effort has been made to address the underlying social and economic determinants of ill health.

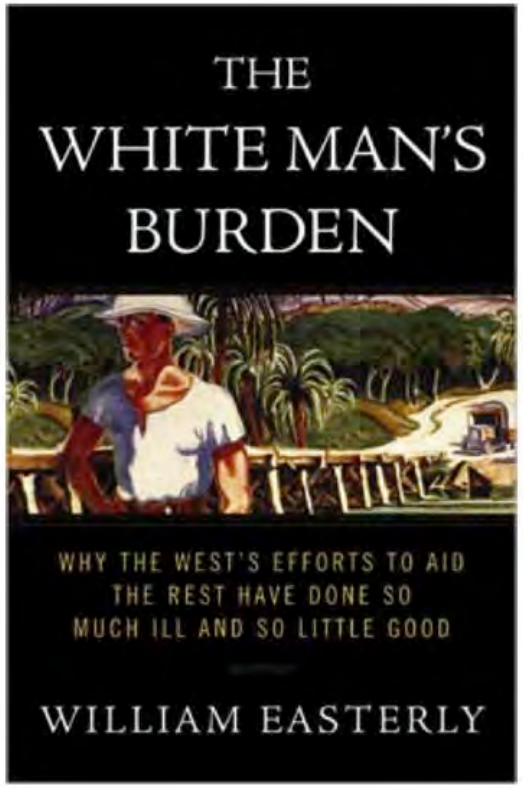
Global-health campaigns have relied on the application of biomedical technologies—vaccines, insecticide-treated nets, vitamin A capsules—to attack specific health problems but have failed to invest in building lasting infrastructure for managing the ongoing health problems of local populations.

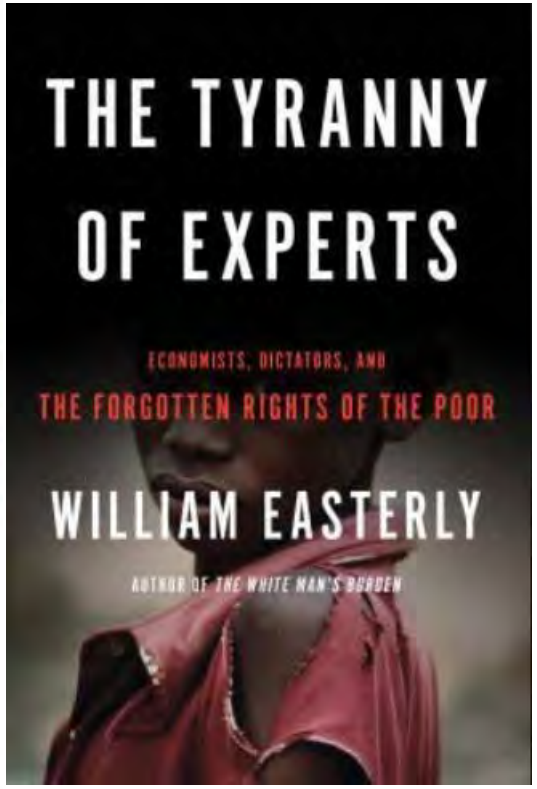
https://jhupbooks.press.jhu.edu/content/history-global-health

Foreign/external aid is good versus bad

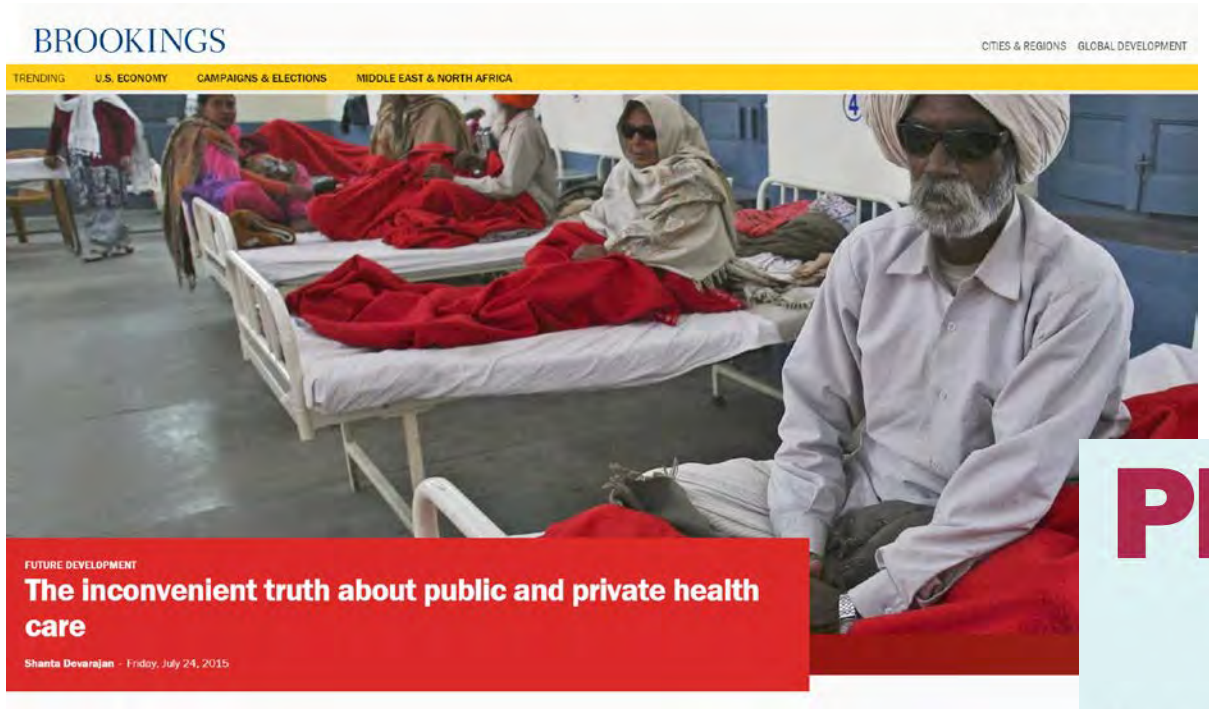








Public versus private provision of care



PRIVATE VS. PUBLIC

Jorge Coarasa, Jishnu Das, and Jeffrey Hammer

In many countries the debate should not be about the source of primary health care but its quality

THE private sector provides between one-third and three-quarters of all primary health care in low-income countries, depending on the survey. But for most patients private sector medicine does not encompass large, modern hospitals and integrated service providers. That private sector exists and caters to a relatively wealthy urban clientele. The private sector for the poor is a mixture of modern providers operating small for-profit clinics or working for nonprofit institutions and providers trained in traditional systems of medicine, herbalists, homeopaths, and many with no qualifications. instance, providers may choose cesarean sections when cheaper, normal deliveries are sufficient or dispense unnecessary medicines that earn the provider a profit. Indeed, it is widely believed that "asymmetric information"—when the provider knows more about the patient's condition than the patient does—leads to problems with the private provision of curative health care.

But it is not clear that governments do better. Low-quality private providers and serious market inefficiencies often coexist with low-quality public sector providers. Potential regulators often lack monitoring and

Corporate and entrepreneur involvement is good versus bad (market-based approaches are good versus bad)

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FIGURE 2: UNITAID MARKET EFFECTS FRAMEWORK FOR PUBLIC HEALTH

https://www.usaid.gov/sites/default/files/documents/1864/healthymarkets_primer.pdf

http://www.unitaid.eu/images/strategy/UNITAID-Strategy_2013-2016-Full-English.pdf

Corporate and entrepreneur involvement is good versus bad (market-based approaches are good versus bad)

Tropical Medicine and International Health

VOLUME 6 NO 11 PP 945–951 NOVEMBER 2001

Drugs for neglected diseases: a failure of the market and a public health failure?

Patrice Trouiller[1], Els Torreele[2], Piero Olliaro[3], Nick White[4], Susan Foster[5], Dyann Wirth[6] and Bernard Pécoul[7]

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MSF Calls on Davos Leaders to Stop People Dying of Market Failure

"Research has ground to a standstill for leading global killers like tuberculosis(TB) and malaria, while market investment is leading to progress in fighting cancer, heart disease and lifestyle diseases such as obesity and impotence."

http://www.dndi.org/images/stories/pdf_scientific_pub/2001/trouiller_p_tm-ih_2001_945.pdf

http://www.doctorswithoutborders.org/news-stories/press-release/msf-calls-davos-leaders-stop-people-dying-market-failure

Engagement of philanthropists is good versus bad

GREAT EXPECTATIONS

The Bill and Melinda Gates Foundation is the world's biggest grant giving charity and has done much to raise the profile of global health. But critics claim its special brand of philanthropy is damaging health systems in developing countries and distorting aid priorities. **Hannah Brown** reports

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1857776/pdf/bmj-334-7599-feat-00874.pdf

PRAISE AND CRITICISM FOR THE GATES FOUNDATION

Pros	Cons
Raised profile of global health	Focus on technology rather than delivery
Forced UN and other agencies to rethink role	Perpetuated vertical programmes; not strengthening existing health systems
Created a more stable environment for research	Funding mainly goes to northern organisations
Brought in much needed funds	Too slow to make decisions
	Not sufficiently accountable

Gates's grandest challenge: transcending technology as public health ideology

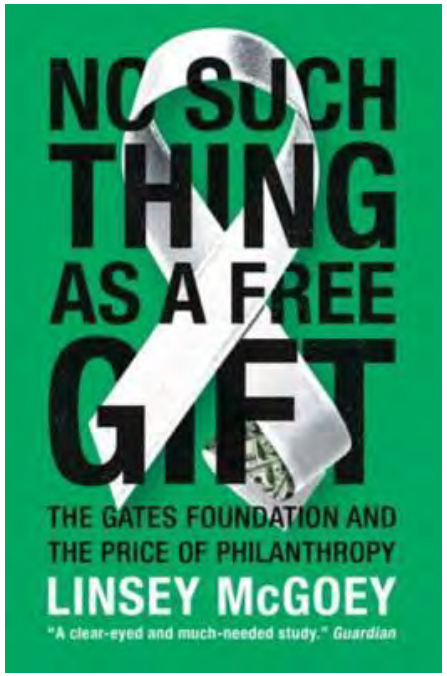
Anne-Emanuelle Birn

http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(05)66479-3.pdf

No Such Thing As a Free Gift: The Gates Foundation and the Price of Philanthropy by Linsey McGoey – review

Is his vast charity empire changing the world for the better? Or is Bill Gates playing God?

Melinda and Bill Gates visit the Meera Bagh slum, New Delhi, during their 2005 South Asia tour. Photograph courtesy of the Bill & Melinda Gates Foundation/Prashant Panjiar



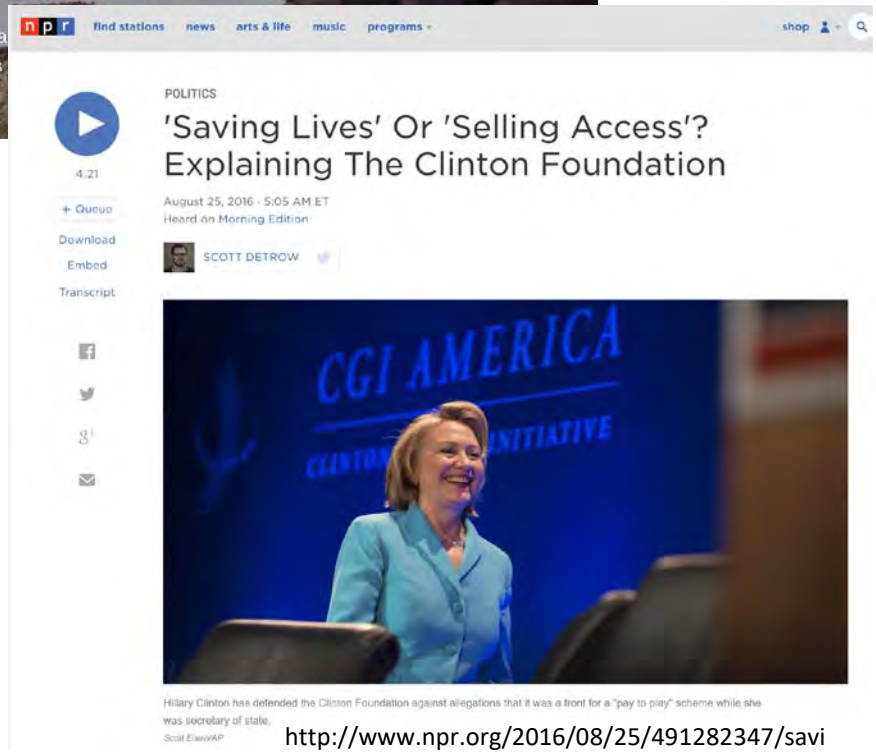
Global Governance 22 (2016), 349–368

The Bill and Melinda Gates Foundation and Legitimacy in Global Health Governance

Sophie Harman

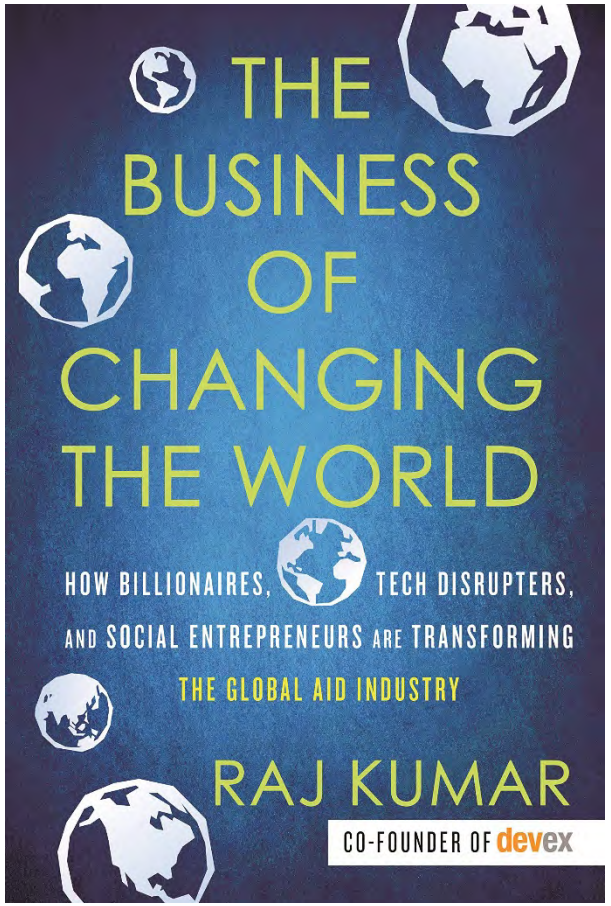
http://www.theguardian.com/books/2015/oct/24/no-such-thing-free-gift-gates-foundation-philanthropy-review

http://www.nytimes.com/2015/10/19/us/politics/rwanda-bill-hillary-clinton-foundation.html?_r=0



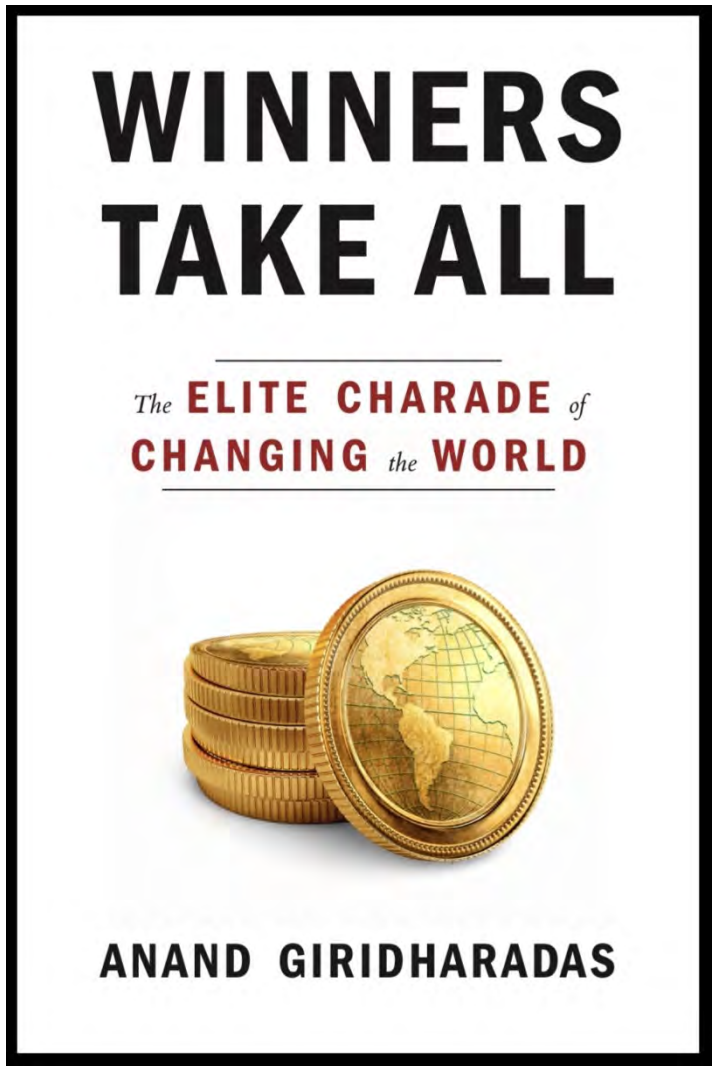
http://www.npr.org/2016/08/25/491282347/saving-lives-or-selling-access-explaining-the-clinton-foundation

http://www.independent.co.uk/voices/mark-zuckerberg-facebook-priscilla-chan-3-billion-cure-all-disease-cancer-alzheimers-obvious-reasons-a7323416.html



“Old aid was driven by good intentions and relied on big-budget projects from a few government aid agencies, like the World Bank and USAID. Today, corporations, Silicon Valley start-ups, and billionaire philanthropists are a disrupting force pushing global aid to be data driven and results oriented. This $200 billion industry includes emerging and established foundations like the Chan Zuckerberg Initiative and the Bill and Melinda Gates Foundation. Entrepreneurial startups like Hello Tractor, which offers an Uber-like app for farmers in Nigeria, and Give Directly, whose app allows individuals to send money straight to the phone of someone in need, are also giving rise to this new culture of charity. The result is a more sustainable philosophy of aid that elevates the voices of the world’s poor as neighbors, partners, and customers.”

https://pages.devex.com/the-business-of-changing-the-world.html



An investigation of how the global elite's efforts to "change the world" preserve the status quo and obscure their role in causing the problems they later seek to solve.

Why the super rich have such fortunes in the first place is more the focus of Anand Giridharadas.

"those at the greatest risk of being resented in an age of inequality are recast as our saviors from an age of inequality".

Philanthropy has its place. But, argues Giridharadas, to do nothing about the system of inequality that both generated these vast fortunes and brings problems in its train is, quite simply, wrong.

Michael Marmot, Lancet 2019

Global health security agenda: protects us

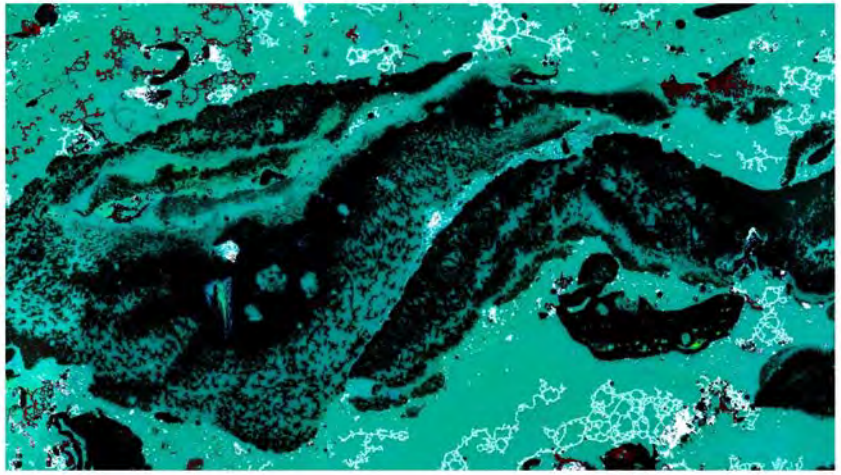
Harvard Business Review

GOVERNMENT

The World Is Completely Unprepared for a Global Pandemic

by Ranu S. Dhillon, Devabhaktuni Srikrishna, and David Beier

MARCH 15, 2017



PLOS | MEDICINE

POLICY FORUM

Toward a Common Secure Future: Four Global Commissions in the Wake of Ebola

Lawrence O. Gostin[1]*, Oyewale Tomori[2], Suwit Wibulpolprasert[3], Ashish K. Jha[4], Julio Frenk[5], Suerie Moon[6], Joy Phumaphi[7], Peter Piot[8], Barbara Stocking[9], Victor J. Dzau[10], Gabriel M. Leung[11]

Summary Points

- Four global commissions reviewing the recent Ebola virus disease epidemic response consistently recommended strengthening national health systems, consolidating and strengthening World Health Organization (WHO) emergency and outbreak response activities, and enhancing research and development.
- System-wide accountability is vital to effectively prevent, detect, and respond to future global health emergencies.
- Global leaders (e.g., United Nations, World Health Assembly, G7, and G20) should maintain continuous oversight of global health preparedness, and ensure effective implementation of the Ebola commissions' key recommendations, including sustainable and scalable financing.

Global health security agenda: securitization hurts global health

Offline: Global health security—smart strategy or naive tactics?

Global health becomes just another instrument to assert the power of the nation state. People become a secondary concern. The agenda of global health is rewritten. Global health becomes oriented towards infectious diseases and health crises. Concerns about non-communicable disease, the social determinants of health, and the part played by corporate actors are marginalised.

www.thelancet.com **Vol 389 March 4, 2017**

From Ebola to Zika: international emergencies and the securitization of global health

Finally, viewing the response to international emergencies only through the limited prism of security would condemn global health to an infinite succession of periods of "war" interspersed with "truces" focused on surveillance systems, rather than confronting the causes of the epidemics, rooted in the social determinants of health. If the immediate responses are not accompanied by structural changes capable of promoting a radical reduction in inequalities, the question remains: who will truly be safe at the end of each "war"?

Cad. Saúde Pública, Rio de Janeiro, 32(4):e00033316, abr, 2016

Other issues that make me worry…

- GH might be an improvement over colonial or international health, but it is still too colonial in its mindset; it is still too unidirectional (rich to poor world); not reciprocal enough; high income country researchers and students benefit more than LMIC partners
- We mostly train students in the rich world, when the biggest training needs are in LMICs
- We might be getting too reliant on philanthropists while countries under-invest in health– a handful of people have as much wealth as half the world's population; yes, some of these people are now philanthropists supporting global health, but it still does not address the underlying inequities
- Parachute research is still too common; global health tourism is also common
- LMIC colleagues are not leading the agenda setting – they are not adequately represented in GH boards, WHO committees, policy making, publications, editorial boards, etc
- Experts & leaders in GH are mostly NOT the ones who are actually dealing with the most complex challenges

THE CONVERSATION

Academic rigour, journalistic flair

Global health still mimics colonial ways: here's how to break the pattern

August 18, 2019 4.17am EDT

Author

Madhukar Pai

Director of Global Health & Professor, McGill University

https://theconversation.com/global-health-still-mimics-colonial-ways-heres-how-to-break-the-pattern-121951

No easy answers, but we need to find a way to work through these schisms & concerns

False dichotomies in global health: the need for integrative thinking

Julio Frenk, Octavio Gómez-Dantés

"need to leave behind the dichotomous mindset that has characterised international and global health in the past decades, which tended to emphasise the extremes of the global health situation and disregard its grey areas and its complexities…"

In global health, we need to

- Be aware of our privilege and work hard to not perpetuate colonial attitudes and practices
- Respect talent and expertise in LMICs
- Let LMIC experts lead on projects that affect them and enable/support them
- Avoid parachute research
- Be reciprocal
- Build sustainable capacity in LMICs

Time to decolonize global health

"…decolonize global health by being aware of what we do not know, that people understand their own lives better than we could ever do, that they and only they can truly improve their own circumstances and that those of us who work in global health are only, at best, enablers." – Seye Abimbola

https://academic.oup.com/inthealth/article/10/2/63/4924746

REIMAGINING
GLOBAL HEALTH AN INTRODUCTION

PAUL FARMER, JIM YONG KIM, ARTHUR KLEINMAN, AND MATTHEW BASILICO

NO SUCH THING AS A FREE GIFT

THE GATES FOUNDATION AND THE PRICE OF PHILANTHROPY

LINSEY McGOEY

"A clear-eyed and much-needed study." *Guardian*

WINNERS TAKE ALL

The ELITE CHARADE *of* CHANGING *the* WORLD

ANAND GIRIDHARADAS

A HISTORY OF GLOBAL HEALTH

INTERVENTIONS INTO THE LIVES OF OTHER PEOPLES

RANDALL M. PACKARD

If you want to dive deeper…