

Remaking international health: refreshing perspectives from Latin America

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Two-plus decades ago, as the Cold War was melting away, an accompanying transition took place in the overarching appellation applied to the times—from an era of polarization to an era of globalization. While only the most ahistorical and ideologically foolhardy heralded globalization as marking the undeniable triumph of market capitalism (1)—and despite globalization’s patent rationale for neoliberal economic policies (2) and its totalizing and anxiety-producing prospects (3)—the term has become omnipresent in the vernacular and academic discourse alike.

The health arena, of course, has not been immune to these developments. Since the mid-1990s a crescendo of institutions and individuals have seized upon the vogue of globalization to rechristen the field of international health as global health, furthering a variety of agendas, be they idealistic, opportunistic, or driven by realpolitik (4). The term global health had been employed on occasion, variously, by the World Health Organization (WHO), the U.S. government, and population control agencies, as well as by progressive anti-nuclear, environmental, and universal health care movements (5)—suggesting competing interests over use of this term. However, its resurrection has been mostly greeted uncritically (with certain exceptions (6)) or justified *ex post facto* either aspirationally, albeit with concerns regarding U.S. unilateral or hegemonic globalism, or as a theoretical and methodological challenge (7–11). To be sure, a variety of analysts have unleashed powerful assessments of the impact of globalization on health (12–17), but the global health moniker has stuck. It remains in desperate need of interrogation—well beyond the proliferation of global health definitions—in order to explain why global health has displaced international health.

Is global health (or the globalization of health) simply a reflection of “capitalism without borders” or does it incorporate a dialectic of power involving imposition from above, resistance from below, and opportunistic game-playing in both directions from mid-level players? Is it a slogan that is naively descriptive—in the sense of geographic simultaneities or problems and common solutions transcending physical and political boundaries? Is the arena of global health uncynically sanguine as it strives for equity and transnational human rights? Is it a fashionable renewal and bowdlerizing of the previously used term “international health”? Or is it patently ideological in the sense of putting forth a metropolitan Euro- or North-centric hegemonic universalism to promote the diffusion of goods, technologies, financial products, and values while maintaining domestic security (18–21)?

Amidst this muddle, a characteristic feature of the new global health is undoubtedly the soaring investment opportunity for private capital, previously kept under check by the exigencies of the Cold War (22). Global health’s profit-making prospects have been implicitly sanctioned by the explosion over the last few decades of public-private partnerships (23, 24) and fortified by the WHO’s 2000–2002 Commission on Macroeconomics and Health, with its double entendre of “Investing in Health” (25) (echoing the World Bank’s identically titled report of 1993) as a means of enhancing economic productivity *and* amassing private profits (26). This trend is widely evidenced by the stated missions and activities of numerous food, insurance, and pharmaceutical corporations; global health agencies; foundations; and public-private partnerships; including the Rockefeller Foundation’s “Impact Investing” initiative, the Global Fund’s lucrative “Business Opportunities,” the University of Toronto-based McLaughlin-Rotman Centre for Global Health’s “Commercialization Pillar,”

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UNITAID's promise of a "market for health commodities," and so on. If anything, global health distinguishes itself not just as *business as usual*, but as *far more business than was usual* under the field's international health designation.

Notwithstanding this reality, the dominant articulations of global health exclude discussions of the commodification of health, private profit-making, and the role of market capitalism. Moreover, despite widespread, inspiring invocations of equity, "benefitting everyone," and "including southern voices," mainstream approaches are silent on why social inequalities in health have developed in the first place and how they might be fundamentally addressed (27).

For example, the U.S. Institute of Medicine's 1997 definition of global health as "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions" (28, p. 2), remains mum on the directionality, nature, and causes of these influences and what is meant by cooperation. In a 2009 update, global health is characterized optimistically as "the goal of improving health for all people in all nations by promoting wellness and eliminating avoidable disease, disabilities, and deaths," and even calls for "an understanding of health determinants," before returning to the aim of "improv[ing] health in low and middle-income countries" through "basic and applied research on disease and disability" and their risk factors (29, p. 18). Old wine indeed!

Perhaps most widely cited of late is Koplan and colleagues' "common definition of global health" (30), which merits extensive analysis precisely because it sidesteps so many crucial issues. Incredibly, as colleagues and I noted (in a rejected letter to the editor of *The Lancet*²), the definition excludes the political context of global health altogether. There is no mention of who the stakeholders are and who wields power in global health. Nor is there discussion of questions regarding who/what drives the global health agenda and to what ends. Moreover, the devised definition of Koplan et al. invokes globalization but ignores its documented negative effects on health, including the impact of: trade liberalization on inequality and economic insecurity; international financial institution conditionalities and privatization policies on access to social services; deregulation on environmental and occupational health (15, 18); and massive financial fraud on the lives of billions of people (31).

Additionally, the distinctions drawn by Koplan et al. between international and global (and public) health are misleading. While global health is "meant to transcend past ideological guises of international health—as a 'handmaiden' of colonialism or a pawn of Cold War political rivalries" (32), in reality these terms lie along a continuum. International health arose, backed by powerful nations and economic interests, for similar reasons as global health has surfaced—to address health issues that cross borders, and to pursue security and economic/commercial goals (18) (the international dimensions of health and health dimensions of international political and economic relations) (33).

To say that global health is primarily concerned with "achieving equity" and "emphasizes transnational health issues, determinants, and solutions," (30, p. 1995) sounds promising, but there is little evidence that global health overcomes the patronizing and self-interested patterns of the past. It certainly belies global health's profit-oriented present. A more useful analysis would seek to examine health in the context of the global order of political and economic power, either explaining why global health deserves to displace international health—or rejecting this proposition.

² Birn AE, Holtz T, Benatar S, Pillay Y. "Neither common nor a definition," unpublished manuscript, 2009.

For all of these reasons, it is most refreshing that PAHO's Leaders in International Health Program "Edmundo Granda Ugalde" (formerly Residency in International Health) has not bent to the seductiveness of global health, instead retaining international health as a valid and appropriate designation for the kinds of activities it fosters, including country-to-country cooperation and cross-fertilization of policies and practices. As attested to by the rich array of studies in this special issue, Latin America is an ideal region in which to explore the renewed possibilities for international health. It has the longest tradition of any region of, at one and the same time, shaping the international health field, participating in it, and challenging its premises and approaches (34, 35). Emerging from centuries of colonialism, the region's republics led the way in early 20th century international health cooperation and in the building of incipient welfare states, albeit cognizant of limits to universality and coverage. Later in the 20th century—amidst conditions of repression, dictatorship, and neoliberal policies across Latin America—health scholar-activists developed bold new ideas and practices around social medicine, collective health, and citizen inclusion, today continuing to implement them following protracted struggles to return to democracy (36–41). As well, highlighted by Cuba's longtime international solidarity work and now playing out through UNASUR, the region has pioneered South-South health cooperation, with extremely positive repercussions (42–46). As shown in the title and work of the dynamic online journal *PoSibles* (Política, Salud Internacional, Desarrollos Sustentables³), international health in / from the Americas is very much alive.

Rather than being behind the curve, Latin America is ahead of it. In this 25th anniversary of PAHO's international health residency (in which I was privileged to participate as a historian in 1994), it is vitalizing to note that its founder, María Isabel Rodríguez, who was inspired to train young public health professionals in the Americas to contribute theoretically, practically, and as emerging leaders in conjunction with the international health community's social justice call for Health for All by 2000, is now El Salvador's Minister of Health. Among her top priorities are renewing international health's crowning campaign for a rights-based approach to universal primary health care and advocating for "health sovereignty" in international cooperation, so that nationally-defined agendas for health equity in El Salvador and other developing countries can be realized (47–50). This remade international health is not old wine in new bottles but rather the best of new and old vintages in recycled bottles!

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³ Available from: <http://www.elagora.org.ar/site/posibles/inicio-Posibles.html>

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