FORUM

GLOBAL HEALTH AND SOCIAL JUSTICE

Global health policies have too often proved unworkable, unable to meet the particularities and needs of individual countries. Finding a balance between global and local, adapting broad guidelines to specific realities, actively engaging all actors: these are just some of the possible starting points for putting the health of human beings at the center once again.

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It's fair to ask whether the pervasive and overworked word "global" is not but a typical example of the post-WWII vision of the public good that has since been transformed into an ideological justification for many facets of neocolonialism. A large body of literature demonstrates, in fact, how global approaches to the development of health policies have systematically failed to meet the needs of local communities (Thomas et al. 2005)[1].

Indeed, the linkage of global health with development remains an example of "political correctness" that has failed to translate into an actual connection between integrated programs for health *and* the reduction of poverty and inequality. And while the issue of rights is now part of the broad global, legal, moral and political debate, their actual *enjoyment* has struggled to be incorporated into global health practices.

GLOBAL AND LOCAL: A NECESSARY CONVERGENCE

The limitations of the global discourse could not be more evident: a universal but tenuous medical epistemology, the pervasive and vested interests of the pharmaceutical industry, a cultural hegemony of professional lobbies, and the cultural universalism of global agencies limited to declarations of principle or normative recommendations, while struggling to face up to the very disparate realities found in the countries where implementation of such measures would be vital. The burden of this limitation becomes clear by surveying WHO's actual impact in countries worldwide and, more generally, the systematic gap between United Nations discourse and the realities on the ground of its member states.

Is there a way to bridge the local and the global so that they "can become reciprocal instruments in the deepening of democracy"? (Appadurai 2002)[2]. The answer to this question is crucial if we want to understand the countless failures of global health programs designed to rescue the failed local policies of low- and middle-income countries. In a nutshell: local failures, global failures.

Stewart, Keusch, and Kleinman note[3] that the proverbial failure of primary health care models in poor countries can be attributed to the verticality of programs focused on single diseases, a traditional biomedical disease control model that ignores the broader cultural setting and social determinants of health, and, finally, enormous inequity in access to health care systems. A vast gap exists between an understanding of the local and the rationale of global programs, and as long as local actors are excluded from the design, production, assembly and dissemination of these programs, this gap will continue to be an obstacle to the effective implementation of the latter. In addition, use of the notion of "local" often seems merely formulaic, with local actors being engaged less as active players than (primarily) as passive recipients.

"DEEP DEMOCRACY": A POSSIBLE KEY TO INTERPRETATION?

Could "deep democracy" be the vital dimension to understanding the settings in which health programs ought to be developed? "Deep democracy is democracy near at hand, the democracy of neighborhood, community, kinship and friendship, expressed in the daily practices of information sharing, house and toilet-building (...)" (Appadurai 2013)[4].

The personal dimension of *morality* – i.e., of individuals working on projects to "build" collective health – and the collective dimension of *rights* – i.e., the set of political, social and legal guarantees expressed by every local or national community – could constitute the vectors of the collective "building" of health and the encounter of global and local tools.

The technological rationale of medicine cannot be a vector in and of itself, only a *technical* complement to the primary vectors, i.e., collective rights and individual morality.

WHEN HEALTH IS SHAPED BY ECONOMICS

As Gianni Tognoni writes, "The growing influence of economic factors (which translate into the IMF's restrictive prescriptions of social, educational and health rights), the taking on by the World Bank of the roles of the WHO in identifying health priorities

in terms of the economic compatibility of disease costs (…) have led to the disappearance of health as a right, replaced by health as a *set of benefits*, that is, commercial goods"[5].

This "growing influence" both has a real impact on the choices made by health systems and permeates health care culture and terminologies. It dilutes the moral and technical power of the vision of public health by turning health into a commodity rather than a public good, and reducing it from an absolute right to a relative one: health policies and the organization of services are increasingly focused on management and cost containment, while living rather than dying, or being well rather than ill, have become dependent on economic logic rather than independent variables.

Some tentative conclusions can be drawn from all this:

1. **Global health isn't global.**
   What is global, instead, is inequality. The major global campaigns promoted by WHO have been major failures (recent examples: alcohol and Covid-19 vaccines). One need only think of the alcohol industry's powerful lobby, which not only sabotaged WHO's Global Strategy to Reduce the Harmful Use of Alcohol (2010), but actually nullified it thanks to aggressive policies that led to major governmental defections from the battle for public health and achieved a rise rather than a drop in the consumption of alcohol.

2. **The major global public health victories have not been those won by international institutions and specialized UN agencies, but rather by grassroots movements and low- and middle-income countries such as India, Brazil and South Africa.**
   Think, for example, of the historic and successful battles over patents and antiretroviral drug costs and the associated changes to World Trade Organization regulations on drug patents and possible related waivers.

3. **Social determinants: a question and a challenge.**
   Social determinants cannot be viewed as an "interesting" etiological feature of diseases and disabilities. On the contrary, every type of intervention aimed at "poverty alleviation" and the reduction of risk factors caused by social determinants should be incorporated into the standard protocols for health interventions.

4. **The issue is always the same: whether the right to health is, as a *right*, an independent variable or, as a *commodity*, a dependent one.**
   Rights must regain a central role and place in the design, planning and organization of health systems. It is both urgent and imperative that we stop considering them as "desirable settings" in which health systems deliver care and services, and start treating them as actual *indicators* of health and health policy, planning and delivery.

NOTES

1 Thomas P., Bracken P., Cutler P., Hayward R., May R., Yasmeen S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health,* 2005, 4,3, 23-32.
2 Appadurai A., *"Deep Democracy: Urban Governmentality and the Horizon of Politics"* in Public Culture, 2002, 14 (1), pp. 21-47.
3 Stewart K.A., Keusch G.T., Kleinman A., "Values and moral experience in global health: bridging the local and the global", in *Global Public Health*, 2010, 5:2, pp. 115-121.
4 Appadurai A., "Cosmopolitanism from below", https://studylib.net/doc/18706964/cosmopolitanism-from-below
5 Tognoni G., La dominanza del fattore economico contro salute, diritti e beni comuni. In: *Rapporto sui Diritti Globali*, p. 1132-1136, Ediesse, Roma, 2012.