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Adrian Kay and Owain David Williams

## 6

### Unpacking Economism and Remapping the Terrain of Global Health<sup>1</sup>

Matthew Sparke

We are in transition from what seemed a relatively stable, state defined and structured world of international health to a diffuse political space of global health. We need to analyse to what extent the political ecosystem that inhabits this space transfers power and to whom. We need to map the epistemic communities and the multitude of networks and their spheres of influence (Ilona Kickbusch, 2003).

The microbe is nothing; the terrain everything (Louis Pasteur, 1890).

#### Introduction

By connecting the topics of global health and global governance this book invites a whole series of questions about how different practices, structures and philosophies of governance configure the 'global' in global health. How do they map the terrain of the 'global'? What do they prioritise as 'global' problems and 'global' solutions? And how does the space of 'global health' – its inclusions, exclusions and underlying implications about shared global ties – relate to the more general political-economic ties of globalisation? Economism – the core focus of this chapter – presents both openings and obstacles for any attempt to answer such questions. According to the *Oxford English Dictionary* 'economism' describes 'a belief in the primacy of economic causes or factors'. In academic arguments and polemics today the term further implies that an insistence on such primacy is either theoretically essentialist or ideologically interested. Whether used to condemn an approach to explanation or an approach to governance, the implication is that the stress on economic factors or economic rubrics is reductionist and inadequate. It is increasingly clear, however, that using 'economism' in this way as a polemical category of condemnation is itself reductionist and inadequate. It risks obscuring the actual force of particular economic policies in globalised regimes of governance, and it meanwhile abstracts important arguments over how the political and economic interconnect in the world at large into entirely

academic and epistemological issues. To be sure, there have been some important theoretical and empirical correctives to these tendencies, correctives that explore both the economic rethinking of government and economic remaking of the state that happen when politics comes to be dominated by economics (for example Brown, 2003; Tabb, 2004; and Teivainen, 2002). However, none so far have focused specifically on the implications for rethinking and remaking 'global health governance' in the context of economic globalisation. This is what the present chapter aims to do.

In order to move beyond the pitfalls of polemic and abstraction the following pages unpack and distinguish three different types of economism as they relate to global health governance. These three types are identified in terms of their broad-brush discourses about capitalist markets as: 1) the economism of *market fundamentalism*; 2) the economism of *market foster-care*; and 3) the economism of *market failure*. The three labels are useful heuristically, but, more than this, their simplicity as buzzword formulations about markets also captures something of the real-world resonance and power of each economism as an influential economic discourse about the world. It is precisely this influence that the following pages seek to explore in terms of the remapping of global health. The mapping concept-metaphor is exact because, it is argued here, each economism also assumes and activates a distinct 'imaginative geography' of globalisation that then frames and visualises the terrain of global health in a distinct way. The notion of imaginative geographies (which heralds from historical and humanistic literatures) may itself appear epistemologically nebulous and abstract, if not altogether inappropriate in relation to the urgently embodied challenges of today's global health crises. However, taking inspiration from the physician-anthropologist Paul Farmer's powerful critique of the 'geography of blame' framing Haiti's devastatingly embodied experience of AIDS (Farmer, 1992), the thesis in what follows is that different imaginative geographies of the 'global' not only distinguish the different kinds of economism as modes of representation, but also have profound, life and death consequences for how global health problems are framed as 'global' (or not) and how global health governance is conceptualised and practiced in response. Historically it is clear that preceding regimes of health governance have been characterised by their own distinctive spatial assumptions about the geographies of health, including the territorial sweep of infection and vulnerability, as well as the spatial organisation of medical and public health interventions. City spaces, colonial control zones, 'natural regions' and national-state territories, have all served in this way as influential historical-geographical horizons for visualising both health challenges and arenas for medical action. However, in the context of economic globalisation, and specifically in relation to today's increasing extension and entrenchment of pro-market 'neoliberal' approaches to government, these older geographical horizons are being revised and reterritorialised. They

have by no means been replaced altogether, and the place of the nation-state as an influential imagined community of health and sickness continues to shape health governance in obvious ways. Indeed, as the basic 'unit' of health statistics, as the taken for granted 'community' wherein sickness and health are understood as communally related, and as the epidemiological 'population' of record that is counted, compared and considered for control in international health planning, the nation-state with its borders and internal administrative areas is still a very prominent space amidst the overlapping spatial frameworks of health governance around the world. But none of this alters the basic fact that, as Kelley Lee has emphasised, 'new spatial configurations of health and disease are emerging as a consequence of globalization' (Lee, 2003, p. 6; see also Lee, this volume). Moreover, the global reterritorialisation of governance driven by market-based globalisation has also obviously led to a series of reappraisals of the national territorialisation of health governance. As market-forces have come to both open and curtail access to healthcare across the transnational spaces regulated by free-trade agreements, concepts of health citizenship have also been transnationalised in uneven and contradictory ways. In turn new global norms for inclusion in and exclusion from health interventions have been established based on varying visions of how disease, health and socio-economic ecologies intertwine globally. All these developments have involved distinctive forms of reterritorialisation, remapping and retitling. And even the terminological take-off of 'global health' and 'global health governance' as academic terms (see Figure 6.1) can be

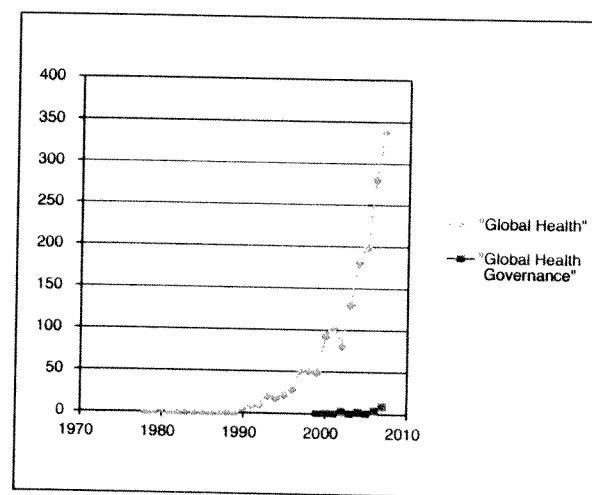


Figure 6.1 The Use of 'Global Health' and 'Global Health Governance' as Registered in Web of Science Citations

understood in this way as a reflection of the 'new political space' noted by Ilona Kickbusch (2003, p. 197). Thus, to quote a telling use of 'landscape' language from *The Lancet*, 'as the importance of global and supra-national determinants of health increases, so does that of global public health institutions.... The time has come for a significant rationalization of the global-health landscape' (McCoy *et al.*, 2006, p. 2179).

Other commentaries on particular features of the actually emerging global health landscape highlight how it is mainly being remade (if not rationalised) by transnational market actors and institutions (including, according to an influential corporate consultancy, transnational medical tourists: see McKinsey, 2008). In a particularly notable instance, a recent landmark assessment of the new 'social and institutional geographies' of pharmaceutical governance notes thus that: 'Elements in this new ecology include the World Bank, the World Trade Organization, and TRIPS, and a host of international and national regulation and law, which set the terms of pharmaceuticals' worldwide and regional circulation. This institutional ecology moves within and across more traditional, territorially bounded apparatuses of governance' (Petryna *et al.*, 2007, p. 6). Reviewing many such changes to the geography of health governance more generally, it fast becomes clear that key amongst the global determinants driving the reterritorialisation are the pro-market transformations of governance that scholars of globalisation explain in terms of neoliberalism (Harvey, 2005), marketised constitutionalism (Gill, 2003) and the transnational entrenchment of economic governance (Tabb, 2004). All sorts of new private sector actors, non-governmental organisations (NGOs) and global philanthropies have come to populate this new market-made landscape. But, as shall be documented below, the actual remapping of health governance itself reflects the ways these global actors, along with older national and international agencies, are interpreting the underlying economic forces of change.

### Unpacking the three economisms

What then are the three dominant forms of economic interpretation and argument used to connect debates over global health and global governance in the context of economic globalisation?

The first is the most dominant and egregious kind of economism we see today, the neoliberal economism of *market fundamentalism*. It is as common as it is unquestioned, as political as it is economic, and as entrenched in public policy as it is normalised in the micro-economics classroom. For the same reasons it now functions as the hallmark and working discourse of the globally dominant system of business-led and market-based governance. It is *neoliberal* because it returns to the free-market *laissez-faire* liberalism of nineteenth century liberals, but after, and hence the *neo*, the development and decline of the welfare-state liberalism of the twentieth century. At

intergovernmental meetings of the Group of Eight (G8), World Bank, International Monetary Fund (IMF) and World Trade Organization (WTO), as well as at a plethora of business meetings such as the World Economic Forum, market fundamentalists continue to denounce 'big government' while adapting the underlying axiom of free market rule to a wide variety of global challenges, infectious diseases such as HIV/AIDS, malaria and tuberculosis (TB) often among them.

Whatever the place and whatever the problem, market fundamentalists repeatedly assure their audiences that it is jobs, growth and the efficiency of the liberated invisible hand that will ultimately save all of humanity. Good health, it is argued, is dependent on good growth, entrepreneurial innovation in pharmaceuticals, and the market delivery of these innovations to global health consumers. Poor health, by contrast, is seen as a result of poor integration into the networks of global capitalism. Out of these arguments comes in turn the policy assertion that only by integrating the poor economically into the global free market system is it also possible to include them finally in a fully global community of universal good health. Contrastingly, but quite tellingly, in practical policy-making arguments over global health governance the economism of market fundamentalism leads not to inclusionary but instead exclusionary stipulations about healthcare rationing predicated on 'cost-recovery' policies and 'cost-effectiveness' analysis. It is true that while IMF/World Bank emphases on cost-recovery have come with a much criticised insistence on austerity, user fees and healthcare cut-backs (see Weber, this volume), cost-effectiveness analysis is often seen as less punitive and exclusionary, being presented as just a rational economic calculus for determining funding priorities in the context of limited resources. However, along the way the elaborate algebra of Quality Adjusted Life Years (QALYs), Incremental Cost Effectiveness Ratios (ICERs) and Willingness to Pay (WTP) metrics simultaneously reflect and reinforce the ways market fundamentalists turn care for human life into care for human capital.

The second economism is also contradictory, and in many ways is equally neoliberal in its guiding assumptions about the inherent efficiencies of individual choice-maximising behaviour, market-based governance and capitalist growth. However it also contrasts with, and thereby compensates for, the economism of market fundamentalism insofar as it argues that certain areas of global governance can only function efficiently, sustainably and humanely when capitalist markets are made more accessible, and the poor and unhealthy are more adequately prepared for integration. This is the economism of *market foster-care*, and it tends to guide calls for targeted global health interventions for those without access to the so-called bottom rung of the global economic ladder. Global health crises in these foster-care accounts are explained in terms of a 'poverty trap' that is itself explained in part by the sickness of the poor themselves. In other words, while market

fundamentalists point a huge explanatory arrow that says good growth will lead to good health, market foster-care interventionists turn this arrow around to argue in often equally simplified ways that removing obstacles of ill-health will give the poor the vitality they need to climb the ladder of growth. For advocates of this foster-care work it is envisaged as providing the medical interventions that will ultimately enable the poor in particular places to pull themselves up previously unreachable rungs of economic development. The work of foster-caring for poor others (who are also repeatedly represented as children in need of tutelage) becomes seen in this way as a therapeutic focus on the weak spots of a global body coded as having curable place-based pathologies. Accordingly, foster-care interventionists can come into the pathological places presented by so-called poverty traps and prescribe cures based on the idea that relief from disease and high infant mortality are real rungs on the ladder out of poverty. A notably bio-medical vision of care is thus twinned with an economic instrumentalism to fashion a therapeutic as well as a so-called enlightened and self-interested investment in the health of the global economy itself.

The third economism abandons global economic ladder metaphors altogether, replacing them with vocabularies and interventions better attuned to the recriminations of those who report being rung-out rather than rung-less in the context of globalisation. It is an economism that is based on critiques of both market fundamentalism and market foster-care, and, as such, focuses instead on the double standards and suffering that signal *market failure*. The primary marker of market failure according to this kind of economism is economic inequality. Health inequalities are tied thus to economic inequalities, and effective responses to health crises and medical pathologies are linked in turn to effective reevaluations and treatments of political-economic pathologies too. Yet while inequality is the common economic reference point in such accounts linking market failure and health failure, it is a reference point that leads in two very different sorts of direction when it comes to health policy analysis and intervention. The economism of market failure is for this reason much less singular and ultimately much less economic than the economism of market fundamentalism and the economism of market intervention. It can certainly lead to predictive 'black-box' approaches to epidemiological explanation that turn economic inequality into an instrumental independent variable explaining health disparities in and between particular nation-states. However, it can also lead to much broader transdisciplinary and transnational efforts to tease out the complexity of the causal connections by examining the diverse political, economic and historical forces that come together across borders to overdetermine unequal health outcomes around the world. While such transdisciplinary efforts may begin from the same territorial statistics pointing to strong correlations between economic inequality and reduced life expectancy in particular nation-states, states, provinces, counties and cities, the transnational attention to territory-

transcending, multi-factor historical-geographical processes leads ultimately to an epistemological problematisation of economic correlation as a stand-alone instrumental guide for health governance. It is in such moments of problematisation that we can witness in turn a critically transnational remapping of the *terrain* of global health in relation to the unevenness of global economic development.

### Economic base-mapping for global health

If the outline of each economism is now clear, the way each one in turn outlines the terrain of global health is not. How do each of these economisms provide an economic base-map that frames how the global in global health is understood?

#### Market fundamentalism and the flattening of global space

The base-mapping of market fundamentalism is so prevalent today and so established as a common-sense imaginative geography of our supposedly 'borderless world' that it does not need extensive elaboration. Its most common spatial metaphor is 'the level playing field' and in the symptomatic sound-bite of *New York Times* globalisation guru Thomas Friedman it presents us with a simple global vision: namely that *The World is Flat* (Friedman, 2005). Friedman's flattening is meant to function as a jocular 'new world order' return to 1492 and the world's most famous discourse of Discovery (although, he does not address the contemporary implications of the global spread of disease in the original age of Discovery). Posing as a latter day Columbus on a trip to Infosys in India, Friedman charts a freshly flattened new world of free-market opportunity, a world where, amongst other things, outsourced medical analysis in India and Australia is depicted as introducing efficiencies and cost-savings into medical treatment in America. For Friedman 'There Is No Alternative' to this flattened world, and his appeal to the conjoint 'inescapability' and 'inevitability' of the level playing field in turn indicates the political bull-doing work he wants the imaginative geography to accomplish. In short, it helps him naturalise neoliberal norms and pro-market reforms as the only options available for governance in a flat world. Notwithstanding all the uneven development unleashed by this *laissez-faire* approach to governance, the flattening invoked by Friedman has for the same reasons become a commonplace of TINA-touts all around the world (for more on the contradictions of touting 'There Is No Alternative', see Sparke, 2006).

The most obvious and extensive way in which the flat world base-map delineates global health governance is through free trade legislation itself. Whether negotiated at a global level through the GATT turned WTO agreements, or at a regional level such as represented by the EU, North American Free Trade Agreement (NAFTA) and Central American Free Trade Agreement

(CAFTA), or even just bilaterally as in the recent US–Singapore free trade agreement, free trade rules are fundamentally premised on the principles of removing tariff and non-tariff barriers to trade. To pick one such free-trade regime that has had especially far-reaching implications for global health, the WTO's Trade Related Aspects of Intellectual Property Rights (TRIPS) preamble provides a typical rendition of the flattening vision. '*Members Desiring,*' it begins in italics,

to reduce distortions and impediments to international trade, and taking into account the need to promote effective and adequate protection of intellectual property rights, and to ensure that measures and procedures to enforce intellectual property rights do not themselves become barriers to legitimate trade ... Hereby agree (WTO, 2008).

The TRIPS agreements that follow the preamble show that when flat-world desires for barrier free transnational market spaces are put into the official language of trade accords they create new legal landscapes that constitutionalise the profit-making rights of transnational businesses while simultaneously straitjacketing what national and local governments can do to regulate the marketplace (Labonté and Schrecker, 2007). Not only are the production and distribution of free medicines and cheap generic drugs curtailed this way, but, if we also consider other WTO rules relating to trade in services (GATS) and Sanitary and Phytosanitary Measures (SPS), a vast variety of other important public health measures are controlled and conditionalised too. From direct government provision of healthcare, to national procurement programs, to subsidised pharmaceutical research, to the regulation of toxic pesticides and carcinogenic additives, to the application of precautionary principles to risky foods, to the enforcement of environmental clean-up laws, the forms of health governance that thereby become re-regulated by free-trade law is long indeed (see Labonté *et al.*, this volume). Moreover, considering the case of NAFTA's Chapter 11 with its rules allowing private companies to sue national governments for actions 'tantamount to expropriation', we also can note that, as well as making it difficult for governments to ban toxic chemicals and waste (McCarthy, 2004), the agreement's legal level playing field also features a remarkable neoliberal lock-in mechanism that makes it impossible for liberal-left politicians to *reverse* neoliberal reforms, including the privatisation of health services, enacted by pro-business governments (Sparke, 2005, Chapter 3). Overall, this 'disciplinary neoliberalism' – to use Stephen Gill's critical term – is what makes the flat world base-map a legal reality (Gill, 1995 and 2003).

The imaginative geographies of connection and disconnection enframed by the flat 'borderless world' vision may at first blush seem merely metaphorical. But when repeatedly put to work to make arguments over the best approaches to global health, the geographic metaphors and relentlessly

repeated 'solutions' they inspire become considerably more practical and consequential on the geographic ground. The sort of globalist enthusiasm for market-based solutions expressed by, for example, *The Economist* is just as common in the more specialised reports written by and for global health professionals themselves (on the neoliberalisation of World Health Organization (WHO) reports in particular, see Navarro, 2000). Especially in areas where scientific innovation and drug development are involved, the advocates of free market openness, good commercial governance and a global level playing field are never far away (although, to use the fluvial metaphor that runs in and across the vision of the level playing field, they sometimes advocate upstream governmental support to protect downstream profits, see Rajan, 2006). For instance, Chapter 3 of a recent UN sponsored report on *Genomics and Global Health* makes the connections very clear in the course of outlining why corporate intellectual property rights must be protected as part of allowing the private sector to play its invisible hand in genomics innovation. The chapter seeks thus to summarise the

specific actions that are needed to foster the rule of law and to create a level playing field for entrepreneurship, as well as to improve access to financing and the availability of skills and knowledge. It notes that a level playing field, access to finance, and knowledge and skills are key factors within the domestic private sector (Acharya *et al.*, 2004).

Of course, from the point of view of the critics of neoliberalism such level playing field rhetoric rests on a giant contradiction: that, by privatising scientific innovation and turning it into intellectual property, the advocates of market-led global health cut off life-saving innovations from all those suffering from the sicknesses of poverty and dispossession. Cheap generic copies of genomic pharmaceuticals, for instance, will clearly be very hard to produce if the 'rule of law' is used to 'level the playing field for entrepreneurship' and keep medicines in the locked cabinets of for-profit dispensaries. And if poor populations are unable to pay for for-profit medicine, then the medicines they need are hardly likely to be the highest priority for innovation by big pharmaceutical companies for whom lifestyle drugs for wealthier westerners promise much larger returns.

Given that the authors of the *Genomics and Global Health* report were working in a UN Millennium Development Goals Task Force, the contradictions between their level playing field language and the inevitable exclusion of the poor from expensive genomics therapies seems all the more deep and disconcerting. However, for elite market fundamentalists themselves the contradictions are not so much ethically troubling as useful in their arguments against egalitarian health ethics. Indeed, if one reviews the global health related reports of free-market think tanks such as the *American Enterprise Institute*, the contradictions of the UN agencies struggling to



develop global health policy in the context of neoliberalism only help illustrate the baseless ethical idealism of setting health inequality reduction goals in the first place (and for an unfortunate academic replay of the same anti-ethics arguments see Fidler, 1999). Criticising the 'Faux Forecasts' of UNICEF and the WHO, one recent *American Enterprise Institute* report thus makes the market fundamentalist case that estimates of the need for Artemisinin-based Combination Therapies for malaria were economically irrational because they were based on idealist ethics about equal treatment for the world's poor. 'Forecasting by UNICEF and WHO is based on need,' the author complained, 'which is qualitatively different than what economists call "effective demand".'

This means that production estimates – driven as they are by unrealistic expectations – may be higher than effective demand. ... WHO and UNICEF are of course health cheerleaders, aiming for higher spending but bearing no cost for wildly unrealistic projections (Bate, 2007).

Such reports do not have a problem squaring such complaints about unrealistically egalitarian global health goals with their own cheer-leading for a global level playing field: cheer-leading which, as we have seen, works by visioning a more globalised and leveled plain in the particular *economic* interests of cross-border business, profit-making and property rights. Wishful thinking on the part of the market's player-managers, it would seem, is not so economically irrational as wishful thinking on the part of the WHO. Moreover, this double standard helps in turn to explain why the market fundamentalist appeals for inclusion through global markets can so easily be coupled with the 'cost-effectiveness' calls to exclude the world's poor from high-cost treatments. Another recent *American Enterprise Institute* report, for instance, makes the case that Highly Active Anti-retroviral Therapies (HAART) are not an economically rational treatment for the world's poor living with AIDS all the while arguing that the best way forward is to keep the playing field level for pharmaceutical companies by maintaining a research and development climate that is 'conducive to and propitious' for business.

HAART interventions still look like a problematic health care choice. This is because there remain vastly more cost-effective channels through which to extend life in low-income areas ... Above all else, it is research and development – especially in the pharmaceutical area – that promises the potential for recasting the cost-benefit calculus for HIV/AIDS treatment for low-income populations. To grasp this potential, of course, we must maintain a climate, for both business and universities that is conducive to and propitious for research and innovation (Eberstadt, 2004).

It is in such moments of market fundamentalist double-speak that we come face to face with the 'strange beast' identified by Paul Farmer in his 2001

Preface to the paperback edition of *Infections and Inequalities*. 'Market utilitarianism,' he argued there,

is a strange beast, since it seems to permit all sorts of inefficiencies so long as they benefit the right people – namely, the privileged. Confident claims about what is cost-effective and what is not should be viewed with some suspicion by those bent on providing quality care to the destitute sick (Paul Farmer, 2001, p. xxiv).

Moving forward with the critical suspicion demanded by Farmer it remains nonetheless imperative to examine how the development of cost-effectiveness analysis by health economists differs from the overt political posturing of free market think-tanks. This is important because for many practitioners the purpose of such analysis is to maximise the health benefits that can be developed from limited health funding. To use an economical axiom of the field that also illustrates the attendant tendency to take health budgets as 'given', the 'emphasis is not on more money for health but on more health for money' (Murray and Frenk, 2000, p. 1699). Approaching cost-effectiveness analysis with this overt agnosticism about overall levels and forms of funding also mutes market fundamentalist posturing. It means that proponents do not always assert a fundamentalist faith in good economic growth growing funds and private provisions for good health. Nor do they necessarily invoke the neoliberal policy argument that cost-effectiveness demands cost savings and thus cost-reducing cuts in publicly funded health services as part of a more general pro-market global development policy (see Arnesen and Kapiriri, 2004; Grosse *et al.*, 2007). Their economic calculus, in the vocabulary of an influential WHO guide to Generalized Cost Effectiveness Analysis, instead involves identifying 'allocative inefficiencies' within a 'given' budget for a 'given' population (Edejer *et al.*, 2003). Still, in the end, cost-effectiveness analysis with its practical ties to healthcare rationing in market-based systems, repeatedly capsizes (Bastian, 2000) or otherwise cancels-out (Farmer, 2005) ethical invocations of health as a basic human right, replacing them with a de-contextualised and thus methodologically flattened landscape of health services as commodities as metrics.

While the economism in cost-effectiveness analysis often leads – as Farmer and others have complained – to a revisioning of global health citizenship in the narrow budgetary terms of just those who are 'QALY-fied' to pay, this is not necessarily always the case. Indeed, outside of the wealthy west and its prudential metrics of human capital, cost-effectiveness analysis can also be employed in examining the health deprivations of all those who cannot pay. Of course, for market fundamentalists the health problems of such impoverished communities are easy to understand. They are obdurate isolationists holding out in the slow world valleys of capitalist disconnection. However, for the many other analysts who see a need for market foster-care

such convenient and comfortable alibis for inaction are inadequate. They still believe in global capitalist connections as a basis for global health and they sometimes turn to cost-effectiveness analysis to determine which sorts of connection should be prioritised, but they work with mental maps more attuned to the place-based geographies of disconnection. It is to their calls for market foster-care and to their proposed treatments for the pathologies of places deemed disconnected that we now turn.

### Market foster-care and the pathologisation of place

While the flat world vision turns geography into a history of connection – albeit, *à la* Friedman, a stupendously hasty history of overnight globalisation sometime in the late 1980s – the calls for market foster-care turn history into imaginative geographies of disconnection. To do this they pathologise particular places as ‘poverty traps’, a form of place-based pathologisation that, while less comforting than market fundamentalist alibis, still offer a way out, indeed an economical out, from more radical critiques of global structural violence. It cannot be stressed enough, however, that the market foster-care calls to intervene in particular places of poverty and poor health are often made with great sincerity. While the corporate social responsibility reports of the big drug companies too often seem like self-interested public relations stunts, and while shifts by the G8 finance ministers and IMF economists often appear like reluctant and retarded responses to public pressure, the embrace of interventionist ideas and health improvement goals by a wide range of doctors, NGOs and UN agencies is much more urgent and earnest. Their commitment to designing healthcare interventions to relieve the sickness and suffering of the world’s poor is not questioned in this section. The question and analytical entry point here is instead with the distinctive approach to imagining the geography of global health that informs their commitment and shapes their market-foster-care approach to global health governance. Taking aim at particular diseases in particular places, this approach has led to a verticalisation of health governance with targeted bio-medical programs against specific diseases being justified in the geographically-partitioning terms of lifting people out of poverty traps and fostering their ascent of the global development ladder. As this approach is adopted and implemented by a widening circle of global health agencies and NGOs, its imaginative geography of partitioned and pathologised poverty traps is becoming just as powerful and globally consequential as the flattening figured by the market fundamentalists. For the same reason, therefore, its distinctive, and, as will now become clear, *selective* vision of the terrain of global health calls out for critical examination.

In his best-selling book *The End of Poverty* (Sachs, 2005), Jeffrey Sachs seeks to introduce a new attention to the uneven geography of what he calls ‘poverty traps’. ‘A large number of the extreme poor,’ he explains, ‘are caught in a poverty trap, unable on their own to escape from extreme

material deprivation. They are trapped by disease, physical isolation, climate stress, environmental degradation, and by extreme poverty itself’ (Sachs, 2005, p. 19). Sachs argues thus that new forms of foster-care intervention are necessary to enable those who are unable to help themselves climb out of these traps of poverty. He calls this correction of *laissez-faire* orthodoxy ‘Clinical Economics’, and he deliberately models its diagnostic terminology and methodology on clinical medical practice. ‘Development economics is not like modern medicine,’ he says, ‘but it should strive to be so’ (Sachs, 2005, p. 75). What this means in practice for Sachs involves treating individual countries like individual patients, abandoning the one-size-fits-all fundamentalism of the IMF, and replacing it with a detailed ‘differential diagnosis’ of each country’s discrete national situation. At the center of such diagnosis Sachs in turn puts great emphasis on the need for detailed poverty maps that can be used in conjunction with a thorough mapping of the physical geographical challenges facing particular countries to determine how best to build new ladders out of old poverty traps (see also Sachs, 2008, pp. 178–179).

Sach’s argument about how to do development differently is not a radical repudiation of neoliberal structural adjustment. Like Friedman, he still believes that ‘second and third world strategies failed, and needed to be reoriented to a global, market-based international economic system’ (Sachs, 2005, p. 81). In such terms, the shift from market fundamentalism to market foster-care hardly seems revolutionary. Yet, if we focus in on the transformed imaginative geography of global health it represents and if we track in turn the more general invocation of similar imaginative geographies in policy-setting commentary on the need for global health interventions, the consequences are far-reaching. With Sachs as chair, for instance, the WHO Commission on Macroeconomics and Health came to consensus precisely through its new attention to the geography of poverty traps. ‘We found that the health crisis in Africa and other impoverished regions was indeed causing a poverty trap,’ explains Sachs. ‘Massive proportions of the poor are sick and dying, and sick people are unable to generate income and pay taxes. Without household incomes and with bankrupt governments, health systems have collapsed and epidemics are running unchecked’ (Sachs, 2004). Having thereby diagnosed the pathology, the Commission was led to a newly interventionist approach to health governance too. ‘To break this vicious cycle, the rich countries would have to help’ (Sachs, 2004). As Sachs and others try to explain this need for help to other agencies of global governance, the justifications for intervention are in turn predictably made in terms of making investments in order to make the world safe and secure for economic globalisation. ‘By helping these countries rise above extreme poverty, we would also enable them to become stable neighbors and trading partners instead of havens of terror, disease, unwanted mass migration, and drug trafficking’ (Sachs, 2004). Such appeals to recouping a return

on investment reflect the wider links between market-foster-care economism and the financialised global governance vocabulary in which individual countries are ranked like so many regional mutual funds in terms of risk and return. However, beyond the return on investment rhetoric, the deeper appeal of the call for global health investments lies in the imaginative geography of the poverty trap itself: the pathological place that needs fresh funding for health in order to return it to productivity, growth and secure integration into the global economy.

Sachs no doubt would insist that his own approach to geography is empirical and ecological, not imaginative at all. He presents detailed maps and charts documenting the problems facing countries located in landlocked, mountainous and tropical terrain, and like other fashionable environmental determinists such as Jared Diamond (who effusively praised *The End of Poverty* on the back-cover), he suggests that such focus on empirical environmental conditions actually provides an objective and non-ideological starting point for development. However, the very fact that this approach resonates with a wider enthusiasm about environmental determinism should provide pause, as too should the way in which the arguments turn the so-called natural environment into an independent variable. This is not because environmental influences can be discounted. But rather because the determinist discourse obscures the ways in which such environmental influence is, as a wide range of geographical research has consistently shown, everywhere intertwined with political and economic influences that co-constitute and mediate what is experienced as 'environmental' (Braun and Castree, 1998; Dalby, 2002; Newman, 2005; Peet and Watts, 1996). Natural hazards and environmental catastrophes, for example, are only violently destructive of lives and livelihoods under structurally violent political and economic conditions (Watts, 1983; Peluso and Watts, 2001). Likewise, the poverty traps that Sachs tends to naturalise are unnaturally pre-conditioned by all sorts of political and economic forces, and these, far from being just local endogenous ecologies of vulnerability, all involve complex local-global historical geographies of development and underdevelopment (Lawson, 2007). This is why the environmental conditions on which Sachs places such emphasis as explanations of poverty – on being landlocked, mountainous, tropical, and so on – also introduce so many wealthy counter-examples: Austria is landlocked, Switzerland is mountainous, and Singapore is tropical. More soberingly, there are many extremely poor countries such as Haiti where it has been the problem of *not* being landlocked – of having been instead at the very center of trans-Atlantic triangular trade – that has been so damaging: creating the conditions for plantation slavery, counter-revolutionary repression and neocolonialism that subsequently allowed diseases (tropical and non-tropical, both) to have such devastating consequences (Farmer, 1992, 2006).

As Paul Farmer has explained in much more detail, the example of Haiti highlights how important it is to interrogate naturalised geographies of

blame. Unfortunately, though, this is precisely what the environmental determinism in market-foster-care economism denies as an analytical possibility (even as Farmer is cited by Sachs as a 'saint of global health', 2005, p. 205). By pathologising poor places as places with poor environments, sickness and self-reinforcing poverty traps – where, in short, a sick environment begets a sick population, a sick economy, and thus a still sicker environment – the imaginative geography of market-foster-care hides the historical geography of dispossession. It replaces a dynamic and longitudinally discerning approach to geography with the sorts of snap-shot diagnoses and bench-marking more commonly found in business journal rankings of the so-called 'business climate' – itself an uncanny inversion of an environmental metaphor as economic code.

One of the most eloquent, and, as Paul Farmer himself puts it in a supportive foreword, 'magisterial' attempts to call for a form of foster-service approach to global health is Edward O'Neil's recent book, *Awakening Hippocrates: A Primer on Health, Poverty, and Global Service* (O'Neil, 2006a). Published by the American Medical Association and praised profusely by some of the leading advocates of global health, the text also came out with a companion volume entitled, *A Practical Guide to Global Health Service* (O'Neil, 2006b). Together the two books provide both a chart and guide for intervention, or what O'Neil imagines himself as 'a map and compass through which many will find their way to service' (2006a, p. xix). The emphasis on global service itself is obviously also a complete rejection of *laissez-faire* orthodoxy. O'Neil is critical of trickle-down development ideology, of structural adjustment policy and the one-size-fits-all neoliberalism of the traditional Washington Consensus; he argues with moral fervour against the inequalities of global capitalism; and he generally avoids invocation of some shamanic hand of free-market healing. He has also evidently put much personal energy and self-sacrifice, including considerable care work in Belize and Kenya, into the project of developing and advocating interventionist global health policies. However, for exactly the same reason, his adoption of imaginative geographies of pathological poverty traps demands all the more attention. It demonstrates how strong the vision is in deflecting attention from global pathologies of power even in the work of someone who is personally committed to fighting the impact of such pathology as it is embodied on the ground. It also reveals how market-foster-care discourse looks likely to be translated more generally in writing aimed at a broad medical audience. And relatedly, *Awakening Hippocrates* indicates how influential this economism seems set to become as a guide map for visualising the terrain of global health work in the contemporary moment.

At first the argument of *Awakening Hippocrates* appears alert to the dangers of blaming the victim. Early on O'Neil cautions against focusing 'erroneously on corruption when trying to understand why poor countries remain poor'



(O'Neil, 2006a, p. 15). Instead, he follows Farmer in emphasising the pathogenic effects of economic inequality and in graphically describing the horrific personal suffering resulting from poverty. However, as his analysis of the causes of inequality proceeds, the familiar outline of the imaginative geography of pathology also comes into focus. First the concept of the 'poverty trap' is introduced (p. 16). Then Jeffrey Sachs makes several star turns first to emphasise how poverty and global isolation are linked, and then to insist in O'Neil's efficient summary that 'concentrations of wealth don't make people poor' (p. 174), or, as Sachs is quoted as saying himself: 'My own analysis doesn't suggest that the reason that poor people are poor is that rich people are rich. I think rich people are rich because they developed technology successfully to address a lot of challenges and because they were lucky enough not to have some of the ecological barriers that the poor have' (p. 174).

'To a large extent,' explains O'Neil, 'global poverty is determined by climate and location. In a study published in *Scientific American*, economist Jeffrey Sachs and colleagues showed that merely by looking at a map, one could predict a country's wealth' (p. 244). It is this global map of poverty that subsequently does doubly duty as a global health map too. Tropical countries are doomed to poor agriculture and insect infestations, while temperate countries are said to benefit from good summers for growing food grains and healthily cold winters that eliminate insects bearing malaria, dengue and yellow fever. Sachs is thus quoted as saying that 'winter could be considered the world's most effective public health intervention' (p. 245). O'Neil concludes this expedient medical geography lesson by saying Sachs also proved Adam Smith right on the bad luck of being landlocked, and, through this neoliberal reprise to the original liberal linking of land and luck, returns us once more to the map that so rightly, instrumentally and predictably explains poverty based on location. 'Where one's country sits geographically determines to a great extent how poor one will be' (p. 246).

Taken altogether O'Neil's arguments exemplify how depoliticising the imaginative geography of pathological places can become. Here is an advocate of global health service who deeply cares about the embodied violence of economic inequality, but yet who is also guided away from an analysis of global structural violence through his use of an imaginative geography that highlights the pathologies and poverty traps of particular places. The depoliticising power of this map is especially clear when one reflects on the narrative progression of the book which moves from clear acknowledgment of global-local domination near the start to an increasingly obfuscatory insistence on the environment as an independent ecological variable explaining poverty and thus bad health in particular places later on.

The pathologisation of place works thus as what James Ferguson – an anthropologist especially attuned to depoliticising accounts of African

poverty – calls an *anti-politics machine* (Ferguson, 2006, pp. 50–68). In place of extended political-economic analyses of dispossession (and what is undoubtedly its ecological as well as market-mediation), it substitutes an environmental determinism twinned with a moralism that insists that those in more gifted locales have a quasi-religious duty to help out those who are environmentally unlucky. O'Neil's own Christian messianism exacerbates this moralism (also bringing Bono into the inspirational chorus), and there are other concerns that might be raised about how this messianism is itself tied to a US-nationalism and masculinism in the book's references to US military 'service' and all-male list of inspirational examples. However, it is the way in which O'Neil maps out the pathologisation of place, and, in particular, the way his environment-as-independent-variable explanations abstract away from transnational processes of dispossession, that makes *Awakening Hippocrates* such an illustrative indicator of the wider market-foster-care mapping of the terrain of global health.

While *Awakening Hippocrates* aims at explaining the non-medical contexts that necessitate medical action, the World Bank's 2007 *Healthy Development* signals a new focus on medical action as a way of addressing non-medical problems. The poverty trap is in this sense the meeting point of these converging forms of thinking about global health, and the way out of this place of pathology is predictably conceptualised by the World Bank (along with other global governance agencies such as the OECD and UN) in terms of bringing health to impoverished populations so that they can climb the ladder of economic development, compete globally, and enjoy the good health of good growth. There is a clear transition away from the old World Bank austerity order: an order that often involved demands for cost-cutting in health services in order to balance budgets and control inflation as a condition of debt rescheduling (Gloyd, 2004, and Harman this volume). But with the 2007 *Healthy Development* strategy the World Bank does more than just revise its earlier tendency to sacrifice health for growth. It instead portrays good health policies as the very foundation for good economic growth: the vicious cycle and sickness of the poverty trap is transformed into a new vision of a virtuous cycle in which good health boosts good growth which in turn creates a route out of poverty.

Taken on its own – and therefore ignoring the difficulty of implementing the new strategy in the context of ongoing insistence in World Bank Poverty Reduction Strategy Papers (PRSPs) on paying off old debts (Harman, this volume) – the market-foster-care philosophy of *Healthy Development* represents a notable revision to structural adjustment orthodoxy and the normal neoliberal edicts about increasing private provision and market competition. NGO complaints about the pro-privatisation emphases of earlier drafts evidently played a role in shaping the final report, and ironically one of the most important outcomes of these revisions is the strategy's argument for fostering more centralised governmental control over the multitudinous global

scattering of non-governmental health interventions (McCoy, 2007). However, the main goal of *Healthy Development* still remains a form of foster-care for the market, and this care, moreover, is routinely imagined as being administered on a country by country basis. Particular problems of health in particular countries become reinterpreted thus as place-specific impediments to economic expansion because of the ways in which they diminish human capital and discourage inward investment into the particular places under examination.

In other institutions of global governance beyond the Bank, the emphasis on the market-improving outcomes of health-oriented foster-care is also a common feature. WHO policies and the UN's Millennium Development Goal initiatives often echo the same basic idea that targeted relief from poor health will help the poor climb the ladder of market-led global development. Increasingly, though, such commentary is becoming more critical of market failures, especially when it is articulated by non-governmental agencies who do not need to worry about alienating Washington Consensus consensualists. A good example of this hybrid economism between market-foster-care and market failure was recently provided by Joe Cerrell, the Director of Global Health Policy and Advocacy for the Gates Foundation. In a speech entitled 'Making Markets Work' that was published on the IMF's website, Cerrell (2007) offered what was at once an indictment of market failure and an explanation of how he sees private sector health funding providing a compensatory form of foster-care. From the perspective of theorists of neoliberal managerialism his argument for intervention may still seem market-based and entrepreneurial in its formulations about leveraging private sector innovation. Similarly, it is clearly associated with a targeted and vertical bio-medical approach to intervention that many public health specialists argue is limited by its geographical and epidemiological selectivity, as well as by its tendency to use private labour market incentives that can further undermine already insecure public health systems in countries desperately trying to hold on to well-trained local health professionals (McCoy *et al.*, 2006, p. 2180). Yet limited as they may be, Cerrell's criticisms of market failure are no less real or consequential. They also clearly lead to an emphasis on global public goods, and by doing so offer insight into other, much more transnational, imaginative geographies of global health associated with more radical critiques of market failure. It is to these critiques and their geographies that we now turn.

### Market failure and the pathology of inequality

Whereas market fundamentalists see a looming flat world of healthy growth, and advocates of market-foster-care see particular places of pathology in need of bio-medical treatment, critics of market-failure map the terrain of global health with an acute sensitivity to how economic inequalities reflect and reproduce the failure of markets to provide health for all. Such attention to inequality can clearly serve as an antidote to both flattening and

pathologising imaginative geographies. By treating economic inequality itself as a form of pathology, it makes it possible to see the vast asymmetries that exist amidst global economic interdependencies while also enabling much more nuanced analyses of how local patterns of health and affliction are code-termined by political-economic forces. However, approaches to understanding inequality as a pathogenic force take two quite different forms, and each of these forms involves in turn its own distinct imaginative geography of the terrain of global health. The first approach to examining the health effects of inequality treat it as an *independent variable* that can itself explain poor health in space specific populations. The second approach, by contrast, conceptualises inequality as a *symptom* of more systemic economic processes that produce health vulnerabilities *in* and, just as importantly, *across* different spaces. Both discourses are animated by ethical concerns with inequality as an affront to human rights, and both also therefore involve appeals to universal human rights and allied ideals about how good health ought to be a birth-right globally. But when it comes to explaining how inequality curtails improvements in global health, the two imaginative geographies implicated in the two explanatory approaches to inequality serve as very different guides to the global terrain. By first outlining the *inequality as independent variable* approach and turning next to accounts of *inequality as symptom*, we can compare and contrast these guides while also tracking how each one also leads to distinct epistemological and political implications about economism itself.

The most expedient and, indeed, economic way of expressing the argument that economic inequality can function as an independent variable that predicts ill-health is with a formula.

$$LE_{si} = \alpha_0 + \alpha_1 \text{Gini}_{si} + \alpha_2 X_{si} + \varepsilon_{si} \text{ (Zimmerman, 2008)}$$

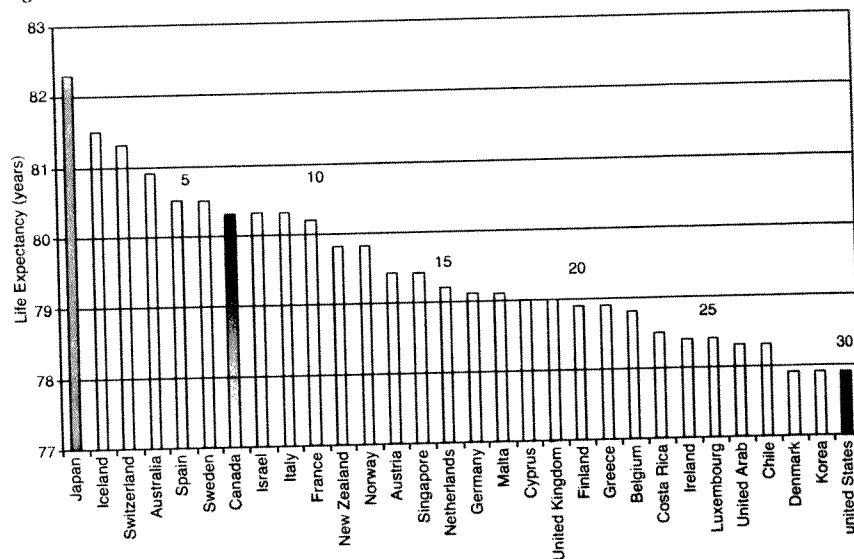
Life expectancy (LE in this example), or some other health metric such as infant mortality, can be expressed in this way as a product of an adjusted measure of economic inequality in a given population, the Gini coefficient, plus various controllable covariates. Following the work of Richard Wilkinson (1992, 1996 and 2002), a large empirical literature now exists that establishes the basis for such formulae in fact, revealing a strong negative or inverse relationship between inequality and health in empirical data sets, including data sets from richer countries that have passed through the so-called epidemiological transition and eliminated most mortality due to infectious disease (Kawachi *et al.*, 1999; Subramanian and Kawachi, 2003; Wolfson *et al.*, 1999).

It is important to underline that the implication of such studies goes beyond the straightforward association of absolute poverty with poor health (the latter being a more fundamental pattern that continues to be documented even by scholars who are skeptics about the explanatory implications of inequality, *for example* Wagstaff and Doorslaer, 2000). The point is

that inequality in and of itself is associated with lowered health standards for populations. As an intervention in epidemiology this has been critical precisely because it shifts attention to a certain sort of market failure at a population level. By moving the epidemiological focus away from health failures of a more personal kind – alcoholism, obesity, drug use, or even the supposed individual failure of being poor – it highlights instead how addressing systemic socio-economic inequalities can do much more than individualistic changes to improve overall population health.

Transformed into a normative argument about social change, the prescription of the inequality-predicts-poor-health argument is also clear. 'Economic justice is the medicine we need.' So summarises Stephen Bezruchka (2001 and 2006), a University of Washington public health professor who has become especially effective at communicating the health costs of inequalities to a wider public. One way he has done so is by reusing the representational rubrics of country-competitiveness rankings. As we have seen in prior sections, putting countries in league tables often ends up pathologising place and localising blame. However, used in conjunction with an argument against the pathologies of inequality itself, such rankings have been assembled by Bezruchka to create a form of global health Olympics (see Figure 6.2).

Figure 6.2 Health Olympics 2005



Source: Population Health Forum, n.d.

In this way he can point to the market-mediated failure of the US – which spends the most money on healthcare but ties for 30<sup>th</sup> place in the global health Olympics – while simultaneously upholding other, more egalitarian models of population health as bar-setting benchmarks for 'gold' in global health standards. Such subversion of business competitiveness rankings seems to represent a particularly creative way of representing arguments about market failure in a global context that remains dominated by the competitive logics of market fundamentalism. However, just as with cost-effectiveness research on 'given' populations, the rankings of the global health Olympics are limited to the extent that they remain prisoners of the proximate. Based on *national* health and income distribution statistics, and calling attention to correlations between these statistics within discrete *national* spaces, the rankings remain unable to address the ways in which *transnational* processes of exploitation and dominance might also codetermine differences in health outcomes. Japan's 'gold', for instance, may well reflect the fact that it has less income inequality than the US, but it also may be an outcome of the ability of Japanese corporations to generate income and good pensions for Japanese citizens while outsourcing some of the most exploitative and hazardous parts of commodity production to other Asian countries (see also Bezruchka and Namekata, 2008).

More generally the literature charting how economic inequality and poor health are correlated *within* discrete statistical spaces remains imprisoned by an epistemology focused on finding space specific independent variables in contexts shaped by historically changing and globally interdependent forms of codetermination and overdetermination. As health economist Fred Zimmerman has pointed out with mathematical precision, 'as long as there are some potential confounders that have not been or cannot be measured and included in analyses, this research endeavor will be hung over with question marks' (Zimmerman, 2008, p. 1886). The most common question mark of all, of course, concerns *why* exactly inequality predicts poor health. Expressed as an equation, the causal connections underpinning the association are only ever presented in the form of a black box. Moreover, when scholars such as Wilkinson attempt to go inside this black box and create hypotheses that might account for the correlations, their approach is often held captive to an individualising epistemology that seeks to track the ties through the psychosocial link of stress. They argue that even small economic inequalities cause stress and thus lower average life expectancy. By pointing to famous studies such as Michael Marmot's (on the lower life expectancy of lower ranking Whitehall civil servants), they reason thus that inequality-induced physiological stress in turn induces vulnerability to premature death (Wilkinson, 2002; Marmot, 2001). No doubt there is some explanatory significance in these ties (Sapolsky, 2005), but, as other critics point out, they tend to obscure wider power relations of class and market-mediated exploitation (Muntaner and Lynch, 2002). This makes it

hard to break out of the epistemological prison of the proximate. Thus even when investigators of the health-inequality association attempt to socialise their accounts with further attention to the so-called social capital, social cohesiveness and social goods that shape the effects of inequality, the analyses still remain unable to address market-mediated processes that transcend the spaces of different statistical populations. One unfortunate outcome of this is that there is a built-in tendency in the method to return to blaming the victim, suggesting that it is country-specific and population-wide deficits in social capital that account for poor health outcomes rather than, for example, the market fundamentalist austerity policies enforced by neoliberal elites (for evidence of the latter argument, see Navarro and Shi, 2002). This problem highlights in turn another wider weakness in the literature on inequality and health: namely its neglect of the processes, including the often transnational processes, that actually produce inequalities. Given the well-documented rise in in-country inequalities that has accompanied the global expansion and entrenchment of pro-market models of governance (ILO, 2004; Harvey, 2005; Wade, 2004), this is an especially limiting lacuna (but see Bezruchka, 2000). It is not without reason, then, that Vincente Navarro, one of the world's leading scholars of neoliberalism and public health, has complained that:

Missing from this literature are analyses of *how* and *why* the social inequalities within and among societies are generated and reproduced, and *how* the socioeconomic and political forces responsible for this situation are affecting the quality of life of our populations (Navarro, 2002, p. 1).

Approaching global health with the attention Navarro demands to how inequalities develop in and between societies around the world clearly does not mean abandoning inequality as a socio-economic focus for analysis (Marmot, 2007). However, it does demand a reconceptualisation of inequality as a product of complex, historically-changing and often globe-spanning processes. In short, it means treating inequality as a symptom rather than as an independent variable. Not surprisingly perhaps given the familiarity in health research with the complex causal mechanisms underlying medical symptoms, the symptomatic approach and the associated medicalisation of economic metaphors has proved especially inspirational to global health scholars concerned with answering the sorts of how and why questions posed by Navarro. Thus a growing number of books are emerging with titles that reflect a keen sensitivity to how illnesses and inequality emerge in tandem as symptoms of more complex and space-spanning socio-economic pathologies. *Dying for Growth* (Kim *et al.*, 2000), *Sickness and Wealth* (Fort *et al.*, 2004), and *Health and Illness in an Increasingly Unequal World* (Wermuth, 2003), all reflect this symptomatic approach to inequality in important global health texts, as too do the titles of at least two of Paul Farmer's influential books: *Infections and Inequalities* (Farmer, 2001) and *Pathologies of Power* (Farmer, 2005). Farmer,

of course, has led the way in charting this more globally searching approach to inequality, and, while his NGO *Partners in Health* has been funded by market fundamentalists and while Farmer himself has been beatified by market-foster-care interventionists for his work as a physician to the poor, his written analyses provide some of the best and most sophisticated maps we have of how market failures contour the terrain of global health.

To be sure, Farmer has been criticised by anthropologists for not going far enough to socialise and complicate economic explanations of affliction (see the responses in Farmer, 2004). It seems at times that his sensitivity to the cultural politics of blame and culturalist excuses for substandard care lead him thus to downplay the ways in which racial violence and gendered violence overdetermine the economic imperatives of structural violence. But he does still clearly examine racialised and gendered inequalities too, and while describing these forms of oppression in terms of power 'inequalities' risks reifying power as a quasi-economic commodity that can be hoarded and withheld, it can equally open post-economic pathways for examining these same relations as profoundly social determinants of health globally. This is exactly what enables Farmer's embodied but global remapping of the terrain of global health. Sometimes following Farmer, sometimes not, this is also clearly what a growing number of global health researchers are doing as they too explore local examples of socio-economic inequality as symptoms and thus entry-points into mapping multi-dimensional global pathologies of power. Vinh-Kim Nguyen and Karine Peschard have thus documented in detail how anthropologists and other ethnographic scholars have contributed to studying affliction as a form of embodied inequality in the context of global neoliberalism. 'Ethnographies on the terrain of this neoliberal global health economy,' they note, 'suggest that the violence of this inequality will continue to spiral as the exclusion of poorer societies from the global economy worsens their health' (Nguyen and Peschard, 2003, p. 447). In a different way, but with epidemiological attention to mapping some of the same terrain, Nancy Krieger notes that as social epidemiologists have turned to examine the diverse diseases associated with socio-economic inequalities their work has also prompted new multi-dimensional spatial depictions and eco-social analyses (Krieger, 2001, p. 671). And meanwhile, other scholars studying the global inequalities embodied in particular diseases such as AIDS suggest that simple one-dimensional visions of 'global health' risk ignoring the material conditions of those who suffer most. Contrasting AIDS in South Africa with the very different experience of the disease in the US, Mark Heywood argues thus that: 'Today the notion of global health is a misnomer' (Heywood, 2002, p. 218).

For the many researchers, activists and policy-makers who want to end the misnomer and make global health a reality, the entry point of inequality has also proved clarifying and productive in remapping the terrain of global health governance too. The People's Health Movement (<http://www.phmove->

ment.org/cms/) and a host of health activists meeting at gatherings such as the World Social Forum (Sparke *et al.*, 2005), have thus moved far beyond treating economic inequality as an independent variable that policy-makers must simply correlate and chart in relation to population life expectancy. By treating it as a symptom instead, and by tracing its formation as both globally produced and locally embodied, they have thereby sought to revitalise a global vision of 'health for all' while also outlining all the many social determinants that present obstacles to realising the hopes articulated in 1978 at Alma Ata (now Almaty in Kazakhstan). This has led on the one side to various restatements of the health for all vision, including the 1986 Ottawa Charter, its more recent renewal in Bangkok, and rearticulation in the People's Health Charter (People's Health Movement, 2008). And this in turn has clearly been one of the important inspirations behind one of the most universal and inclusive revisionings of global health citizenship by the WHO that has yet been seen: namely, the finely critical 2008 report of the Commission on the Social Determinants of Health (2007).

### From remapping global health to remaking global governance

While the People's Charter for Health represents a vision of global health governance by non-governmental critics of market failure, its advocates have not hesitated from attempting to challenge formal agencies of global health to take up its global political-economic vision. 'Although some would argue that issues such as trade and financial markets fall outside the remit of the WHO,' they argue, 'we believe that the WHO should advocate changes to the macroeconomic and political determinants of ill-health if we are to reduce child and maternal mortality, achieve universal access to antiretroviral treatment, and allow all countries to pay their health-care workforce an adequate living wage' (McCoy *et al.*, 2006, p. 2179). No doubt such calls to remake global health governance resonate deeply with all critics of market failure whether they be concerned with inequality as an independent variable or as an interdependent symptom. However, we should briefly reflect in closing on the ways in which the playing field of global health nevertheless remains set up against them.

For the market fundamentalists who claim that the playing field is flat, the advantages of claiming that the free market knows best and there is no alternative are enormous. As we have seen, the inconvenience of having to exclude the poor from treatment because of their ineffective demand can be concealed by appeals to global flattening even as it is used as an argument against the unrealistic ethics of health for all. Meanwhile for the advocates of market-foster-care it is the challenges of poverty traps and endogenous ecologies of ill-health and economic malaise that are the real problems. They do not so much want to change the global marketplace as enable more places to join it by intervening and removing the burden of

disease. These are ethically accountable alternatives to the unaccountable market fundamentalist ideology of *laissez-faire*. However, as we have also seen above, by setting palliative goals, pursuing these goals with a biomedical bias in vertical and privately-funded interventions, and pathologising particular places along the way, advocates of market-foster-care do not consistently address the deep global pathologies identified by critics of market failure. What they do however do with remarkable success is colonise the language and landscapes of 'alternatives' in global health. As critics of market failure continue their efforts to repossess this landscape for the globally dispossessed, it will be useful to have better, more reflexive understandings of the maps being used by all the different disputants. Hopefully this chapter contributes these, as well as a convincing argument that these mappings matter in actually shaping the terrain and thus the possibility of real global health.

### Notes

- 1 My thanks to Griffith University's *Democracy, Security & Public Policy* Strategic Research Program for supporting the Brisbane conference on global health governance at which this paper was first presented. My thanks to Kelley Lee for her encouraging comments in Australia and for alerting me to the history of tropical disease in London. In addition, I am grateful to all the ideas shared by students in my Spring 2008 graduate class on Global Health at the University of Washington.

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