



Perspective

# Can the Sick Speak? Global Health Governance and Health Subalternity

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**Abstract:** Global Health Governance (GHG) uses a set of financial, normative, and epistemic arguments to retain and amplify its influence. During the COVID-19 pandemic, the GHG regime used its own successes and failures to prescribe more of itself while demanding further resources. However, the consistent failures of this form of governance and its appeasement to a dominant neoliberal ideology lead to the following question: Is the global health governance regime failing at its goal of improving health or succeeding at other political and ideological goals that necessitate such failures? Using concepts and ideas from social theory and post-colonial studies; I examine the definitions, epistemic basis, and drivers of GHG and propose certain conditions for the legitimacy of a global health governance system. Examining historical and current cases, I find that the GHG regime currently fails to fulfil such conditions of legitimacy and instead creates spaces that limit rather than help many populations it purports to serve. Those spaces of sickness confine people and reduce them into a state of health subalternity. In being health subalterns, people's voices are neither sought nor heard in formulating the policies that determine their health. Finally, I argue that research and policymaking on global health should not be confined to the current accepted frameworks that assume legitimacy and benevolence of GHG, and propose steps to establish an alternative, emancipatory model of understanding and governing global health.

**Keywords:** global health governance; COVID-19; COVAX; subalternity; neoliberalism; necropolitics; post-colonialism; social theory



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## 1. Introduction

Global health gained prominence as a field of governance over the past three decades (Packard 2016; Fidler 2009; Kenny 2015), a status that has been further elevated by the COVID-19 pandemic with its devastating impact on people's health and the economy.

Global health actors use their financial, normative, and epistemic power (Shiffman 2014) to increase their political influence and exclude other discourses and solutions. This is seen in the proposition of a binding legal instrument for pandemic preparedness and response under the auspices of the World Health Organization (WHO 2021) to the exclusion of other extra-institutional solutions.

A pandemic treaty can increase the global capacity to mitigate the negative effects of future pandemics (Ghebreyesus 2021; Nikogosian and Kickbusch 2021), but it also continues to seek solutions exclusively with the same of dominant actors who claim sole legitimacy.

I argue that conditions of legitimacy are often lacking and question GHG's claims of aiming to achieve health equity and examine whether other motives can better explain the current structures of GHG, its often-paradoxical policies, and its shortcomings.

I propose a model that might explain the failures observed where GHG serves, in addition to their explicit health goals, both to perpetuate the power of its dominant actors and to maintain the dominant neoliberal status quo (Navarro 2007; Kim 2021).

As a result, the financial and normative power of GHG creates spaces that confine marginalised, racialized, gendered, or otherwise excluded populations. Those spaces of sickness arrest the future potential of people through their all-consuming occupation with their health and well-being and those of their families and communities. Thus GHG, by determining who must die and who can live, acts as a necropolitical agent that creates a wide-spread state of health subalternity.

The health subaltern has no agency over their health or the policies that determine it. Their perpetual ill health then determines their social, cultural, economic, and political potentialities. The health subaltern cannot speak. They are silenced by an absence of agency imposed on them by dominant powers that use the GHG regime as its agent.

I conclude that by taking the claims of benevolence made by GHG at face value, academia and civil society can become complicit in its harm. I finally propose some ways forward to shift to an emancipatory global health governance.

## 2. Trickle-Down Moral Failure

I recently spent a day at a “summit” that brought together a large segment of the global health oligarchy. Prominent global health figures made speeches about the future and about the great work they do every day. The conference took place in a cinema-turned-conference centre, which ironically sits on Karl Marx Strasse in the heart of Berlin. Experts defined concepts, discussed goals, and navigated with ease across a sea of jargon and acronyms. There was no patient in sight, nor was there a mention of one as far as I could tell.

A few years earlier, I worked in the paediatric ward in Magaria District Hospital near the Niger-Nigeria border, which hosted a Médecins Sans Frontières (MSF) project for over a decade after the famine of 2005 (Fleshman 2005). On this side of the global health universe, I stood with a treating clinician and an interpreter at the bedside of a child suffering malnutrition and severe malaria. The child needed an urgent blood transfusion and the interpreter, who explained the situation to the child’s mother, told us that she has consented to the procedure. I could barely hear the muted voice of the mother, but at that moment, intervening in the hope of saving the child’s life superseded the need to fully contemplate the nature of informed consent.

These two experiences could not be any more different. The people and the environment, the climate and the scenery, the setup and the company, were worlds apart despite the summit’s ostensible goal of determining, albeit indirectly, conditions on the paediatric ward; while the latter, and similar such healthcare services, supplied the knowledge that informed the summit.

However, one thing was common to the two events: the patient whose existence is the *raison d’être* for both the ward and the summit had neither been heard nor was able to speak (Biehl and Petryna 2014). As such, patients and communities suffering the risk of ill health remain the objects acted upon by global health, rather than the subjects of the collective pursuit of health equity.

## 3. Defining Global Health and Its Governance

Global health still lacks a convincing definition of its nature (Koplan et al. 2009; Salm et al. 2021), what constitutes its governance, its actors (Hoffman and Cole 2018), and its epistemic basis (Shiffman 2014; Kenny 2015).

Existing definitions assume benevolence. A common definition, for example, is that of Frenk and Moon (2013): “The global health system is the group of actors whose primary intent is to improve health, along with the rules and norms governing their interactions”.

Such an assumption of benevolence lacks empirical evidence. It can, however, mask other motives of global health actors and distort analyses of the system, its achievements, and its failures.

Recent literature, however, argues that global health does not only have its explicit function of improving health but an implicit ideological function of maintaining existing power structures (Kim 2021; Sparke and Williams 2021). Moreover, the combination of the

“mood of failure” of global health governance (Kay and Williams 2009) with the continuing legacies of its colonial past must arouse more scepticism (Fofana 2020; Affun-Adegbulu and Adegbulu 2020; Akugizibwe 2020; Abimbola and Pai 2020; Khan et al. 2021; Chaudhuri et al. 2021).

To better grasp global health and its governance, I propose the following definition: “Global health governance is any set of deliberate institutional<sup>1</sup> policies or actions that systematically affects health beyond national borders whether directly or indirectly, negatively or positively. Such policies are shaped by dominant power balances, hierarchies, politics, and inter-dependencies”.

This definition accounts for actors whose primary engagement is not in health, such as mass and social media in relation to the spread of misinformation and disinformation and the extractive industry in relation to environmental degradation. It also accounts for positive and negative impacts on health regardless of the intentions of the actor.

#### 4. Epistemic Challenges

The need for a new epistemology of global health is evident (Marstein and Babich 2016). However, for the purposes of this paper, I will address a few pressing epistemic challenges:

First, the current academic work on global health comes from a narrow worldview generated in Western universities that act as gatekeepers for what knowledge can be produced and accepted. This results from a Eurocentric and colonialist history based on the exclusion and elimination of other worldviews (Grosfoguel 2013; Erongu et al. 2020). Alternative sets of assumptions, world views, and methodologies are required (Alvarez 2011; Keikelame and Swartz 2019; Smith 2012).

Second, the predominant academic discourse on global health is confined to the accepted liberal/neoliberal world order where GHG situates itself in a space of sovereign nation-states acting as custodians for the health of people they govern. This limits the available solutions to health inequities within this framework, and on the implicit condition of not challenging dominant ideologies.

Finally, knowledge production in global health, particularly as it comes to the mainstream due to COVID-19, happens within other disciplines such as philosophy, sociology, anthropology, and security studies (Zizek 2020; Davis 2022; Boston Review 2020; Lord 2020; Malm 2020; Bratton 2021) but rarely finds a place in high impact global health journals.

A shift in the epistemic framework of GHG that should approach it within its historical context, examine it from new and trans-disciplinary angles such as social and critical theory and post-colonial studies, and question its purpose, mechanisms, stakeholders, and power.

#### 5. COVID-19 and the Power of GHG

Global health governance, as a diverse set of objectives and actors, has both been part of the successes and failures of the response to the pandemic. It has also benefitted from both those successes and failures.

The world was caught unprepared to respond to the pandemic despite the inevitability of a pandemic being a matter of common knowledge both in academic and political discourse (Barclay 2008; Obama and Lugar 2005). The initial shock came particularly from the massive effect of the pandemic on people living in HICs where advanced health systems and abundant resources didn't spare Italy initially then the United States and the United Kingdom from the pandemic's disastrous loss of life and overload on their respective health systems.

By the time of writing this paper in June 2022, COVID-19 had killed more than 6.3 million people<sup>2</sup> and caused the world economy tens of trillions of dollars in losses<sup>3</sup> while continuing to evade complete control attempts.

The development of multiple vaccines for SARS-CoV-2 and their abundance in HICs didn't bring much reprieve either, as ideological battles continued to fuel vaccine hesitancy and cause new surges (El-Mohandes et al. 2021; Bennhold 2021). In the meantime, LMICs

continue to lack access and have low vaccine coverage despite the mechanisms created to ensure the equity of vaccine delivery globally<sup>4</sup>.

Global health demanded and spent massive resources during the pandemic. One of the mechanisms, the “Access to COVID Tools Accelerator (ACT-A)”, for example, budgeted for over USD38 billion for 2020–2021 and secured nearly USD19 billion in funding<sup>5</sup>. This still doesn’t account for billions in funding for research and development of vaccines and other technologies paid directly by states to pharmaceutical companies to develop vaccines and other technologies.

#### *Global Health Outcomes during COVID-19*

The failure of global health in preparing for and responding to the COVID-19 pandemic is now evident. Countries like the United States, who were thought to be best prepared (Oppenheim et al. 2019; Abbey et al. 2020), suffered catastrophic failures in their response, which led to massive impacts on people’s lives and economic well-being.

Furthermore, the inequitable distribution of vaccines, among other indicators for the response, provides evidence for a global failure on top of that of individual states. This collective failure of the COVID-19 response arguably resulted from the protectionist attitudes of HICs whose self-interest took priority over even the pretence of solidarity with others. However, GHG designed and established the normative frameworks that failed to respond to the pandemic.

One of the main tools to the pandemic response was the creation of COVAX, a mechanism for the procurement and distribution of vaccines that was supposed to build on the strengths of the system and provide a more equitable distribution of vaccines once they became available.

COVAX is a Public Private Partnership (PPP) that went beyond the limited traditional model and hence was described as a Super PPP (Storeng et al. 2021). It proclaimed a goal of vaccine equity, but even the humble goals of vaccinating 20% of the at-risk population in poorer countries became untenable as HICs started buying and hoarding the vaccines when they became available. COVAX, described optimistically as a “beautiful idea”, not only failed to achieve the goals assigned to it by the same stakeholders that were the cause of its downfall, but it also became a reason for further delays in obtaining vaccines for countries that put their faith in its ability to function (Usher 2021).

Rather than admit the failure of COVAX and the global health community that was described by the Director General of the World Health Organization as ending in a situation of “vaccine apartheid”<sup>6</sup>, many in the upper echelons of global health governance insist on defending its existence (Berkley 2021) and even asking for more funding for the same mechanisms that have consistently failed to achieve their announced goals. The Director General of WHO described the moral failure and vaccine apartheid went on to ask on 28 October 2021 for more than USD23 billion in additional funding for ACT-A<sup>7</sup>.

## **6. Conditions of Legitimacy**

Questioning the legitimacy of a narrow set of institutions that govern, analyse, and allocate resources in GHG on behalf of the global population is essential, especially if its inability to deliver its explicit goals, both current and historical, have no sign of abating.

Legitimacy cannot be granted by the mere acceptance of the system by dominant geopolitical actors, especially as the dominant market-driven and/or populist ideologies that perforates and mobilises them is incompatible with and often in opposition with the wider health and wellbeing of wide swathes of people. (Navarro 2007; Kenny 2015; Sparke and Williams 2021; Daley 2013; Rushton and Williams 2012; Sengupta et al. 2018; Smith 2016).

While GHG has attempted to rebrand itself away from the colonial legacies of international health and tropical medicine and weave contemporary narratives of health improvement and equity (Packard 2016; Fofana 2020); it has not gained legitimacy either in principle nor in the eyes of people most marginalised by its impact (Fukuda-Parr et al.

2021; Lakoff 2017; Ottersen et al. 2014) as well as in the expanding activist and indigenous people's circles<sup>8</sup>.

The concern of GHG with its recognition by dominant powers has resulted in further marginalisation and exclusion of the people it purports to serve—patients and communities at elevated risk of ill-health both in poorer and richer countries—and resulted in the reproduction of the oppression inflicted upon people who share the loss of agency over their bodies, health, and life, and who are subjugated to power and politics in a way that instrumentalises their existence.

I suggest that the GHG regime should obtain its legitimacy from people who are sick and communities at an elevated risk of ill-health resulting from complex and overlapping oppressive circumstances, rather than from the global power brokers who supposedly confer such legitimacy. Currently, those who should legitimate the policies and actions of GHG are not only unheard, but any utterances of their views of what constitutes their health and how it can be realised are diluted by a dense network of overlapping and inter-connected layers of custodianship imposed by frequently undemocratic local authorities and self-mandated by external agents, including influential foreign governments, corporations, development and humanitarian international organisations, and philanthro-capitalist entities (Bosworth 2011; McGoey 2012).

Observing the track record of this collective GHG regime, I argue that they are more interested in the silence of the sick rather than in their empowerment and emancipation that would result from attainment of health on their own terms and with their collective inclusion and involvement.

By and large these layers of bureaucracy, power, and influence serve to reproduce and perpetuate the current dominant neoliberal ideology, the constitution and consequence of which is the creation of a global class of people who exist precariously in a perpetual cycle of subordination to ill health that not only restricts their development but also any chance to challenge existing power structures and institutions.

I propose a model where the proper legitimacy of a GHG regime hangs on several interdependent attributes:

- GHG regularly achieves better health and health equity through its policies.
- Populations regain agency over their bodies and lives and can imagine and realise routes to a healthy life within their own epistemic, cultural, and social frameworks.
- GHG policies and actions are verifiably intended, above all else, towards the objective improvement of peoples' health and achievement of their potential.
- GHG ensures the balance of health policy with other priorities (economic, social, political, and cultural) consideration identified by the people affected by the policies.
- The demonstrated reactivity and accountability to people whose health is affected by such policies.

A legitimate global health governance is, in short, an emancipatory force rather than a subjugating one.

## 7. Elusive Legitimacy

GHG does not fulfil the conditions of legitimacy proposed above. It is a given that achieving positive outcomes consistently in a field as complex and contingent as global health is difficult; however, the loss in legitimacy is not due to any given event or failure but to those consistently not leading to systemic change rather than promises of reform and superficial adjustments.

### 7.1. A History of Failure

While some successes are undeniable like the elimination of smallpox and the reduction of measles prevalence as well as the massive reduction in child mortality due to the widespread vaccination programmes, those cannot obscure or justify other systemic and repeated failures.

In addition to the failure in responding to COVID-19 described above, the broken promises of “Health for All” by 2000 (Chowdhury and Rowson 2000; Hall and Taylor 2003; Meier 2010), treating 3 million people with HIV/AIDS by 2005 (Harries 2005), the response to the 2013–2016 Ebola epidemic originating in West Africa (Kentikelenis et al. 2015), and the Millennium Development Goals (Cimadamore et al. 2016; Briant Carant 2017) are some of the examples of a habit of overpromising and under-delivering.

Justifications for such failures note a generalized lack of political will, resource deficiency, systemic complexities, and competing interests of major actors. Such justifications often ignore the underlying causes of protectionist nationalist politics and the neoliberal commodification and liberalisation of health (Rushton and Williams 2012; Kay and Williams 2009; Sparke and Williams 2021).

Other justifications relate to specific failed responses and can include unanticipated epidemiological shifts, political actions of states or other actors, or logistical complexities. All are mentioned within a generalised denial of the failure itself and with unproven theories of worse situations without the current system.

The response of Seth Berkley, the CEO of GAVI, to a critique of COVAX (Berkley 2021) is a good example. He states that the (massive and continuing) delays in delivering COVID-19 vaccines were due to “the early supply being bought by a small group of wealthy countries and the unfortunate epidemiological situation in India”. He goes on to speculate: “The counterfactual without COVAX would be a Lord of the Flies-like effort with more than 200 countries trying to negotiate deals with a myriad of manufacturers”.

While denying or justifying its consistent shortcomings, GHG continues to prescribe itself as a remedy for its own failure. This prescription is often accepted, if with some demands of reform and course correction (Gostin 2015; Moon et al. 2015; McInnes 2015).

However, the consistency of failure of GHG gives rise to the question of the implicit intentions of the system. In other words, is it consistently failing to achieve its pronounced mission of improving health globally or is it succeeding at a wholly different function?

### 7.2. *Serving Dominant Ideologies*

The status quo in global health governance often accepts, and inadvertently legitimates, the inequalities reproduced by Western universalism (Affun-Adegbulu and Adegbulu 2020), predatory neoliberalism (Rushton and Williams 2012; Sengupta et al. 2018), continuing legacies of colonialism (Akugizibwe 2020; Banerjee 2002; Büyüm et al. 2020), and increasing isolation inside national populist bubbles (Lasco and Curato 2019; Lasco 2020).

Global health governance, in a manner similar to other forms of international aid, reproduces a highly problematic form of what Hobson (2017) calls a paternalistic “liberal imperialism” that seeks the “cultural conversion to liberal norms of behaviour that are deemed by the paternalizers to be in the *real* interest of the object peoples”. The conversion here is neither only cultural nor is it abstract; it invades and limits people’s bodies, prevents them from achieving a life they would deem healthy, forecloses the potentialities a healthy life provides, and brings about their demise.

### 7.3. *Self-Perpetuating System of Power*

Iatrogenesis, or the ill effect caused by a medical or health activity, is not a new concept. Ivan Illich (1974) expanded the concept from the clinical to the social and cultural in his book *Medical Nemesis: the Expropriation of Health*. He describes social iatrogenesis where medical providers have a vested interest in perpetuating sickness, creating unrealistic health demands, and treating non-diseases. Additionally, he calls cultural iatrogenesis the destruction of traditional ways of understanding death, suffering, and disease. Moreover, the self-interest of medical providers has been described as the medical-industrial complex already before the time of GHG (Relman 1980).

This is more evident than ever in the case of GHG that favours leadership from a narrow oligarchical elite composed mainly of white men from HICs. This monotonal concentration on the top tier of global health has not changed even when opportunities arise. Moreover, even

when others (women, people of colour) reach the leadership of global health organisations, they are likely to have been assimilated into the same epistemic realm through education in a narrow set of institutions in the Global North ([Global Health 50/50 2021](#)).

When GHG responds to its own failures by prescribing more of the same, it implicitly prescribes more of the same leaders and their worldviews. The service of dominant ideologies here is also a selfish service to their own interest in continued power and prestige.

## 8. Questioning the Intentions of Global Health Governance

Is GHG then failing at its role of improving health or is it succeeding at another political and ideological goal which necessitates such failure?

[Kim et al. \(2019\)](#) find that democratic deficit, depoliticizing of the discourse, and marginalization of scholarship that interrogates relations to power reproduce inequalities in global health outcomes despite the improvements it achieves. These emerge from neoliberal domination of international financial institutions such as the IMF and the World Bank and their drive for Structural Adjustment Programmes. While I agree with Kim et al.'s analysis of the ideologies and their historical origins, I go a step further and argue that the inequities implicit in the current GHG aren't just what emerged because of those histories but what is *required* of the GHG by the current dominant neoliberal ideology.

## 9. Problematising Global Health Governance

There have been multiple attempts at classifying the drivers and modes of action of global health. [Frenk and Moon \(2013\)](#) list the production of global public goods, management of externalities, mobilisation of solidarity, and stewardship as the main drivers of the system. [Lee \(2009\)](#), on the other hand, counts four normative bases of global health: biomedicine, economism, security, and human rights.

A more analytical approach was taken by [Lee and Kamradt-Scott \(2014\)](#) in seeking conceptual clarity. They distinguish three concepts of global health governance: The first is globalisation and health governance that is concerned with health institutions (such as the World Health Organization) governing collective responses to health issues that are deemed global and that deal with health issues arising from the intersection of the globalised economy and local lives. The second is the global governance and health analysis institutions outside of the health sector, mainly economic ones such as the IMF and World Bank, with effects on health in low- and middle-income countries. Finally, governance for health, a more normative view of the governance arrangements that further particular health goals, such as access to medicines and primary health care.

While Lee and Kamradt-Scott's conceptualisation is useful, none of the classifications above address the issue of intention or implicit purpose of global health as an institution.

I classify global health drivers with a view of their apparent intention. Here, I use one normative driver and two critical perspectives ([Table 1](#)). The normative perspective covers governance for better health, where global health actors provide policy and programmatic inputs that primarily intends and leads to better health outcomes for people who need it most. The two critical perspectives take other motives into consideration. One of these drivers is related to what global health actors do to stay in their privileged position. The design of COVAX and the continuing insistence on using it despite its lack of performance is not for the lack of other possibilities, but because other possibilities don't keep the power over the system in the hands of the same players. Finally, the third driver is governing through health. This is when non-health actors cause positive or negative effects on health beyond their national borders while serving their own political agenda, without necessarily intending to do so. The dispute on intellectual property rights for pharmaceutical companies is about protecting private businesses, and the negative health impact of intellectual property rights is an externality of neoliberal practices. Another example is the gag rule that bans organizations funded by US foreign aid from performing or aiding in the termination of pregnancy. This is not about the health of women in LMICs but about the appeal to a conservative electorate.

**Table 1.** Drivers of Global Health Governance.

	Governance for Health	Governance of the GH System	Governance through Health
Motive	Improving health	Retaining power	Achieving political ends
Actors	Health providers, civil society, local health authorities	Global health brokers (IOs, foundations, INGOs)	Governments, corporations
Methods	Public health	Health diplomacy	Domestic policy
Location	Communities affected by ill health	GHG circles, headquarters	Capitals
Examples	Smallpox eradication, extended programme for immunisation (EPI), treating HIV with generic medicines	WHA and executive board, governance mechanisms, COVAX	US global gag rule on termination of pregnancy, trade deals, IP protection, Structural Adjustment Programs

### 10. The Politics of Life and Death in Global Health Governance

The global health governance regime chooses who is allowed to live, and hence, who must die. This system that is assigned the de facto role of allocating the available scarce resources possesses power beyond its technical or moral capacity and does so without any mandate from the people whose lives it determines. This politics of life and death is reminiscent of what Achille Mbembe (2003) describes as Necropolitics<sup>9</sup>. However, in the case of global health governance, the power of choosing who may live and who must consequently die has moved from the war room controlled by generals into meeting rooms in global health institutions controlled by technocrats.

The politics of life and death in global health carries the echoes of the colonial “civilising mission” and the “white man’s burden” that has acted as a cover for the colonial endeavour. Global health has what I describe as a “healing mission” that takes place despite the people it ostensibly serves rather than for and with them. Hence, the interest of the sick is only determined by the global health system that claims to act in their best interest without providing them with any recourse to choose what health might mean to them or how they might want it to be realised. This form of governance fits in what Hobson (2017) describes as imperialistic international paternalism.

Global health is co-opted into the role of serving the dominant powers. Those are the ex-colonial nations that continue to dominate politically and economically and corporations that control the junctions of the global economy. It is, hence, not ontologically malevolent. Its malevolence is based on accepting to be subordinated to the interests of a hegemonic order that aims to keep power in place and to prevent an emancipatory act from taking place by the people it serves.

Global health governance accepts its role as one of the guardians of the current hegemonic order, in part, because that serves the self-interest of those who are on its helm. This leadership is mostly comprised of white males from rich countries (Global Health 50/50 2021). This elite oligarchy largely comes from the educated upper classes who identify more with other global elites than with the people they impose the politics of life and death upon. The liberal “progressive” appearance of such elites does not mask their imperialistic tendencies (Hobson 2017).

Another reason for the subordination of GHG to political and economic interests other than those of the people it serves is a false sense of scarcity of resources. Resources available for health equity globally are only scarce as far as they are not provided. They are available and relatively inconsequential to the larger global economy. This can be gleaned from the numbers: the global health sector’s share of development assistance in 2019 amounted to a mere USD22.4 billion<sup>10</sup> compared to a nearly USD2 trillion in global military expenditure in 2020 (da Silva et al. 2021).

The imaginary scarcity of resources makes it impossible to fulfil even the most basic health needs of the sick and communities at high risk of ill-health. The global health experts are hence reduced to the role of triage. This triage, as the name suggests, is not only about equity of outcomes but also about efficiency in achieving programmatic goals. Such triage



boils down to providing cheaper interventions such as vaccines (as opposed to life-long treatments for chronic conditions, for example) to specific populations using arbitrary measures such as allocating resources to nation-states according to the GDP per capita rather than based on the actual needs as identified by the people at the receiving end of such interventions.

The politics of life and death is outsourced to global health technocrats who often come from backgrounds that do not allow them to see the needs, contexts, politics, desires, bodies, or humanity of the populations they supposedly serve. The technocrats then espouse efficiency and cost-effectiveness of interventions. These neoliberal views attribute more value to the interventions that are effective rather than those that are more suitable or desirable for people they target. They end up, wittingly or not, serving to consolidate the *status quo*. The global health governance regime, therefore, serves as the class that enforces global hegemony by “extending the world view of the rulers to the ruled” (Bates 1975).

### 11. Spaces of Sickness

By this arrangement, acting on and justifying the macabre outcomes of the politics of life and death falls directly into the interest of a global patriarchal, neoliberal, populist nationalist, and neo-colonial world order that doesn't materialise in a single government or governance structure, but rather in the global interests of a hegemonic class.

This can explain why global health policies and actions reduce mortality and bring a certain level of health to the poorer populations of the world while never going (or aiming to go) far enough to achieve full health and the potential life that comes with it. This state of being of the sick and their communities consumes them in a constant health anxiety where disproportionate time and effort is put into reducing pain, curing illness, avoiding starvation, finding resources, reducing risk of injury, and caring for the ill.

This space of sickness left in place by the GHG spans whole populations who live on the edge of sickness and the consequent poverty, lack of potentiality, and exposure to violence (Chakraborty 2021). In it, people are offered solutions that are exclusively within a Western epistemic conception of health and disease. These solutions are often unaffordable to them and can only be obtained if the global health system deems them a target to its policies and programmes. The solutions are technical, biomedical, and void of any similarity to the culture or epistemic frameworks of the affected populations.

To receive the benefits of global health philanthropy, the inhabitants of those spaces of sickness must wholly accept not only the biomedical but also the cultural dimensions of global health solutions. They will have to acculturate, give up their own conceptions of what constitutes health and wellbeing, and accept the totality of the Western epistemic framework of health and disease (Stephens et al. 2005; Biehl and Petryna 2014; Smith 2012). Without such blanket acceptance, people and their communities lose their access to services rendered by global health and are labelled incapable of adhering to treatment or as altogether backward and unable to understand the science or the values of modern healthcare (Adams 2013; Barnes and Brown 2011).

The acculturation that takes place not only strips communities of their conceptions of health and wellbeing, it also renders them dependent on the Western model of healthcare provision that they cannot locally reproduce and that is often protected by intellectual property rights and technical exclusivity (Naidu 2021). The residents of These spaces of sickness, both in poorer countries and in poorer and minority groups in rich countries, are then made dependent on corporate-defined and run and publicly defended neoliberal models of health that requires resources beyond their means.

The spaces of sickness are all consuming by their very nature. People are prevented from any engagement in public life, future planning, or realisation of any potentiality beyond the immediate labour of survival. They are relegated to the margins of humanity with no means of regaining their autonomy or any control over their lives. Their only partial relief is the aid they may receive from the outside.

By losing their cultural understanding of health and well-being and becoming dependent on external aid, people are left with a narrative and an environment that are entirely foreign to them. They must accept the primacy of biomedicine in all its manifestations: the doctor, the clinic, the hospital, and the social control of medicine if they are to receive some of the benefits of global health assistance. By doing so, they are turned into consumers whose lives are commodified in a global marketplace.

## 12. Health Subalternity

These spaces of sickness are inhabited by the health subalterns. I propose that the concepts of subalternity that originate from post-colonial thought in the Indian Subcontinent (Chaturvedi 2012) are particularly pertinent in the context of global health governance.

The conception of subalternity addresses two important issues of relevance to global health: the description of the subaltern as those with no access and who are displaced to the margins of society applies to those victims of the global health politics of life and death. The subaltern, in Gayatri Spivak's (1988) description, cannot speak, in that their voices (and hence interests and desires) have no place in the discourse that determines their fate. This is the same case for those subjected to the policies of global health. The health subaltern are not defined by their nationality, geography, or any other attribute other than their inability to gain health and the absence of a space for their voice in the GHG regime.

Spivak asserts that the subalterns have no platform to express their needs or the voice to express it with. The subaltern is deprived of the opportunity to interject into the policy-making processes. Hence, there is a duty to "speak for" the subaltern both in revealing their plight and demanding their emancipation. Those who are acted upon by domestic or global health and who are faced with the choice of losing their voice and agency or losing the rudiments of healthcare they get should be the real subject of global health governance rather than its victims.

The provision of healthcare through the machinations of global health governance is currently a tool of subjugation of the health subaltern. They not only cannot speak or get into a state of health as they would want it in the moment of their sickness but are also deprived of the potential of a better future. The all-consuming labour of seeking health becomes both the purpose and the limitation of their existence.

It is in this framework that the coloniality of global health can be understood. Coloniality was described by Anibal Quijano as the "long-standing patterns of power that emerged as a result of colonialism, but that define culture, labour, intersubjective relations, and knowledge production well beyond the strict limits of colonial administrations" (Maldonado-Torres 2007).

Global health, in its role as an agent for the predominant power politics, and in its creation health subalternity, is then the manifestation of this coloniality for many peoples whose opportunity for better health, and hence a possible future, is foreclosed by the very discourse that claims to provide them with health.

## 13. Conclusions and Ways Forward

In understanding this form of politics of life and death as outsourced to GHG and their neoliberal ideological engine, the narrative of benevolence of the current regime become more difficult to accept. This narrative is based on accepting the current status quo in GHG where the only way of governing the health of the world population is through undemocratic and unrepresentative elites in dominant nations, international organisations, public-private partnerships, philanthropies, and academic institutions.

Remaining within that framework that depicts GHG as a well-meaning or inevitable system that can only be approached within its own framing risks co-opting the scholar and practitioner of global health into the service of a regime that subjugates the people they aim to serve.

Rejecting the inevitability of this narrative, another dimension is opened to the scholar and the practitioner, one of the possibilities of an emancipatory global health.

The alternative that can be enacted is one of emancipatory global health that is neither only technical nor imposed from the outside. It rejects pre-cooked policies and grows from indigenous and locally conceived and driven understandings of what health and well-being are and what level of care and intervention in their direction can be.

This view is primarily local and based on the health subalterns themselves taking the reins of their life while remaining open to a pedagogical dimension that incorporates, on the one hand, science and biomedicine as far as they serve the interests and needs of the health subaltern as well as the experiences and knowledge generated by other health subalterns in their own cultures and circumstances to be adapted and operationalized.

Global health, if it is to be legitimate, is an emancipatory praxis. The paternalistic global health that subordinates people's lives to the interests of the state and the corporation forces their confinement to the spaces of sickness and their health subalternity. An emancipatory global health, on the other hand, is one where the medical act is a product of, and is subordinated to, the voices of the people who are no longer health subalterns and who control their own health and potentialities.

In aiming to realise such a vision of emancipatory global health, a few issues can be considered:

- Within a hegemonic system such as GHG, the route to emancipation starts with people who are the victims of ill-health and global health governance. Hence, the first step would be an unadulterated and insistent pedagogical exercise of understanding where the knowledge is not only produced in the laboratories of Northern universities and pharmaceutical companies but by the people who suffer ill-health themselves. Unlike the mediated and largely selective exercise of "giving people voice" which is choreographed and selectively practised by global health actors, the scholar and the practitioner of global health can indeed hear, and act as a conduit of, the pure voice of the health subaltern<sup>11</sup>.
- Research, policymaking, and practice in global health governance cannot start from the current status quo as the only legitimate framework. Research that a priori accepts the failures of GHG and its functioning within the current hegemonic world order will fail to find emancipatory solutions. Global health scholarship should expand to cover all epistemic and political potentialities including the upending of and alternatives to the current global health governance regime.
- Practising global health on the ground should move from accepting that the only way to achieve the fleeting benefits of its programmes is a justification for its politics of life and death. An emancipatory global health does not only get enacted from headquarters in Geneva and New York but from the act of dissolving its power to the people who should benefit from it in every project, clinic, and community. An exercise of conscientization as described by Paulo Freire (2017) in his classic *Pedagogy of the Oppressed* has been implemented in educational contexts and should be a guiding rule for emancipatory global health governance.
- Finally, in transforming the dominant global health governance, reform is sorely needed. This is not an aesthetic reform that retains power in the hands of the same oligarchy, but is rather in different forms. This is a non-reformist reform as described by Andre Gorz (Bond 2008) and can be a guiding methodology that aims at reform without making the preservation of the current system a precondition.

The steps above are only a start towards a conception of emancipatory global health. Much of the future remains unknowable. However, a movement led by patients, communities, practitioners, and transdisciplinary scholars can expose the meagre appearance of reform that takes place after every failure of GHG and open the possibility of change. In doing so, the risk of animosity within any movement for change should be mitigated. A change can be enacted without having a dogmatic agenda for change and a movement for change does not require central command. The acceptance of multiple dimensions of change, from within the system as well as from its fringes, and a sense of alliance and unity of purpose, if not of methods, might be required.

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## Notes

- <sup>1</sup> Institution in the widest sense including governments, international organisations, civil society, academia, private businesses, religious authorities, the media, and informal or traditional institutions.
- <sup>2</sup> Johns Hopkins Coronavirus resource centre <https://coronavirus.jhu.edu/map> (accessed on 2 July 2022).
- <sup>3</sup> Budget and funding numbers are reported as of 29 October 2021. The budgets have been changed on the website. By 1 July 2022 the numbers became USD16.85 billion budgeted, USD5.63 billion received, and USD 11.22 billion gap. <https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker> (accessed on 13 November 2021).
- <sup>4</sup> In June 2022, 40 LMICs had vaccine coverage below 20%, most of them in Sub-Saharan Africa. <https://coronavirus.jhu.edu/vaccines/international> (accessed on 30 June 2021).
- <sup>5</sup> Budget and funding numbers are reported as of 29 October 2021, <https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker> (accessed on 13 November 2021). The budgets have been changed on the website. By 1 July 2022 the numbers became USD16.85 billion budgeted, USD5.63 billion received, and USD 11.22 billion gap.
- <sup>6</sup> <https://www.reuters.com/business/healthcare-pharmaceuticals/world-has-entered-stage-vaccine-apartheid-who-head-2021-10-17> (accessed on 24 October 2021).
- <sup>7</sup> <https://www.reuters.com/business/healthcare-pharmaceuticals/who-partners-seek-234-bln-new-covid-19-war-chest-2021-10-28> (accessed on 13 November 2021).
- <sup>8</sup> See, for example, the proceeds of the People’s Health Hearing on the side of COP26. <https://www.medact.org/event/peoples-health-hearing-2021> (accessed on 11 November 2021).
- <sup>9</sup> Necropolitics in Mbembe’s 2003 essay is about the war on terror post 9/11 and the ability to impose death as a form of sovereignty translated into violence. This sovereignty of imposing death and choosing who is allowed to live and who must die. This, for Mbembe, is more than the right to kill, it is the ability to keep some bodies in a state between life and death such as in the case of slavery and apartheid where those “living dead” inhabit “death-worlds” imposed on them.
- <sup>10</sup> <https://donortracker.org/sector/global-health> (accessed on 28 October 2021).
- <sup>11</sup> See People’s health hearing mentioned above in footnote 8.

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