Beyond rebranding from international to global? Lessons from geographies of global health for global development

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Funding information
Research Councils UK > Economic and Social Research Council ES/J013 234/1.

With the potential for a major geographic shift from international to global development as paradigm for development studies and practice, this paper seeks to draw lessons from the closely related field of health as to what a shift from “international” to “global” may involve. In both fields, an earlier “international” framing emerges from a state-dominated system which, although it superseded prior colonial origins, is outdated vis-à-vis an ability to fully reflect the contemporary range of actors and problems in a more interdependent context. Little agreement is present over the definition of global health, where the “global” is deployed in multiple ways and often involving only a modest shift in geographical imaginary from international health. The case highlights the potential of such an “international” to “global” shift being a 21st-century rebranding, which captures some aspects of change but remains a partial perspective on present challenges that are global in scope. It is concluded that the shift from “international” to “global” in development must go beyond rebranding to address a wider range of 21st-century development challenges.

KEYWORDS
development geography, global development, global health, international development, international health

1 | INTRODUCTION

The growing use of the term “global development,” in relation to development study, research, and practice, offers the potential to mark a key geographic shift in the framing of development. The Sustainable Development Goals, finalised in September 2015, are explicitly presented as “global goals” that relate to all countries. A global development paradigm is increasingly advocated as more fitting to the range of contemporary problems, processes, and actors than a North–South oriented international development framing often associated with aid (e.g., Gore, 2015; Horner, 2020; Horner & Hulme, 2019). However, there is considerable confusion and some controversy over what global development is and what the consequences are of a shift from “international” to “global” (see, for example, the 2019 Forum issue of Development and Change).

This paper builds on vibrant recent debate surrounding a move from international to global in development by examining the closely related field of health to understand what some of the potential consequences of such a geographic shift may be. The health case is selected because of similar origins, orientation, and trajectory to the field of development, partly being an instrumental field, traced back to the colonial era and influenced by wider political economic processes and
context. Although the fields of health and development are not completely independent of each other, the turn to global health caught momentum somewhat earlier than that to global development and has been widely debated. The case is thus highly relevant for current debates on the geographies of global development to learn from.

The paper proceeds as follows. The next section introduces the origins of international health and international development, which both superseded earlier colonial-era approaches and were associated with a state-dominated system. The turn to, and debate over what is meant by, global health is then examined, including the lack of a commonly agreed definition or understanding. The subsequent section focuses on the various deployments of the global and geographical imaginaries in global health, showing that a move from “international” to “global” may in some cases be a mere rebranding for the 21st century rather than a more substantive shift towards a relational approach attuned to the nature of challenges facing our world today. The contemporary relevance of these lessons to the field of development, and its geographies, are then highlighted. The paper concludes that considerable work needs to be done to meet the potential of a global development paradigm than a mere rebranding will deliver.

2 FROM COLONIAL ORIGINS TO INTERNATIONAL HEALTH AND INTERNATIONAL DEVELOPMENT

The origins of what we would today call global health and global development can be traced back to the colonial enterprise. Missionary and civilising rationales were applied to both health and wider development in colonies. Although interest in public health had existed for many thousands of years across a whole variety of civilisations, tropical medicine emerged under colonial enterprise to focus on health issues specific to the tropics (Birn et al., 2017; Packard, 2016). The growth of trade and extractivism led to concerns over the spread of diseases, such as malaria, which threatened European settlers, labour productivity, and trade. The key roots of “development” as idea and practice have also been identified in colonial relations (e.g., Cowen & Shenton, 1996).

The growth of international health somewhat precedes that of international development. International health’s first usage is traced to around 1900 in relation to intergovernmental coordination and the subsequent establishment of bodies, including the International Sanitary Bureau (1902), the Office International d’Hygiène Publique (OIHP, 1909), and the League of Nations Health Organisation (1923), to address mutual health interests across certain countries (Birn et al., 2017, p. xxi). International health grew especially in the middle of the 20th century with the growth in international cooperation among countries for the promotion of health (Macfarlane et al., 2008). The establishment of the United Nations provided an umbrella for guiding the inter-state activities in a range of domains. The World Health Organization (WHO) unified health efforts, playing a key coordinating and mediating role (Brown et al., 2006), while many key international development organisations, such as the Bretton Woods Institutions, were also set up in the mid-20th century. The institutionalisation of the international arena, in both health and development, reflected a post-Second World War geopolitical context of US-led multilateralism and extensive state-building with newly independent states.

Rather than a sharp break, however, key continuities have been pointed to between international health and international development and the colonial era (Cooper & Packard, 1997; Packard, 2016). A colonial, biomedical angle continued in health (Brown et al., 2006), protecting against the threats from the diseases of others through epidemics crossing national boundaries (Brown, 2011; King, 2002). Strong continuity has also been pointed to between colonialism and development intervention, drawing on evidence from the UK (Kothari, 2005). This sustained many of the unequal relationships, but also ideas of modernity and progress, as well as dichotomies of West and rest. Continuity often prevailed in some aspects of development practice between colonial and postcolonial governments (Cowen & Shenton, 1996). Nevertheless, given the international organisations, the changed political status of former colonies, and a Cold War geopolitical context, international health or development did involve important changes from the colonial period.

Today, however, both international health and international development appear increasingly incommensurate with the range of contemporary actors, processes, and problems facing our contemporary world. For decades, international health “was the term used for health work abroad, with a geographic focus on developing countries and often with a content of infectious and tropical diseases, water and sanitation, malnutrition, and maternal and child health” (Koplan et al., 2009, p. 1993). Associated with the inter-state system, with foreign aid and colonial medicine (Frenk et al., 2014, p. 94; Garay et al., 2013), by the late 20th century international health appeared increasingly partial and ill-fitting for a number of reasons. The following two sections elaborate on this transition in order to draw lessons for the more recent shift from international to global development.
3 | FROM INTERNATIONAL TO GLOBAL HEALTH

A shift from international to global health has gathered momentum in the 21st century. Global health has increasingly been referred to, outstripping international health, and not just in English, but also for similar terms in French and Spanish. The term’s usage among UN organisations grew more widely following 2006, when the WHO defined a “global health agenda” (Garay et al., 2013), and has been embraced by a whole variety of governments, and philanthropic and civil society organisations (e.g., Brown et al., 2006, p. 70).

A transition to global health fitted with late 20th and early 21st-century globalisation (Brown et al., 2012), and the heightened interconnectedness that emerged post-Cold War. Globalisation has involved increased interdependence in health as well as in other domains (e.g., economic, social) which also affect health (Frenk et al., 2014), including in relation to non-communicable diseases. Such interconnectedness has also shaped perceptions of vulnerability (Brown, 2011). A state-based, aid-associated international health seemed increasingly partial vis-à-vis the complex realities of late 20th and early 21st-century interconnectedness and interdependence (Frenk et al., 2014).

The shift from state-focused international health to a broader global health was also more fitting to, and embraced by, a range of existing and new stakeholders as part of a wider political-economic shift (Brown et al., 2006; Farmer et al., 2013; Packard, 2016). The WHO, a leader of international health, struggled from the mid-1980s onwards with the growth of neoliberalism (Sparke, 2018) and a new range of actors (Birn et al., 2017, p. 79). The World Bank’s health budget expanded (by 1990 greater than WHO’s total budget; Brown et al., 2006, p. 69), while the WHO’s funds were increasingly a priori assigned. UNAIDS was launched in 1996 to lead work on HIV. The WHO repositioned itself as a player within the new system, advocating and facilitating various “global partnerships,” and has been identified as an agent itself in the transition to the concept of global health (Brown et al., 2006). New organisations such as GAVI, the Vaccine Alliance (created in 2000), and The Global Fund to Fight AIDS, Tuberculosis and Malaria (founded in 2002) were established and were immediately influential organisations. Moreover, global philanthropic organisations, especially the Gates Foundation, and NGOs, such as Médecins sans Frontiers, were also key new players. Some of these new organisations had governments involved, but others often bypassed international organisations or national governments, while national health infrastructures decayed (Packard, 2016).

Global health has expanded rapidly as a field of study and research in the 21st century. The University of California has been cited as the first academic institution to incorporate the name “global health” with the establishment of its Institute for Global Health in 1999 (Macfarlane et al., 2008). A Consortium of Universities for Global Health (CUGH) was founded in 2008 and by 2019 involved over 170 academic institutions and other organisations (CUGH, 2020 - see https://www.cugh.org/about). Three drivers of expansion of programmes, and interest, in global health on US university campuses have been identified – an emphasis on internationalisation, heightened public visibility of global health, and expansion of resource flows (via US government, foundations, corporate, and philanthropic opportunities for universities and students) (Merson & Page, 2009, p. 2).

Despite the growing frequency of usage of the term global health, considerable confusion has been reported over its actual meaning, given deployment in accordance with different meanings and framings. A 1999 survey of 29 health leaders in the USA found that approximately half of the respondents thought “global health” was meaningless jargon, while the other half saw clear differences related to something transnational and to globalisation, yet they were unable to clearly indicate what was implied (Bunyavanich & Walkup, 2001). The term has been used as the current state of health around the world (i.e., a “notion”), a goal that state and non-state actors seek to achieve (i.e., an “objective”), and a mix of “scholarship, research and practice” (Koplan et al., 2009, p. 1993).

An important distinction is between understandings of the “global” in global health as “scale” and as “scope.” Deploying an understanding of global as “scale,” Bozorgmehr (2010) proposed that Scholte’s (2002) notion of “global-as-supraregional” provides a distinct focus for “global health” as study/research and practice. In contrast, Koplan et al. explicitly state that “global in global health refers to the scope of problems” (2009, p. 1994). Such an articulation also facilitates inclusion of domestic, as well as cross-border, health disparities. Accordingly, they provided an often-cited definition: “global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide” (2009, p. 1995). This appears to be the meaning adopted by the journal Global Public Health, which focuses on “key public health issues that have come to the fore in the global environment”.

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11This definition is a product of a 2008 meeting by the Consortium of Universities for Global Health.

22According to the journal’s aims and scope: http://www.tandfonline.com/action/journalInformation?show=aimsScope&journalCode=rgph20 (accessed 16 June 2020).
perspectives of global as scope include “global health as public health” closer to the actual burden of disease (including non-communicable diseases) (Stuckler & McKee, 2009, p. 97) and reframing global health as the “health of the global population” (Frenk et al., 2014, p. 94).

Despite well over a decade of debate over the meanings of global health, considerable ambiguity remains and a shift to global health can appear as merely a repackaging. Fassin has argued that global health has “generally been taken for granted as the best descriptor of contemporary issues in world health, as if we all knew what it was” (2012, p. 96). Moreover, Herrick and Reubi have stated that “global health seems to be both everywhere and nowhere, something and nothing” (2017, p. xi). They have even suggested that part of the power of the idea of global health comes from its polysemous nature (Herrick & Reubi, 2017, p. xii). The term “global health” for many then is more a ‘brand name’ than a robust concept – a politically expedient term to denote any program dealing with health outside of [or among marginalised groups in] one’s own country, while appealing to an ideal of broad reach and holistic focus. (Garay et al., 2013, para 40)

Having identified here the confusion over the meaning of global health, the following section shows how the deployments of the term can fall short of the change in spatial ordering that has been called for.

4 | GOING GLOBAL, BUT REMAINING PARTIAL? THE GEOGRAPHIC IMAGINARY OF GLOBAL HEALTH

Although global rather than international health is now widely referred to, the usage of the term invokes various geographical imaginaries (Gregory, 2009) or spatial orderings of the world. Given the lack of a commonly agreed definition of global health, Herrick and Reubi have demonstrated the value of exploring global health imaginaries as “‘normatively loaded’ and ‘often complex visions of the world’ that shape agendas, projects, policies and behaviours in the field” (2017, p. xii-xiii). Paying critical attention to the mobilisation of the global in health (see also Hodges, 2011, p. 724), this section focuses explicitly on the extent these imaginaries involve continuities or change from the spatial ordering of international health. Rather than identify discrete types (e.g., Lakoff, 2010), these imaginaries are discussed here on a spectrum. This ranges from a spatial ordering which is relatively consistent with international health to a substantial geographical shift towards an understanding of global health as scope in relation to the whole world and in some accordance with the global burden of disease. The section shows that the former has often prevailed at the expense of the latter.

At one end of the spectrum, little disruption to the spatial ordering of international health appears. Considerable continuities have been found, including in the security framings, in often serving Northern interests (e.g., pandemics from cholera to AIDS which affect the global North), use in foreign policy as well as struggle for social justice (Birn et al., 2017; Packard, 2016). In some cases, the global has been used as a straight swap for “international” or “colonial” (Hodges, 2011, p. 719). Old associations persist, as “global health is still often perceived as international aid, technologies, and interventions flowing from the wealthier countries of the global North to the poorer countries of the global south” (Fried et al., 2010, p. 535).

In practice, the geographical imaginaries of the global deployed in the discourse of global health often reflect Northern perspectives on, and solutions to, “global” problems (Ollila, 2005; Sparke, 2009). Notions of global health as security have been particularly salient in discourse on global health within the global North, continuing a long-standing genealogy (Brown, 2011; King, 2002; Lakoff, 2010). The emphasis has been attributed to the interests and fears of the rich and powerful, with Brown even claiming that “the focus of the current global health debate appears to be slanted towards the priorities of western nations” (2011, p. 324). For example, securing populations against HIV/AIDS was justified when doing so appeared to serve a Northern interest (Elbe, 2005), and became a dominant focus in global health (Packard, 2016). In another example, emerging infectious diseases such as Ebola have been framed as global and matters of global security, while others, such as maternal health or diarrheal and other so-called neglected diseases as well as non-communicable diseases, are not (Brown et al., 2012, p. 1183; also Ollila, 2005).

The global health discourse which has emerged is telescopic, focused on certain “suffering slots” including biomedical spaces such as hospitals and schools in Africa, yet consequently with a number of blind spots (Herrick, 2017). Confining global health to high-profile security issues or infectious diseases neglects health systems development (Ollila, 2005) and the wider efforts at improvement in health (Brown et al., 2012, p. 1284). The focus of global health courses on certain diseases in low- and middle-income countries also often overlooks the political-economic systems that create poverty and wealth (Birn et al., 2017; Oni et al., 2019). Particular actors (e.g., governments or NGOs in the South in partnership with
international organisations or foundations in the North) and places tend to be considered as part of the domain of formal
global health, with others left outside (Neely & Nading, 2017, p. 56; also Birn et al., 2017, p. xxv; Turcotte-Tremblay
et al., 2020). Instead, using examples of dengue control in Nicaragua and a nutrition programme in South Africa, Neely
and Nading show the influence of “regular” citizens, patients, doctors, and community health workers in producing “healthier”
places (2017, p. 56). A common assumption is that such actors are “not working in global health” (Macfarlane et al.,
2008, p. 393), in contrast with a more social justice-oriented approach where global health is a concern of ordinary people,
and involves their actions and people representing them (Birn et al., 2017, p. xvii). Indeed, Birn et al. have suggested that
“global health is more ‘partial’ health than global, given that its institutions and ideas are heavily influenced by a small
number of powerful players with particular agendas” (2017, p. 44).

In relation to university uptake, despite the global framing, academic global health programmes and research have been
noted to be mostly located within the global North and especially focused on countries, and on particular issues and sites,
in the global South – on the grounds that those are in greatest need. Indeed, Macfarlane et al. wrote that “global health is
primarily being defined by developed country institutions and in terms of their working with developing countries” (2008,
p. 384), while observing that few global health programmes have been created in academic institutions in the global South,
where health research and teaching proceeds in a “business as usual” fashion (2008, p. 383). Richard Horton, editor-in-chief
of The Lancet, subsequently wrote that “global health today is largely a discipline of the Global North” (2014, p. 1705;
also Oni et al., 2019), seeing it as part of the expansion of western universities. The need for more perspectives from lower
income countries in shaping the meaning, scope, and mission of what is encompassed in global health has been persua-
sively argued (e.g., Oni et al., 2019).

Despite their potential for obfuscation through a language of partnership (Crane, 2013; Herrick & Reubi, 2017), inequalities
and power imbalances between individuals and institutions across North and South endure and characterise what is
conventionally defined as the field of global health. While global health has been advocated in terms of not being limited
just to the global South, and to avoid the “us” and “them” approach characterising international health discourse (Rowson
et al., 2012, p. 3), postcolonial research has demonstrated the various uses through which imaginative histories and geogra-
phies such as “West/non-West” and representation of the tropics as “Other” are still deployed in the discourse of global
health (Brown, 2011; Prasad, 2017).

A long-standing focus in health practice has been to target individual diseases and conditions with biomedical interven-
tions rather than approaches to health systems and boosting social development (Packard, 2016). Unfortunately, global
health problems are still often portrayed in a residual context of lack of ideas, practices, resources, knowledge, tools, tech-
nologies, which global health actors seek to address in low and middle-income countries (Birn et al., 2017, p. xxvii). A ten-
dency for taking a biomedical approach and pathologising particular people and places overlooks deeper global pathologies
pointed to by market critics (Sparke, 2009). For example, work on Trade-Related Aspects of Intellectual Property Rights
(TRIPs) and the challenges of an AIDS vaccine have demonstrated a key problem in relation to providing treatment for
people living with HIV is adverse incorporation with, rather than disconnection from, biocapital (Craddock, 2007).

Nevertheless, in contrast with epidemiological studies of the causes of disease, often focused on individual risk factors
(e.g., diet, exercise), a growing body of work has put greater emphasis on basic social conditions including relationships to
other people (Link & Phelan, 1995). A high-profile example is work on the social gradient in health and health inequities
in terms of “the unequal distribution of power, income, goods, and services, globally and nationally … in both ‘rich’ and
‘poor’ countries” (Marmot et al., 2008, p. 1661). The importance of a biosocial approach for the field of global health, with
attention to the links (often across borders) between affluence and privation and involving concern for health disparities
in both global North and South, as well as within countries, has been prominently advocated by Farmer et al. (2013). Some
focus on global health in terms of universal availability for all (Sparke, 2018, p. 5). This is more akin to understandings of
global health centred on “health equity everywhere, including within HICs” (Abimbola, 2018, p. 63). One example of such
research is on tuberculosis and public debt in Berlin (Kehr, 2018). In another, relational comparison has shown how local
problems (e.g., staff shortages, corruption) in a hospital in Sierra Leone are “enveloped within global processes” (Brooks &
Herrick, 2019), as was the Ebola crisis in West Africa (Leach, 2015).

A gap exists between, on the one hand, advocacy for a relational global health (in research at least) centred on interde-
dependency, the contributions of various nations, a biosocial focus across global North and South, and the actual burden of
disease (Fried et al., 2010; Rowson et al., 2012; Stuckler & McKee, 2009), and the realities of much of the field of global
health. Blurring boundaries of disease incidence in relation to the often-held association of non-communicable diseases with
the global North and communicable diseases with the global South (e.g., Frenk et al., 2014) has demonstrated the relevance
of considering potentially shared causal factors and similar challenges across different parts of the world.
Yet despite a transition from “international” to “global health,” the field has not fully adapted to such a more holistic focus or approach – an issue which COVID-19 has highlighted. The pandemic is a health issue that affects people both everywhere in the world and also very unevenly within and across the world (e.g., Rose-Redwood et al., 2020), demonstrating the limitations of framings of global health as just related to particular suffering slots (Turcotte-Tremblay et al., 2020). COVID-19 highlights the need for a more holistic understanding of global health, remade around “real collaboration, solidarity, and equity” (Shamasunder et al., 2020, p. 5). It also demonstrates the relevance of earlier calls for South–North learning (e.g., Syed et al., 2012). Ultimately, COVID-19 requires a different geographical imaginary from that of international health or that dominant in global health to date.

5 | DISCUSSION AND CONCLUSION: LESSONS FOR DEVELOPMENT FOR “GOING GLOBAL”

This paper contributes to ongoing discussions regarding a shift from “international” to “global” in development by drawing lessons from a similar, but slightly earlier, framing change in the field of health. The transition in development has emerged somewhat later than that in health, prompted especially by the formation of the Sustainable Development Goals (SDGs), the increasing salience of climate change, and blurring North–South boundaries (Horner, 2020). A number of similarities emerge between these transitions in both fields, including the almost impossibility of there being a commonly agreed definition or understanding of the global in each. Following Koplan et al. (2009) for global health, we could understand global development as a notion, an objective, or a field of scholarship, research, and practice. We can see the distinction between understandings of global development as scale and as scope (see also Horner, 2020, pp. 424–426). Moreover, like with health, the ambiguous nature of what global development means may be part of its attractiveness and power.

The multiple deployments and geographical imaginaries of the “global” in health raise awareness of the need for critical attention to such dynamics in the broadly understood field of development. The question may increasingly be not of international or global development, but of what kind of global development. Similar to the health case, a spectrum from a spatial ordering more consistent with international development and another with a more substantive shift towards global development as scope may be identified.

At one end of the spectrum, the health warning provided here is that the transition from “international” to “global” could be a “rebranding” for the 21st century, employing a very selective geography of the “global” which departs little from the spatial ordering of international development. Global development may increasingly be invoked and appear more fit or even fashionable for the contemporary context. It may involve some difference from the association of international development with aid, through for example, the recognition of a wide range of new actors (e.g., Mawdsley, 2017; Richey & Ponte, 2014), including new donors, philanthropic and civil society organisations, as well as strategies of repositioning and survival for other. However, it could still largely refer to particular issues and sites (or suffering slots, to invoke Herrick’s (2017) analysis of global health) in the global South. “Global” may be used in various, partial ways with different strategic meanings and interests, such as Northern visions and/or security interests.

Some of the deployments of global development may thus be very different from the necessity of moving beyond the global South to consider development in relation to the whole world. If global health is anything to go by, global development will not automatically involve a global as scope understanding that the SDGs or the challenge of climate change, for example, might justify. Moreover, a transition to global may not necessarily meet the aims of longstanding calls in both fields for more critical approaches that move beyond the partial approaches to international health and development which had existed (e.g., for development; Lawson, 2014; Willis, 2005).

At the other end of the spectrum is a transition towards global development, which goes beyond rebranding of an outdated, North–South oriented, aid-associated international development paradigm. As with global health above, relational approaches are advocated for understanding global development (e.g., Horner, 2020) and hold promise here. The interconnected, relational nature of political-economic processes that underlie contemporary challenges facing the world, including global inequality and climate change, cut across global North and global South and require a more holistic analysis. COVID-19 accentuates this case not just from a health point of view as noted above, but from a broader development angle. The pandemic demonstrates the needs for multidirectional learning and transformation in all countries (Oldekop et al., 2020).

Although the trajectory of the “international” to “global” transition in health does not determine that in development, it provides important lessons. The experience highlights the need for constructive engagement regarding the geographical imaginaries of global development, and what those framings include and exclude.
ACKNOWLEDGEMENTS

I would like to acknowledge a workshop on “Pharmaceuticals in global health” at the University of Sussex’s Centre for Global Health Policy in May 2017, where the original idea for this paper emerged. An earlier version was presented at a “Global development roundtable” at the 2018 RGS-IBG Annual Conference in Cardiff. I would like to thank Jessica Hope for leading the organisation of that session and the participants for their comments. Sam Hickey and David Hulme provided valuable feedback on earlier iterations of the paper, which I am grateful for. The constructive feedback from the editors of Area, as well as the anonymous reviewers, is also appreciated. Finally, I would like to acknowledge the support of the University of Manchester Hallsworth Research Fellowship and an ESRC Future Research Leader Award (grant number ES/J013 234/1) during the time of the writing of this paper.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this paper as no datasets were generated or analysed during the current study.

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How to cite this article: Horner R. Beyond rebranding from international to global? Lessons from geographies of global health for global development. Area. 2020;00:1–9. https://doi.org/10.1111/area.12669