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Family Medicine

BOOK REVIEW

Global Health for All

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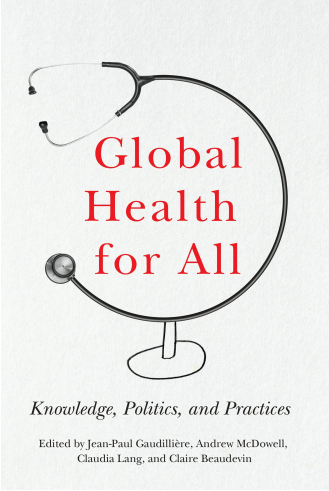

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> (A)n umbrella term created by European and North American organizations working self-consciously to advance health and development on a global scale. Global health is neither a discipline nor a discrete set of practices that scholars can easily delineate. Instead . . . [it is] a grand narrative, but one that, in practice, rarely lives up to proclamations about what it is, does, or will do. (p. 8)
>
> *Global Health for All, p.8*

Thus the editors define global health. This book tells that grand narrative from several perspectives. Global health is distinguished from the earlier international health in that the latter was characterized by national boundaries and bilateral aid while the former involves multiple nonstate actors who prioritize transnational interventions (p.7).

The introduction provides a valuable overview. The material is dense reading—don't get too bogged down in it! The subsequent chapters flesh it out nicely, making global health comprehensible through excellent examples of projects and policies to illustrate each of the points. This reviewer found that rereading the introduction after completing the book nicely reinforced the material.

The first aspect covered is the role of local in the global. Local can refer to space, the people, or customs and practices. Local is the site of innovation, from which novel interventions may be developed and, when shown efficacious, exported globally. Local is also the context into which global health ideas are translated.

> Localization is a font of ideas and a foil of commensurability. It is both the cause and effect of global health . . . [Global health's] laboratory is simultaneously the world and the village, and people are both the test and the control.
>
> *(p. 55)*

The next chapter is the crux of the book, dissecting the ways global health interventions are currently measured. As with Heisenberg's famous principle, this measurement alters its subject. Global Burden of Disease (GBD) is the currency of global health. Its introduction marked a significant shift from myriad prior statistics of prevalence/incidence of specific diseases; its goal was to incorporate morbidity (years lost to disability, YLD) and mortality (years of life lost, YLL) into a single, broad metric (disability adjusted life years, DALY). This metric allows comparison of the effect of interventions on morbidity and mortality across multiple factors, not merely within a single disease. Its adoption correlated with the World Bank's shifting focus from infrastructure to human capital and an accompanying change in investment from developmental economics to health.

The authors trace the evolution of GBD as it "turn(ed) vitality and suffering into countable statistical units, outcome measures, and fiscal value" (p. 19) and then became a tool

for economic triage. Although initially envisioned as a metric free of moral value, decisions based on GBD are absolutely dependent on how life—and specifically, productive life—is valued. For example, the trade-off between disability and mortality is a highly individualized decision, yet the resulting audit culture among funders has forced central authorities to make decisions based on investment performance. The metric does not provide a rationale for allocation of resources between health and other critical budgetary items. Nor does it help establish decision-making priorities among political, economic, and technocratic considerations. Of great concern, GBD does not guide resolution of conflicts between economic triage and human rights: there is no calculus for equity in the formula; performance is measured solely by cost-effectiveness. Additional potential issues with GBD include its privatization and that—as a massive collaborative effort—finding knowledgeable individuals without inherent conflicts of interest to provide ongoing peer review is virtually impossible.

One of the consequences has been the death of primary health care. The horizontally integrated approach to basic needs defined by Alma Ata[1] has been eclipsed by a vertical model ("one disease, one technology, one bureaucracy," p. 82). Rather than comprehensive primary care of basic needs, a selective primary care package limited to the most cost-effective interventions was adopted and program performance evaluated based on a single indicator, the DALY. Now, successful programs follow only half of Alma Ata's principles (p. 95).

In the present era of global health, chapters offering valuable insight into the positive and negative effects of markets and technology, the unacknowledged role of hospitals as site of care, and the World Health Organization's drift toward irrelevance (though it is "both indispensable and inadequate," p. 195) add understanding of the impact of the application of the current metrics.

Those involved in global health, interested in social determinants of health, or fascinated by the interplay between governmental, intergovernmental, and nongovernmental actors will critically ponder current global health effectiveness measures as a result of reading this book.

REFERENCES

1. Europe: Declaration of Alma-Ata. *World Health Organization.* 2024. https://iris.who.int/bitstream/handle/10665/347879/WHO-EURO-1978-3938-43697-61471-eng.pdf?sequence=1.