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Commentary

A spanner in the works? anti-politics in global health policy

Comment on "A ghost in the machine? politics in global health policy"

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Abstract

The formulation of global health policy is political; and all institutions operating in the global health landscape are political. This is because policies and institutions inevitably represent certain values, reflect particular ideologies, and preferentially serve some interests over others. This may be expressed explicitly and consciously; or implicitly and unconsciously. But it's important to recognise the social and political dimension of global health policy. In some instances however, the politics of global health policy may be actively denied or obscured. This has been described in the development studies literature as a form of 'anti-politics'. In this article we describe four forms of anti-politics and consider their application to the global health sector.

Keywords: Global Health Policy, Global Health Governance, Politics, Anti-Politics

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It seems extraordinary that we need reminding of the fact that policy-making is fundamentally political; and that there is no such thing as a 'neutral policy'. If 'politics' describes how competing values, ideologies, and interests shape the way policies are formed and implemented, then there is little about 'global health' that is not political.

In their paper, *A ghost in the machine? politics in global health policy*, Carlos Bruen and Ruairi Brugha remind us that *"political and institutional factors are central to global health policy processes, down to and including the development and use of health evidence"* (1). As such, they argue that politics is of fundamental importance to public health researchers; and that public health research itself is part of the political process of policy formulation.

They describe how 'politics' cannot be separated from policy using three brief case studies of the World Health Organisation (WHO), the GAVI Alliance and the Global Fund to Fight Against AIDS, TB, and Malaria (GFATM). Bruen and Brugha's take home message is that the politics of global health policy should be studied by public health researchers; and that we should add methodologies from the political and social sciences to the stock of more well-established public health research methods.

This is all good. It is important that we recognise and study the politics of global health institutions and policy, whilst simultaneously recognising that research and science are themselves fundamentally shaped by politics. But what can be said about the politics of global health, and what questions about it should global health researchers consider? Bruen and Brugha's article provide some useful pointers.

For example, take their quotation of Richard Feachem's description of the Global Fund as a *"very apolitical organization... (where) we've been able to take principled and technical decisions which haven't always been popular because we're not subject to the political influences that would come to bear in the UN"* (2). At first glance, this is an uncontroversial statement. To be sure, the Global Fund is not handicapped by the difficulties and frustrations that come with the politics of multilateral UN governance. It is more focused, pragmatic and business-like; and being governed by a Board of individuals with shared aims and goals (which are also narrow and relatively uncontroversial), it can operate with much less 'political' interference.

But this is not the same as saying that the Global Fund itself is not political, or that its creation was without controversy. In fact, the emergence of multiple global public-private partnerships (such as the Global Fund) as a new and alternative form of global health governance is hugely political – not least because it facilitated the growth in influence of private and corporate actors in global decision-making. Furthermore, the very construction of a multi-billion dollar fund to combat three diseases is itself the epitome of a narrow, selective, and disease-based approach to health and development which is profoundly shaped by particular social, historical, and political perspectives.

But it is the choice to frame global health policy as *apolitical* that is worth exploring more. Is there, for example, a wish by some to actively *depoliticise* global health? And why do some actors frame global health priorities such as HIV/AIDS and child mortality in purely technical and operational terms that are set apart from any social and political context?

Here it may be useful for global health researchers to consider some of the literature from the field of development studies which has explored the interface between politics and the business of development. One observation has been that development actors often self-identify themselves as technocrats who are located outside of politics. For example, Li describes the way in which social-political processes

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are rendered 'technical' by development actors (3); while Ferguson describes how 'development projects' are often constructed and managed to actually ignore or avoid real world politics, often to the detriment of those projects (4). Similarly, Mosse describes the use of 'mobilizing metaphors' such as participation, ownership, capacity building, and good governance 'to conceal ideological differences within the business of delivering development aid' (5).

A more critical and trenchant view is provided by Bebbington who notes how 'anti-politics' may be used as a tactic by which *'poverty discussions are increasingly separated from questions of distribution and social transformation, and in which poverty reduction becomes something sought through projects rather than political change'* (6). In such cases, being 'anti-political' or 'apolitical' is actually a very clear and deliberate political act in itself.

According to Schedler, there are four types of anti-politics (7). The first is an 'instrumental anti-politics' whereby political decisions are made by technocratic experts, often based on cost-benefit analyses that are projected as being rational and neutral. The second is an 'amoral anti-politics' in which the public domain is privatised, and people reduced to rational, utility-maximizing economic human beings whose interests and preferences are expressed through and derived from the market. The third is a 'moral anti-politics' which acts by reifying certain 'normative positions' and stifling democratic or political debate through the labelling of any contrarian positions as being unethical, immoral, unpatriotic, or even treasonous. Finally, an 'aesthetic anti-politics' works by undermining educative, informative, and deliberative communication and debate, through the trivialising use of simplistic imagery, homilies, and symbolism.

We see all four types of 'anti-politics' operating in global health. For example, instrumental and amoral anti-politics are reflected in various forms of health economics and were heavily promoted by the World Bank through health sector reform policy prescriptions in the 1980s and 1990s. Here, policies that denied rights to healthcare, and which institutionalised inequity and wrecked health systems, were dressed up as the outcome of a supposedly rational economic science and technocratic process of health planning. The moral and political context of debt and structural adjustment programmes were ignored by many health actors, as were the ideological assumptions and value judgements that underpinned economic evaluation and health systems policy. These forms of 'anti-politics' are perhaps less potent today. For example, there is a growing backlash against the false assumptions of mainstream academic economics as more people acknowledge that economics is fundamentally social, cultural, and political. That said, there is much of health economics and health systems policy that obscures the politics of competing belief systems, values, and interests.

Moral and aesthetic forms of anti-politics, on the other hand, appear to be more prominent in global health these days. They parallel the rise in prominence of the 'public-private partnership' and 'corporate social responsibility' paradigm in the global health sector, and which has grown significantly in force and influence with the support and encouragement of the Gates Foundation. Here we see an unquestioned acceptance of the participation of private and corporate actors in global agenda-setting and policy-making, and the tacit acceptance of a 'philanthrocapitalist' ideology and belief system. But any fundamental questioning of the ethics, appropriateness, legitimacy, and even efficiency of the emerging structures and systems of global health governance are frequently obstructed by the moral oratory of 'saving lives' and 'fighting disease'. This rhetoric implies that any imperfections or deficiencies in 'global health governance' may be irrelevant or minor given the obvious 'goodness' of improving health. This tendency may run in tandem with the wish of many people to be apolitical or non-political simply because it is easier: take the money and ask no questions (no need to because you are saving lives).

Interestingly, a combination of amoral and aesthetic 'anti-politics' are observable in the Global Fund's approach to estimating the number of 'lives saved' by Global Fund supported programmes to provide AIDS and TB treatment, and to distribute malaria bednets (8). Apart from problems with the accuracy and reliability of the numbers calculated, the approach was criticised for taking attention away from other important investments such as health systems strengthening (which are not readily translated into a measure of 'saved lives' or directly attributable to external aid agencies); reinforcing selective, vertical, and disease-based health programming; failing to produce any measure of efficiency; and ignoring the social determinants of the level of effectiveness of clinical interventions. However, these are easily ignored or rejected by the emotive rhetoric and irreproachable imagery associated with the saving of lives.

But the temptation to be apolitical must be resisted. There is so much in global health policy that is both political and too important to ignore. For example, in the pharmaceutical sector, we need a better system for funding and governing research and development; and for advertising, prescribing, and selling medicines. But this will not happen unless we take a more critical look at intellectual property rights and the regulation of the pharmaceutical industry. And this in turn may require us to think about reducing the power and influence of the industry and delegitimising some of its harmful and unethical practices – not doing the opposite.

More importantly, the global health community cannot afford to be apolitical: it is still the social determinants of health that predominantly shape the global experience of health and well-being. Whether it is climate change, the threat of antibiotic resistance, the effects of war, conflict, and militarisation, or the corrosive effects of economic inequality on democracy, there is both a need and mandate for the global health community to be progressive, principled, and political. This need not come into conflict with the science of public health. Data, research, and evidence remain central to the formation, implementation, and monitoring of global health policy; but they can be misleading and false when viewed out of a social and political context.

So what next for researchers interested in studying the politics of global health policy? There are many lines of enquiry that could be developed. One of them might involve applying

Schedler's typology of anti-politics to a critical study of global health discourse, policy, and programmes.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

DM conceptualised and designed the document; DM drafted the document; GS revised and edited the document; DM and GS agreed final draft.

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