From sovereignty to solidarity: a renewed concept of global health for an era of complex interdependence

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The moment is ripe to revisit the idea of global health. Despite tens of billions of dollars spent over the past decade under the auspices of global health,[1] a consensus definition for this term remains elusive.[2–5] Yet the way in which we understand global health critically shapes not only which and whose problems we tackle, but also the way in which we raise and allocate funds, communicate with the public and policy makers, educate students, and design the global institutions that govern our collective efforts to protect and promote public health worldwide.

The importance of advancing a coherent idea of global health has become clear in recent debates about the post-2015 development agenda. Health was central to four of the eight Millennium Development Goals (MDGs; on hunger, child mortality, maternal health, and HIV/AIDS and malaria) and directly linked as an outcome or determinant to the four others (on primary education, gender equality and empowerment, environmental sustainability, and global partnership). However, health advocates are concerned that health will not feature centrally in the post-2015 Sustainable Development Goals (SDGs), having had its moment in the spotlight and succumbing to competition from other issues demanding attention, such as climate change or food security. But a broader conceptualisation of global health makes clear that health and sustainable development are inseparable. As recognised in the Rio+20 Declaration on the Future We Want, health "is a precondition for and an outcome and indicator of" sustainable development.[6]

How should global health be understood in an era marked by the rising burden of non-communicable diseases (NCDs), climate change and other environmental crises, integrated chains of production and consumption, a power shift towards emerging economies, intensified migration, and instant information transmission? As we explain in this Viewpoint, global health should be reconceptualised as the health of the global population, with a focus on the dense relationships of interdependence across nations and sectors that have arisen with globalisation.[7] Doing so will help to ensure that health is duly protected and promoted, not only in the post-2015 development agenda but also in the many other global governance processes—such as trade, investment, environment, and security—that can profoundly affect health.[8]

Since it was coined, around the creation of the International Health Commission in 1913 by the Rockefeller Foundation,[5] the term international health was identified with the control of epidemics across borders and with the health needs of poor countries.[9] Various textbooks and training programmes also included the health of indigenous populations of developed countries. Supporters of this original view regarded international needs as alien and peripheral, and very frequently as threats. Consistent with these ideas, international activities were identified as aid and defence, and delivered through unilateral perspectives.

The international health agenda was also affected by the idea that most health needs could be fully addressed with technology.[10] This notion is still prevalent nowadays among various global health initiatives.[11,12] The temptation to pin all hope on the latest technology is every bit as powerful as it was in the near past.[13] This reductionist perspective contrasts with the growing realisation that most global health problems have strong behavioural, cultural, social, political, and economic determinants that demand comprehensive—not only technical—approaches.

International health also placed excessive emphasis on vertical programmes devoted to control specific diseases and paid little attention to health systems as a whole, with well documented consequences.[12] This tendency has yet to be fully replaced by a more comprehensive diagonal perspective that would use explicit intervention priorities to drive improvements into the health system.[14]

International health cooperation has traditionally fallen under the rubric of foreign aid—support for polio eradication and treatment of HIV/AIDS are prominent examples. But the very concept of aid conveys an asymmetric image in which problems and risks flow from south to north, whereas resources and solutions move in the opposite direction. This view fails to capture the reality of health interdependence. It also fails to take into account the major shifts taking place in the global distribution of resources, influence, capabilities, and needs as emerging economies continue their expansion.

A sort of linguistic modernisation has revitalised the traditional contents attributed to international health through the use and dissemination of the notion of global health. In the media, in lay and scientific literature, and in major initiatives, global health is still identified with problems supposedly characteristic of developing countries, and global cooperation in health with a sort of paternalistic philanthropy that is armed with the technological developments of developed countries. It is again the idea of the poor, ignorant, passive, and traditional societies in need of the charity and technology of the rich that prevails in the use of this term. Paradoxically, this use of the notion of global health fails itself to capture the essence of globalisation. In a real sense, we need to globalise the concept of global health.

To this end, it is necessary to move beyond reductionist definitions and to reconceptualise global health to reflect

two key notions. First, global health should not be viewed as foreign health, but rather as the health of the global population. Second, global health should be understood not as a manifestation of dependence, but rather as the product of health interdependence, a process that has arisen in parallel with economic and geopolitical interdependence.[15]

The core idea behind the notion of health interdependence is that no single stakeholder—not even the most powerful government or corporation—is singlehandedly able to address all the health threats that affect it. Many determinants of health have globalised, such as the dissemination of patterns of work, lifestyles, diets, and other aspects of consumption that are conducive to diseases once thought to affect only rich societies—diabetes, cardiovascular disease, cancer—now affecting many of the world's poorer citizens in equal or greater measure.

Although communicable diseases such as pandemic influenza, malaria, or HIV/AIDS have attracted the greatest amount of funding, political attention, and institutional innovation,[1] what were once regarded as problems only of poor countries, such as many common infections, malnutrition, and maternal deaths, are no longer the only problems of such countries, who also carry the heaviest burden of many NCDs, mental disorders, and injuries. With the important exception of sub-Saharan Africa, in health terms developed and developing countries have become more alike than different.[16] NCDs have attracted increased political attention, as their growing burden adds to and sometimes outweighs that of communicable diseases in many poor societies.[17]

Public health's traditional binary classification of communicable and non-communicable diseases fails to capture an additional layer of determination, which generates a novel category of health challenges—those arising directly from globalisation. Irrespective of the type of resulting disease, global health risks spread through common processes created to support production, communication, trade, and travel worldwide. These risks do not necessarily move from developing to developed countries. For example, an often overlooked example of the transfer of health risks is the establishment of polluting factories in developing nations, transplanted from developed countries to take advantage of weaker regulatory environments. Indeed, all countries, irrespective of their location, wealth, history, or culture, are exposed to common health threats associated with globalisation. At the same time, the increased interdependence produced by globalisation can generate new benefits and opportunities; every country can benefit from ideas, knowledge, goods, regulatory approaches, and skills originating elsewhere.[18] Although the links between globalisation and health are complex,[19–21] the transfer of health risks and opportunities can be organised into six broad categories: cross-border movement of elements of the natural environment; people; production of goods and services (eg, global value chains in manufacturing); consumption of goods and services (eg, food, tobacco, narcotics, health care); information, knowledge, and culture; and rules (table 1).[22]

These six types of flows underscore the conclusion that no country—whether rich, poor, or middle income—can be isolated from the risks that emerge elsewhere. Such interconnections are not necessarily new. But the intensification of cross-border trade, travel, and communication that are the hallmarks of globalisation have strengthened them and, in many cases, have created situations not merely of interconnection, but also of interdependence. Indeed, perhaps the two most striking features of global health today are interconnectedness—both across countries and across sectors—in the causes

	Examples of threats	Examples of opportunities
Elements of the natural environment	Environmental threats (eg, climate change, air and water pollution); spread of pathogens (eg, animal-borne illnesses such as avian influenza)	Improved access to natural resources (eg, water)
People	Spread of pathogens (eg, human-to-human transmission)	Spread of knowledge and skills through workforce movement
Production of goods and services	Transplantation of harmful practices (eg, high-polluting factories to countries with weaker regulatory systems); changing labour conditions enabling adoption of sedentary lifestyles that contribute to metabolic disorders	Economic growth and technology transfer
Consumption of goods and services	Spread of harmful products (eg, tobacco); global trade in unhealthy foods	Spread of useful medical technologies; adoption of health-enhancing goods and services
Information, knowledge, and culture	Inappropriate use of technologies (eg, leading to antimicrobial resistance)	Spread of health-related knowledge and practices that enhance health and wellbeing, such as family planning; cross-fertilisation and access to new knowledge, whether traditional or modern
Rules	Transnational investment treaties restricting national regulatory policies; transnational intellectual property rules increasing drug prices	Health-focused transnational rules, such as the WHO Framework Convention on Tobacco Control, expanding national policy space for health protection

Table 1: **Cross-border flows that generate threats and opportunities of globalisation for health**

and effects of health threats, and interdependence in our capacity to respond to them effectively.

It is important to distinguish between interconnection and interdependence: interconnection describes the nature of health threats and effects, whereas interdependence refers to the distribution of power, responsibility, and capacity to respond. For the very powerful, such as governments of large wealthy countries, some health threats may be interconnected across borders but do not automatically imply interdependence, since they can largely manage these specific threats alone.[23] However, for many others, particularly smaller, less wealthy countries, or communities that live in closer proximity to neighbouring countries, interdependence is a defining feature of the domestic health landscape. Examples of health challenges linked to interdependence include regulation of the quality of imported food, medicines, manufactured goods, and inputs; getting timely access to information about the global spread of infectious diseases; procurement of sufficient vaccine and drug supplies in a pandemic; and ensuring a sufficient corps of well-trained health personnel.

Additionally, these challenges are interconnected across sectors—ie, their causes and the management of their effects do not sit neatly within the traditional boundaries of the health sector or within the sole control of health officials. Rather, an intricate web of governmental and non-governmental players (eg, private firms, civil society organisations [CSOs], the media, and academic institutions) all exercise some measure of influence over these health threats and the collective responses to them. Situations of complex interdependence frequently result, with many players working across different scales and sectors ultimately shaping health outcomes.

In short, global health challenges are not only the diseases of the world's poorest communities, but rather comprise all components of the triple burden of disease: first, the unfinished agenda of infections, malnutrition, and reproductive health problems; second, the emerging challenges represented by NCDs, mental disorders, and injuries; and third, the health risks directly associated with globalisation. Global health challenges encompass all issues that extend beyond the capacity of any one country to address, and often require concerted responses from governments and non-state stakeholders.

Traditionally, the nation state has been responsible for the protection of the health of its population. But increased interdependence has eroded the capacity of states to do so. The challenge is that in a world of sovereign states, there is no hierarchical authority or world government to fill in the gaps. Rather, there is only a relatively weak system of multilateral institutions built on the shaky foundations of the consent of sovereign states. Yet, the triple burden of disease can only be addressed through international collective action, which must perform four major functions: to provide health-related public goods, such as research, standards, and guidelines; to manage cross-national externalities affecting health through epidemiological surveillance, information sharing, and coordination; to mobilise global solidarity for populations facing acute or chronic deprivation and disasters, whether natural or man-made; and to exercise stewardship of the global health system by convening stakeholders to reach consensus on key issues, setting priorities, negotiating rules, facilitating mutual accountability, and advocating for health in other policy-making arenas.[7]

Fulfilment of these functions at the transnational level will, in most cases, require building more robust global institutions for pooling risks, resources, and responsibilities among sovereign states—and in many cases, also non-state actors. Such institutions must deepen cooperation to make it more predictable and reliable for all countries, even if some states might face short-term costs to build more politically sustainable global institutions in the long term. For example, states could face immediate economic or political costs by swiftly reporting outbreaks of communicable disease to WHO, as they are required to do by the International Health Regulations (IHR). Yet when states do so, provided that the response of other states is measured and reasonable, it strengthens the global regime embodied in the IHR and can improve health security for all.

But generation of the political will within states to share their sovereignty in this manner will require a far more fundamental transformation in the long term—the gradual construction of a global society. The idea of a global society is based on the principles of human rights and the logic of health interdependence. It implies that individuals and the various organisations that they form (whether governmental agencies, CSOs, firms, foundations, or other stakeholders) accept to share the risks, rights, and duties related to protection and promotion of the health of every member of this society. Although the notion of a global society might seem somewhat idealistic, it is partly based on the observation of a growing density of social interactions and the spread of ideas and norms across borders, which raise new possibilities for developing a sense of solidarity between individuals and societies. By setting global targets to improve maternal and child health and combat hunger, HIV/AIDS, malaria, and other major diseases, the MDGs arguably embodied the aspirations of a nascent global society for a common minimum standard of health to which all people should be entitled as an essential human right.

	Development aid	International cooperation	Global solidarity
Relationship	Dependence	Independence	Interdependence
Actors	Donors and recipients	Independent member states	Members of global society
Motivation	Charity; self-interest	Mutual benefit	Shared responsibility
Main instrument	Discretionary allocations	Pooled resources	Shared resources based on universal rights and duties

Table 2: **Alternative framings of international transfers for health**

In the absence of a global government—not only now but for the foreseeable future—the construction of a global society emerges as a feasible alternative to harness interdependence in a world polity where sovereign nation states coexist with expansive social networks transcending national boundaries. In a world marked not only by deep inequities but also by the acceptance of a set of universal human rights, global solidarity becomes the unifying force to build a global society that could redress those inequities and assure the realisation of those rights. We use the term solidarity based on classic sociological theory, rather than any particular political ideology, to refer to situations of interdependence created by the complex division of roles characteristic of modern societies.[24] (In fact, the term has been used by groups all along the political spectrum.)

The three different framings of global transfers for health—development aid, international cooperation, and global solidarity—each imply a different set of relationships, types of stakeholders, motivations, and instruments (table 2). Although there is not necessarily a linear progression from aid to cooperation to solidarity (in fact, nowadays all three framings operate simultaneously), we argue that the term solidarity not only offers a more symmetrical expression of mutual respect between members of a society, but also best corresponds to the underlying conditions of interdependence in an unequal world.

The idea of a global society should not be construed as a utopian world free of conflict. Rather, as in most national societies, one would expect a global society to be characterised by ongoing political conflict and competing views. What the notion of a global society does imply is that underpinning such conflicts would be a widely shared understanding of health interdependence and an acceptance of some responsibility for the health of others as members of the same society—in other words, a shared commitment to realisation of health as a human right based on a recognition of our common humanity.

A clearer understanding of the fundamentally interconnected nature of the health challenges faced by the global community requires moving beyond the narrow view of global health as the problems of the world's poorest societies, to global health as the health of an interdependent global population. Protection and promotion of the health of a global society is one of the most central, yet daunting challenges of our time. Rethinking the term global health is a necessary first step towards its achievement.

Contributors

JF gave the original idea for the paper and contributed to its overall structure and concepts. He contributed to the writing and editing of subsequent drafts, and the conclusions. OG-D contributed to the overall structure of the paper and the development of its concepts. He also participated in the writing and editing of the various drafts and conclusions. SM revised the content and structure of the manuscript. She also contributed to the addition or refinement of concepts, arguments, and conclusions. All authors have approved the final version of the paper.

Conflicts of interest

We declare that we have no conflicts of interest.

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