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EDITORIAL

On the meaning of global health and the role of global health journals

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Whenever I hear the term 'tropical medicine' or see it in print, what often comes to mind is, 'how delightfully quaint!' Quaint because it is dated, reminiscent of the colonial origins of global health. And delightful because it brings to mind how unremarkable it has become to recognize that global solidarity is necessary for health; that 'we're in this together'. Global health did not begin that way. Indeed, my first challenge 2 years ago when I was appointed the inaugural Editor in Chief of BMJ Global Health was how tricky it was to define global health. It is an ongoing struggle. In this editorial I describe where I am on that journey and how a well-considered meaning of global health could transform global health practice, research and journals.

To define the remit of the journal, I had to first define global health—what should qualify as a global health paper and what should be the markers of quality of a global health paper. I recalled a BMJ blog with a set of caricature definitions of four eras in the history of global health[1]: global health 1.0 as tropical medicine, beginning as an effort to keep white people and subsequently the labour force alive in the colonial tropics; global health 2.0 as international health, which was about clever people in high-income countries (HICs) helping people in low- and middle-income countries (LMICs); global health 3.0, which is (note the change in tense) about people from HICs leading health programmes in LMICs; and global health 4.0, which is about people from LMICs leading health programmes in LMICs.

While these definitions offer truth by way of caricature, they say little about the why and how of global health, except for global health 1.0, which began with a clear goal and continues today in efforts to keep people alive by developing drugs and vaccines to tackle largely infectious diseases. I wondered, for example, whether global health 4.0 differs in any way from day-to-day public health work done by nationals of LMICs in their own or neighbouring countries, and whether such work only becomes 'global health' when it is done by a person or with funds from HICs. The definitions also made me wonder if there was any difference between international health (global health 2.0) and global health 3.0 or 4.0. What about the health of disadvantaged groups in HICs? Is addressing high HIV prevalence among Hispanics or African Americans in the USA global health? Is intervening to improve the health of indigenous peoples in Australia or Canada global health?

These are important questions, not only for a journal editor, but also for all of us who work in global health. We need to be able to articulate clearly what it is that we do. However, global health is often defined by how it differs and departs from international health, the difference being a focus on health equity and issues that transcend national boundaries, being multidisciplinary and embracing the role of non-state global actors such as philanthropies.[2] But there is much in the 'international health' era to suggest that this is a false distinction: international health went beyond bilateral relations (e.g., in efforts to eradicate smallpox), focused on health equity (e.g., in the Alma Ata declaration), was multidisciplinary (e.g., academic departments of international health were often multi-disciplinary) and embraced and involved the role of non-state philanthropies (e.g., the Rockefeller Foundation).[3]

So is this distinction between international health and global health in name only; differing brands, but the same substance? I found my answer in a description of global health by Farmer et al., as 'not [an academic] discipline but a collection of problems [that] …turn on the quest for equity'.[4] This is, for me, the distinction between international health and global health—while international health focuses on helping LMICs, global health is about health equity everywhere, including within HICs, such that a paper addressing, for example, indigenous health equity in Australia is eligible for consideration in a global health journal. This is my favourite characterization of global health, as it makes no pretences about global health being defined by global cooperation, national boundaries and specific categories of actors. Nonetheless, this description deserves further consideration—what problems define global health and why is global health not (yet) a discipline?

For me, there are two kinds of problems: problems of discovery and problems of delivery. Problems of discovery are about finding

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technological innovations to improve global health equity, for example, new vaccines for infectious diseases like HIV and malaria, drugs to control non-communicable diseases or a new app to connect patients and providers. The disciplines responsible for finding solutions to these problems either predate or would exist without global health, so they cannot be what defines global health. On the other hand, delivery problems are encountered in efforts to make innovations work in practice. Unlike discovery problems, which belong in the basic sciences, delivery problems require the social sciences, first to understand and then to address the information and motivation problems that may prevent or constrain delivery.[5] They highlight the failure of governments, non-governmental organizations, the private sector, service providers and communities to put in place or demand equitable health systems.

Delivery problems define global health. While the gulf between discovery and delivery exists in other fields, what makes global health peculiar is that discoveries and the decisions on whether or how to deliver them are typically made at a distance, removed from the realities of their targets or intended beneficiaries. They are removed not only geographically, but also socially, culturally and economically, even when geographically proximal. Notably, the distance is not only between HIC and LMIC actors, it is also present within HICs and within LMICs, especially across class, social and ethnic divides. It is present when people with resources to address delivery problems do not have the information or motivation to either make the discoveries available or tailor them to local circumstances. It is present when feedback takes longer or does not work at all; i.e., feedback between actors at the global and national level, the national and subnational level, or the subnational level and the community, or between any of the parties to these combinations. It is present when there are asymmetries of power, motivation and information between the helper and the helped.[5,6]

So, what do these mean for global health practice and research, and for the journals that report them and seek to facilitate conversations to improve them? First is the need to recognize an information paradox at the heart of the delivery problem. On the one hand, the only thing the helper in global health has more of than the helped is power and resources. The helped have far more information on how to get global health delivery right, on how to intervene in their lives. But on the other side of the paradox, the helped in global health (as individuals, households and communities) often do not have the information to help themselves adopt appropriate health practices, to help them hold their governments and service providers to account. We helpers must acknowledge and embrace our ignorance in our work and also reflect in our journal articles how we used information from the ground to inform our work and how we in turn channelled new information back to the people to help them hold their governments and service providers to account.

Beyond the methodological markers of quality, which are specific to each of the disciplines that feed into global health, journals should require that the papers they publish are informed by, framed by and reflect on delivery problems. Editors of global health journals should demand of authors that the ‘so what?’ of their papers be articulated in terms of delivery problems, providing a potential unifying framework for global health papers, thus helping to fulfil the promise (hitherto unfulfilled in global health) of journals serving as a forum for the different disciplines to speak to one another. If we think of an academic discipline as a field in which people share the same assumptions and engage in debates on how to build on those assumptions[7] and the purpose of a journal as a forum for such disciplinary conversation and debate, then an important responsibility of global health journals is to foster, facilitate and forge a common language to link these disciplines that will, potentially, allow global health to become a discipline rather than only a collection of disciplines.[8,9]

In the last two decades, health policy and systems research (HPSR) has emerged as the multidisciplinary field that addresses delivery problems in global health, but the field has so far not moved towards becoming a discipline.[10] To create a discipline of global health, journals should explicitly acknowledge this crucial intersection between global health and HPSR. Beyond finding a way for disciplines to speak to one another, global health journals have a responsibility to make jurisdictions speak to one another. This requires communication at a level of abstraction higher than jurisdictional details and framing delivery problems at the level of social phenomena. And therein lies a tension. Ensuring that insights travel between jurisdictions requires abstraction, but to be meaningful, published global health work requires a high level of contextual detail. Balancing both demands is a challenge that editors of global health journals need to recognize and address, especially given the tendency of journals to require that authors limit the length of their work based on arbitrary word limits.

One way to encourage abstraction is to insist that research papers identify the social phenomenon under inquiry and abstract their research questions and/or their findings in terms of social theories that have been used to study or explain similar phenomena across disciplines. This may encourage deeper thinking and multidisciplinary analysis and reflection, and potentially advance the field of global health as an academic discipline. In addition, global health journals should work together to develop guidelines for structured reporting of context, even if in a regular appendix to global health research papers. It is also important that global health journals create a space and raise the profile of ‘practice’ papers dedicated to reports on implementation that may not achieve the abstraction, theoretical sophistication and analytical rigour of a research paper, but which may provide rich contextual detail and transferable insight based on experience and descriptive data.

In conclusion, it appears to me that we have been looking in the wrong places to define what is the core of our work. If we take the meaning of our field seriously, and go where that meaning leads, we will probably do things differently, as practitioners, researchers and journal editors. If people who are the targets and intended beneficiaries of global health work were to define global health and determine how it is studied, practised and reported, I suspect it will not be about the global commissions, discussions and debates of the day in Geneva, New York and London and on Twitter, and the jostling of the privileged global elite for power and position, but rather about the information and motivation problems that limit and constrain delivery, beginning at the local level. I hope that we can begin to truly decolonize global health by being aware of what we do not know, that people understand their own lives better than we could ever do, that they and only they can truly improve their own circumstances and that those of us who work in global health are only, at best, enablers.

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