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ANALYSIS

# Do the solutions for global health lie in healthcare?

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## Abstract

**Jocalyn Clark** argues that the medicalisation of global health, like other aspects of human life and health, produces a narrow view of global health problems and will limit the success of solutions proposed to replace the millennium development goals

Global health has risen in visibility over the past decade, leading to increased recognition of the world's gross inequalities in health and the disproportionate burden of poverty and disease borne by developing countries. A baby girl might expect to live to 83 years of age in Canada, but her life expectancy is closer to 55 years in some African countries. This is largely owing to high rates of child illness and infectious disease in poor countries but can also be attributed to the rising number of premature deaths from non-communicable causes. Underlying this disparity are inequalities in access to immunisation and clean water, income, education, and other factors important to health. Collective responsibility for improving global health—demonstrated by initiatives such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the GAVI Alliance to increase access to immunisation in poor countries—has helped advance global health goals as part of a broader development agenda, which recognises that good health is conducive to economic growth and stability.

As the millennium development goals programme reaches its end in 2015, a new global health agenda is emerging with mental health, non-communicable diseases (NCDs), and universal health coverage brought to the fore. This is to be welcomed but, as I argued in a recent series of articles in *Global Health Action*, the agenda has become too medicalised, which may limit its success.[1-4]

How health problems and agendas are framed is important. It determines what gets included and excluded, and which priorities, strategies, resource commitments, and policies are made. The global health agenda—formed collectively by influential institutions such as the World Health Organization and other United Nations agencies, donors, research and advocacy organisations, industry, and journals—shapes public perceptions and expectations of how the global community will work to alleviate poverty, redress inequities, and save and improve lives.

## Social rather than medical solutions

As shown for birth, death, sexual dysfunction, addiction, and many other conditions, the medicalisation of human problems is characterised by reductionism that ignores broader contexts. It places responsibility with the individual, disregarding social constraints, and produces a bias toward technological solutions such as doctors, drugs, and devices.[5-8] It is disempowering, costly, and potentially harmful.

Medicalisation does not tackle the root cause of the problem and takes attention and resources away from doing so. For example, when Unicef focused its malnutrition programmes on supplementation with ready to use foods it ignored—and deflected attention from—the economic constraints, barriers to breastfeeding, food pricing, and trade policies that result in mothers and children not receiving adequate and sustained nutrition.[9] Similarly, investment in cholera vaccines and mass distribution of oral rehydration solutions for diarrhoeal disease are only short term medical remedies for the larger problem of inadequate access to clean water and sanitation, which causes up to 1.5 million people, mostly children, to die each year.

History warns us that focusing on healthcare or medical determinants alone will not produce the global health gains desired. Vast evidence indicates that factors such as income, education, housing, governance, and the environment determine health.[10] Recognition of these social and political determinants of health has been apparent in international declarations for decades. Historically, improvements in health and life expectancy were not the result of biomedicine but better living standards and nutrition. More recently, even with substantial modern medical and technological advances, only 10-43% of population health is thought to be attributable to healthcare.[11-13]

## Three medicalised global health concerns

Medicalisation is evident in three prominent priorities on the global health agenda—mental health, NCDs, and universal health coverage (box).[1-4] Understanding of, and solutions for, these problems are tilted in favour of biomedical and technical definitions at the expense of social and political contexts and action. When human rights are acknowledged they tend to be seen in narrow terms of improving access to healthcare. But this will produce limited gains. For example, efforts to improve

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the delivery of mental healthcare in South Africa increased participation and awareness of local health services but failed to tackle the gender inequities, injustices, and poverty that are the underlying causes of mental health problems.[14] As such, recommending psychosocial interventions in addition to drugs for global mental health, as the WHO Mental Health Gap Action Programme does,[15] can still neglect broader social and political determinants.

Responses to the "NCD epidemic" are similarly medicalised. Many recommended strategies are aimed at changing individual behaviour: increased use of drugs and medical monitoring, and decreased consumption of tobacco, alcohol, and unhealthy food. Individualising the problem deflects attention from the social and environmental contexts that constrain people's choices (such as the availability, affordability, and acceptability of food). The NCD agenda is dominated by the views of medical professionals and healthcare industries,[3 16 17] which encourage an enhanced role for doctors and other health professionals and drugs for prevention and treatment.[18-20] Recommended low cost drugs, such as polypills, are "magic bullets" that do not address the social drivers of NCDs; nor are they assured to achieve population health gains.[3 21]

For dietary risk factors, the NCD agenda over-relies on "downstream" strategies to directly change the behaviour of individuals through, for example, mass education or health promotion about healthy diets and active living. This neglects "upstream" determinants of health such as marketing.[22] Evidence also indicates that dietary risk factors and physical inactivity are more strongly influenced by manufacturing and marketing practices and built and social environments than individual preferences.[23 24]

Both the global mental health and NCD campaigns lack the prominent participation of independent non-governmental organisations to challenge medicalisation, in contrast to earlier health movements where, for example, HIV and women's health activists strongly resisted attempts to medicalise health problems.

The campaign for universal health coverage medicalises global health by making access to healthcare the single priority, conflating healthcare with health.[4 25] It focuses on preventive and curative actions at the individual level.[26] But population health can remain poor or decline despite universal coverage.[26 27] Focusing on access disparities distracts from health disparities and overlooks actions needed outside the health sector.[4] The campaign frames access to healthcare as a largely technical and financial problem, with insufficient attention to the social and political determinants,[10] the right to health, community participation, implementation challenges at the country level, and the potential conflicts of interest of private sector involvement.[4 28]

The universal health coverage agenda needs political debates and commitments to equity, quality, and collective responsibility for health.[4 28-30]

## Healthcare and short term thinking

Medicalisation of global health problems reinforces short term thinking when a long term view for health development is needed. The short term view produces a narrow focus on interventions and physical entities such as vaccines, drugs, devices, and equipment that can be bought and distributed quickly.[31] For example, NCD strategies designed to influence individual choice or access to drugs are "quick fixes" that will not have lasting impact rather than effective population level tactics aimed at social and political determinants, including governmental policies such as marketing regulation, nutritional labelling, minimum pricing on alcohol, and urban planning to encourage physical activity.[3 21]

The short term view is supported by donors' increasing focus on results and impact, which incentivises interventions and goals that are easy to implement, monitor, and measure. But sustainable change and improvement need more than medical solutions and short term goals. Structural interventions and policies to target the root causes will require political determination and a long term view. The recent Lancet Commission on Investing in Health [32] recommended a combination of population based and clinical interventions—as well as the strengthening of health systems—to improve global health. It noted the difficulties and time needed to tackle underlying causes of health inequality where "complex and entrenched political obstacles exist."

## Serving whose interests?

Medicalisation of global health advances the interests of the healthcare industry, especially the drug industry, and if left unchecked it can lead to overdiagnosis and harm, disease mongering, and profiteering rather than public health gains. Medicalisation diverts attention away from the fact that the alcohol, food, and drink industries contribute to global health problems, thus distracting from action targeted at exposing and changing corporate behaviour. Unsurprisingly, industry supports the calls for more doctors, more medicines, and more medical products and services, as well as the focus on individual behavioural change.

During the 2011 UN summit on NCDs lobbying by food and drink companies thwarted discussion and commitment to actions related to the most cost effective fiscal and regulatory interventions.[17] At the 2013 World Health Assembly, industry touted the "harmful" effects of taxation and marketing bans on its activities.[33] Instead, industries advocate less effective strategies such as individually targeted information and educational approaches to encourage quitting smoking, eating well, becoming more active, and drinking in moderation.[23]

Furthermore, these industries actively undermine public health programmes and policies by co-opting policy makers and health professionals, lobbying governments and politicians to oppose public regulation, and obscuring public perceptions by referring to government intervention as a "nanny state."[23] Similarly, the drug industry is expected to oppose flexible intellectual property policies for NCD drugs, like those that provided wider access to HIV/AIDS drugs.[34]

The global drug industry is staking its future on the markets of developing countries for NCDs and mental health problems.[2 34] Market research companies predict that annual drug sales in emerging economies will double to reach $300bn (£180bn; €230bn) by 2020,[35 36] and the global mental health market will increase to $88bn by 2015.[37] The International Federation of Pharmaceutical Manufacturers and Associations estimates that 4100 new drugs are in the pipeline for NCDs,[38] and vaccines for cancer, cardiovascular disease, diabetes, and obesity are the industry's new goldmine.[35] More than 200 products are said to be in development to meet the growing burden of mental health disorders,[39] and markets will expand if new treatment areas, such as bipolar disorder and psychosis, are advocated in developing countries. If this happens, the disease mongering of mental health is likely to further globalise.[2]

The private healthcare industry is also likely to flourish as a result of the focus on financing rather than delivery in the campaign for universal health coverage.[4] Public bodies may

**Medicalisation of three global health problems**

- *Global mental health*—Current approach emphasises biological disease, links psychiatry with neurology, and reinforces categories of mental health "disorders." It promotes the universality of symptoms, causes, and biomedical diagnoses across cultures, and takes an individualised view, giving priority to biomedical treatment and scale-up of healthcare interventions[2]
- *Non-communicable diseases*—Bias toward individualistic targets that avoid the root causes of the problem; deflect attention from government policies or regulation of the drug, alcohol, and food and drink industries; and create expanded roles for physicians, healthcare workers, drugs, and medical monitoring[3]
- *Universal health coverage*—Campaign conflates health with healthcare, downgrading the social and structural determinants of health and the risk that healthcare may worsen inequities. It focuses on preventive and curative actions delivered at the individual level, and risks the commodification of health[4]

manage future universal healthcare systems, but the health services themselves are marketable commodities in the current model, creating an entry path for private insurance companies, private healthcare providers, and managed care organisations.[28] Transforming the healthcare needs of a population into specific commodities, mostly defined by medical experts for economic markets, may lead to privatisation of universal healthcare coverage.[28] It is unclear how equity would feature in such a system. Private systems may avoid providing care to people who are poor, aged, or chronically ill and may also risk diverting attention and investment away from the strengthening or rebuilding of public health systems to provide integrated, equitable, and community driven care to meet global health goals.

## Refocusing global efforts

Although the rise of mental health, NCDs, and universal health coverage on the global health agenda is welcome, medicalisation of these matters will not produce the sustained improvements desired. We need to challenge medicalisation through more participatory research, exclusion of industry from agenda setting, management of conflicts of interest, a focus on the right to health, and greater attention to the societal and political determinants of health.[1-4 40 41] Together these efforts can broaden the agenda to include social and political action in addition to medical and technical solutions for the improvement of global health.

Contributors and sources: JC is executive editor and scientific writing specialist at icddr,b (a global health research organisation in Dhaka, Bangladesh), a former senior editor at *PLOS Medicine*, and former assistant editor at *The BMJ*. The article arose from observations as an editor of the growing medicalisation of global health problems and solutions, and conversations with colleagues who were similarly concerned.

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**Key messages**

- Mental health, non-communicable diseases, and universal health coverage dominate the post-2015 global health agenda but are predominantly framed in narrow medical and technical ways
- Medicalising global health discounts the importance of the social and political determinants of health
- It reinforces short term thinking and a focus on physical interventions when a long term view and action on root causes are needed
- Medicalising global health may lead to disease mongering and profiteering and divert attention from adverse corporate influence on health
- Sustained progress in global health requires a broader agenda that prioritises social and political action in addition to medical and technical solutions

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