Global health is one of the major and most fashionable global public policy issues of our age. As Koplan et al (2009) indicate, global health provokes a great deal of media, student, and faculty interest. It has not only driven the establishment or restructuring of several academic programmes, but has become a major philanthropic target and a crucial component of foreign policy for most Western governments. As a discipline, global health is derived from public health and international health, which, in turn, evolved from hygiene and tropical medicine. From scholarly, policy and practice points of view, the field of global health presents a discipline-transcending opportunity for research, education and policy activities, which various UCL units (STEaPP, IGH, GGI, IIPP, among others) have been tackling at different scales and timeframes. The Global Health Thematic area builds on existing UCL-wide intellectual momentum to tackle two separate but related overall objectives in the 2018/19 academic year; firstly, to rethink policy rationales and models in light of Sustainable Development Goal 3 (SDG3), focusing particularly on how policy at different levels (from the global to the local) can best be aligned to deal with persistent and emerging health issues and; secondly, to advance discussion on the concept of local health, as a complementary lens to global health literatures and a new and important opportunity for inclusive and sustainable contribution by low-and-middle-income countries (LMICs) to the health security of their populations and globally.

This brief serves as a summary of the discussions at a half-day workshop, hosted jointly by the UCL GGI’s Global Health Thematic Directorate and UCL STEaPP on 22 January 2019.
WORKSHOP OVERVIEW

Attended by 28 participants (15 UCL and 13 non-UCL) from academia (including some masters and PhD students), policy and practitioner communities, the workshop was conducted as a two-panel event addressing the first overall objective of the Thematic Area. Speakers in each panel tackled empirical and conceptual issues on this overall objective looking at historical, contemporary and future perspectives, guided by some overarching questions, and the workshop’s two specific objectives, namely:

1. Reflection: To share thoughts, empirical and conceptual reflections on drivers and shapers of current health policies and the relevance thereof to attainment of SDG3
2. Exploration: To explore opportunities, new models, rationales and loci of action on how best policy can facilitate attainment of SDG3

PRELIMINARY REFLECTIONS

Reflections shared at the beginning of the workshop were around what ‘rethought’ policy models and rationales would look like, with respect to the following:

- Empirically – what different kinds of historical, current and futuristic evidence/data should they draw on?
- In terms of levels – is there a different way of leveraging the fact that health systems are products and drivers of interactions, synergies, trade-offs and misalignments at micro-, meso- and macro-levels?
- Loci of knowledge production – health systems and health policies are defined locally, yet health challenges are transboundary. How best can capacities and needs be aligned across boundaries?
- Inter-, multi- and trans-disciplinarity – how do we ensure a cognitive and operational premium from the coming together of multiple and diverse disciplines?
- Enhancing linkage between knowledge and action – how can boundary-spanning evidence, processes and organisations from the global to the local be enhanced in terms of credibility, legitimacy and salience?

GLOBAL-LOCAL POLICY DILEMMAS

The global-local policy quandary was aptly illustrated using the following pre-workshop remarks from a health system practitioner working for a global NGO in a low-income country:

“Some of the challenges we see in diagnostics are that each country wants to repeat evaluating performance of an innovative diagnostic test before its use. For example, PIMA Analyser took long to get to full implementation for CD4 testing because each country wanted to conduct its own ‘full scale evaluation of its performance’, yet WHO and even other countries in the region will have done it. As such, there were over 40 studies in high burden HIV settings evaluating PIMA device; same thing with HIV Viral Load devices now; we are slow in the implementation because of the same challenges. We need policy advisors who are well informed of such issues. Policies around essential diagnostics are non-existent neither is there any explicit priority for their quick adoption once it’s been shown through WHO or other neighbouring countries that they have good performance. We need to either limit this to simple feasibility studies that mustn’t take weeks or no studies at all but implementation.”
DEEPER REFLECTIONS AND EXPLORATIONS IN PANEL SESSIONS

Dr Geoffrey Banda (University of Edinburgh), Prof Theo Papaioannou (Open University) and Prof Rainer Kattel (UCL IIPP) spoke in the first panel, guided by the question: *What are the key policy rationales and models that have shaped, currently shape or will shape health policy at global, national and local levels? What justifies them and what adjustments would make them better?*

In the second panel, Prof Joanna Chataway (UCL STEaPP), Samy Ahmar (Save the Children UK) and Dr Gerry Bloom (IDS Sussex) spoke around the question: *How best can local policy makers assume greater responsibility for innovation, risk and uncertainty relating to health security locally and globally?*

Key insights emerging from the presentations, responses and discussions among panellists and workshop delegates are synthesised in the sections below.

**PARADOX OF GAPS AND BLURRED BOUNDARIES**

Much of the early discussion in the workshop addressed global health from the perspective of a global rules-based order including United Nations bodies such as the World Health Organisation, UNICEF and others. This so-called rules-based order includes normative initiatives such as the definition and implementation of the Sustainable Development Goals (SDGs) including SDG3 regarding health. It was noted during the discussion that the SDGs include targets which bias priorities internationally and domestically, although at the domestic level other political considerations also have an influence on health policies. However, the SDGs do not cover things such as dental care, sight or even antibiotic resistance, and as such there are questions around the value of such goals and targets when it comes to driving health interventions or priorities.

The distinction between developed and developing countries may have become less relevant as a growing set of middle income countries continues to emerge. Many countries around the world have been looking for models of development, and the available models of development have increased with the rise of China in particular, but also India and other countries such as Malaysia for example. These models of development include more than just massive and potentially transformative investments in the Belt and Road Initiative for example, but also models of health systems and health care championed by public, private and non-profit sectors. The workshop also raised the question of ‘theory of state’ and what this means for health systems internationally and domestically.

**ACTOR DYNAMICS AND SERVICE RECONFIGURATIONS**

In addition to state actors, there is a growing set of non-state actors important to global health. This includes multi-national companies which have traditionally been from the United States, the UK and Europe and include large pharmaceutical companies and medical technology companies. It was noted in the discussion that there had been issues of coordination, affordability and access. For example, when national health systems adopt a technology as part of the health care system, in some cases procedures or technologies change and become redundant due to international innovation. Looking forward, it was noted that information technology companies appeared to be making large investments in health related applications, and companies such as Fitbit were already having large market penetration. Issues included data ownership, trust, and also the extent to which everyone in society might benefit from possible new technologies. Importantly, it was anticipated that new collaborations and partnerships would emerge between technology companies as they map human health, develop effective algorithms and diagnostics for identifying diseases and integrate with traditional health companies for example drug companies, to provide medicines and health interventions. At a minimum, these collaborations and data partnerships will be marketing platforms for drugs and at most it will be a whole new way of integrating services, including diagnosis, drugs and other interventions. It is unclear how public health services might engage with, integrate into or benefit from these new health innovations.
THE CHANGING MORAL AND POLITICAL ECONOMY OF HEALTH NEED, DEMAND AND SERVICE

With these changes in mind, the issue of people, wellbeing and health was also a key area of discussion. This included health needs and the extent to which individuals versus specialists can speak to and define these needs. This included questions of the role of expertise, power dynamics, equity and inclusivity, and access to health services. Key questions related to needs included: what are these needs, what works addressing these needs, and how can we deliver effective services addressing these needs? Health demand was discussed, including public and private demand. Even in low income countries there are people that can afford, and are willing to pay for, private health services. Meanwhile there are people, even in wealthy countries, that cannot afford private health services by themselves and necessarily rely on public health services.

SYSTEM STABILITY VERSUS INNOVATIVENESS

With regards to the provision of health services, a key issue was the stability of health services which was considered to be in tension with the need to innovate and improve public health services. Other complicating factors included the SDGs, international initiatives and targets for example related to the Global Fund which influence domestic priorities and international collaborations. Meanwhile at the local level and at national policy level, services and delivery are bundled for practical reasons, including optimising the use of resources for example during immunisation drives, or cultural and other reasons as required. The capacity of national health, district and local health systems to absorb innovation and change was noted as being an important practical constraint to innovation.

DISRUPTIVE COLLABORATIONS?

Looking forward, it was anticipated that health systems around the world will be disrupted through the emergence of technological collaborations and partnerships. Technological investments in health were discussed for India, China as well as the USA and other countries. Innovation in China and India may be very different with regards to intellectual property and data privacy. It was noted that low margin high volume health service models may emerge, where diagnostic instruments such as Fitbit coupled with algorithms make it possible for drug companies and others to access very large markets and lower their pricing due to the size of these markets. As such, there is a possibility that new personal health technologies such as Fitbit will become as widespread as mobile phones and many more people are able to be reached than ever before with medical advice (including preventative advice) and drug treatments. However, issues of interaction between drug treatments may emerge as a problem particularly where individuals have multiple ailments being treated at the same time.

TENSIONS BETWEEN TECHNOLOGY SOPHISTICATION AND EFFECTIVENESS

The risk of ‘innovation capture’ was noted. For example, it is possible to imagine international meetings at the WHO in a few years where large multinational technology companies are sitting at the table and participants from member states are wowed by sophisticated personal health technologies. At the same time there is a risk that practical, face-to-face interventions may be neglected. Conceptually it is possible to plot sophisticated technologies against the extent to which a technology helps solve problems and is practical (see Figure 1 below). Personal health devices coupled with algorithms and other information may be sophisticated and effective, technologies in isolation may be sophisticated but less effective, meanwhile some technologies or interventions may be simple but very effective such as the kangaroo care method for premature babies.
It was also noted that some medical conditions may require interventions such as surgery and as such there remains a need for boots on the ground (i.e. medical staff) and health facilities. However, synergies could emerge for example if medical facilities are able to receive data in advance of patients arriving in a clinic, sent from personal health devices.

**FIGURE 1**


Perhaps the most poignant problematisation of the task of rethinking rationales and models for global and local health is the set of questions that were raised on what the metaphorical elephant in the room will feel like in a few years, for example at a WHO meeting when technology companies and others are sitting around the table? What will the legs, trunk, ears, body or tail feel like? How will the international community and different actors perceive global health, health problems and possible solutions? What will be the new coalitions formed? What things will become coupled and which issues, technologies and interventions will become decoupled? It may be at this time that SDG 3 becomes important – avoiding technology capture and bringing a focus on how to ensure healthy lives and promote well-being for all at all ages including in the areas of reproductive, maternal, newborn and child health; infectious diseases and non-communicable diseases; as well as health systems and funding.

**NEW INNOVATION FRONTIERS**

Lastly, it was noted that much of the discussion had been about developing countries along with innovation leadership from new frontiers such as India and China. However, a question was raised about whether and how the UK, Europe and other Western countries will benefit from the innovations emerging from China and India and/or whether the existing regulatory regimes around technology, intellectual property, data and privacy in these countries would limit innovation or uptake of health service models emerging in China and India which have very different regimes?
CONCLUSION AND NEXT STEPS

This workshop confirmed the salience of continuous scholarly, policy and practitioner thinking and action around the relevance and utility of policy tools to ensure their appropriateness, efficiency and effectiveness as institutions for ensuring health-secure global and local spaces. Key messages from this workshop will inform follow-up engagements (partnerships, events, co-publications or research bids) with workshop participants and other stakeholders in the wider academic, policy and practitioner community of global health as part of the UCL GGI Global Health Thematic Area.
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