

Global health: an analysis of the relations between the processes of globalization and the use of health indicators

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The objective of this paper is to discuss the construction of Global Health, identifying its political and epistemological uses. The rhetorical use of global health indicators and their relations to globalization processes are treated here as analyzers. A bibliographic and documentary research on the subject was performed. The analysis has a critical and constructionist perspective about knowledge production and globalization processes in health, and it is based on the work of the sociologist Boaventura Santos. In spite of the use of the adjective 'global', the study highlights the epistemological and political dispute that is in progress in the relations between globalization and health, and the rhetorical use of global health indicators for the construction of policies for poor and developing countries. It is considered that this strategy aims to influence national healthcare systems in a cross-cultural and colonizing perspective that extinguishes local knowledge and traditions, as well as local modes of subjectivity.

Keywords: World health. Health policy. Globalization. Health indicators.

Introduction

In the last decade, global health has been described as a notion, a concept, a policy and an approach appropriated by the academy, by governments and international agencies, by epidemiologists and health militants, among others, to indicate an arena (or even a political-social mode of relation) that is under development¹.

Nowadays, the term Global Health has many perspectives, meanings and uses. Ours is a constructionist perspective of knowledge production and of globalization processes in health, based on the studies conducted by the Portuguese sociologist Boaventura de Sousa Santos about such processes in the contemporary world.

We support the thesis that there are historical, political and epistemological disputes under way in the relations between globalization and health. Among them, policymaking strategies in this arena have been guided by the construction of scientific evidences of cross-cultural character as a

criterion of justification and intervention in national healthcare systems, mainly in poor and developing countries.

This paper results from a set of studies focusing on the role of international agencies in national health policies, especially policies to educate workers for primary healthcare^(c). It aims to discuss the construction of the so-called Global Health, identifying its political and epistemological uses, and also to analyze its relations to globalization processes and the use of health indicators.

To achieve this, an analysis of the literature and of international documents was carried out, especially the database of PUBMED and of international agencies such as the World Health Organization (WHO). The object of analysis was the theme of global health, its history, definition and intervention strategies in the international arena.

Processes of globalization and knowledge production

The phenomenon of globalization has been termed in different ways by several authors, but they recurrently use the adjective “global” in their theorizations: Global System, Global Culture, Global Process, Global Health, among others. This semantics unfolds in the second half of the 20th century and promises, as an inexorable destiny, to establish itself definitely in the 21st century.

We will not present a monolithic view of the concept of globalization. We will follow the path that has been opened by the Portuguese sociologist Boaventura de Sousa Santos, to discuss some themes that will serve as critical arguments in our work.

“A review of the studies about globalization processes shows us that we are before a multifaceted phenomenon with economic, social, political, cultural, religious and legal dimensions interconnected in a complex way. For this reason, monocausal explanations and monolithic interpretations of this phenomenon do not seem to be very appropriate”².

With the intensification of international flows in industry, trade and culture, the emergence of companies and transnational organizations that are responsible for the major part of the financial investments in the world, the development and dissemination of information and communication technologies, the increase in the flow of people and goods in the five continents, and the emergence of new and precarious forms of labor organization, the reduction in the role of the State-Nation and social welfare have been gradually losing their contours and new management forms of the international economic policy have been developed in the contemporary capitalist context.

^(c) Project financed by CNPq – Inflections of International Agencies about healthcare workers’ education: a case study on the World Health Organization (2009-2011).

Globalization, in its economic dimension, according to Santos² and Fiori³, has its political milestone at the end of the 1980s, during the Washington Consensus, of which North American financial institutions for international aid were part, such as the World Bank, the International Monetary Fund (IMF) and the Inter-American Development Bank (IDB). In this document, a series of prescriptions was made to the economic restructuring of Latin America. Monetary structural adjustment was the main objective, which should be fulfilled through fiscal adjustments, reduction of the State's role in the economy, privatization of public services, foreign investment liberalization, property rights and reduction in investments in social policies.

To Santos², this is the most consensual and hegemonic part of the phenomenon of globalization. However, as the globalization processes are neither convergent nor do they present themselves only in their economic side, there are movements, or, according to some authors like Castells⁴, cultural and social repercussions, that are perceived as collateral effects of economic globalization.

The acceleration of globalized capitalism through investments and structural adjustments in the economic policies of peripheral countries has also produced an increase, in a scale that has never been seen before, in economic and social inequality across the world. Several data point to the trench that exists between the wealthier nations and the progressive desocialization of economy in the poorer nations.

These data make globalization be a complex phenomenon, subject to multiple crossings, resistances and processes that range from the universalization of policies, behaviors and discourses, to the recognition of the particularities and singularities of different cultures and ethnicities.

Boaventura points to three types of globalization: economic, political and cultural. The first was already approached above and concerns the new world economic order in which capital and investment flows do not respect national or geographic limits and are controlled by transnational companies which, through their movements of injection or withdrawal of investments, deeply affect the economy of Nation-States.

Political globalization, which redefines entirely the role of the State in economic regulation and in the provision of social policies, privatizing institutions, worships the political ideas of liberal democracy, reducing the State's actions and restructuring legal forms to enable flexibilization to foreign capital and property rights.

Cultural globalization is described as a promise of the emergence of a global culture, founded on the universalization of beliefs, values and behaviors, which would be potentialized by the development of information and communication technologies - television and the internet among them -, and by the increasing migration flow of people across the world, standardizing clothing, food and forms of entertainment. Science has been one of the most intense forms of globalization of knowledge and subjectivities, and it has been expanding across the world as a

modern and Enlightenment expression of truth. In this sense, the globalized world would have, as one of its rhetorical bases, the regime of truth:

“[...] a set of procedures regulated to the production, law, distribution, circulation and functioning of statements [...] circularly connected with power systems, which produce and support it, and with power effects, which it induces and which reproduce it. Regime of truth”⁵.

Boaventura criticizes the existence of one single globalization, as it is marked by the mechanisms of economic and political power of the neoliberal paradigm. The majority of the authors see one globalization that imposes itself on the world and on the forms of struggle against it.

This phenomenon presents contradictions, disjunctions and forms of social organization that are so diverse that range from the dichotomy between local and global to the contradictions regarding the role of the Nation-State in the adherence to/resistance against globalization.

In this sense, hegemonic and counter-hegemonic globalization movements are identified, movements that start from processes that are, at the same time, distinct and contradictory.

In hegemonic globalization, science has a fundamental role in the justification and operationalization of global devices, that is, forms of universalization of concepts, procedures, policies and behaviors.

In recent years, Boaventura developed concepts that corroborate the imbrications between epistemology and politics, in view of the western world's strategies of colonization of knowledge and practices over the developing world. This colonization process has silenced the knowledge that is not recognized as valid by the hegemonic thought, a typical characteristic of modern scientific rationality. This separation between the knowledge that is considered valid in a dominant paradigmatic tradition and the expression of knowledge constructed in other traditions was called abyssal line by Boaventura. On one side, the abyssal thinking of modern science; on the other side, the knowledge, practices and cultures of different traditions treated as inexistent, irrelevant and incomprehensible. With hegemonic globalization, this movement is radicalized, and its influence is felt in different countries and cultures, deterritorializing them.

In response to the abyssal thinking of the developed West, Boaventura proposes the ecology of knowledge as a defense of the world's epistemological diversity, recognizing its traditions, cultures and translation possibilities.

“As ecology of knowledge, post-abyssal thinking has, as one of its premises, the idea of the world's epistemological diversity, the recognition of the existence of a plurality of forms of knowledge beyond scientific knowledge. This implies renouncing any general epistemology”⁶.

In this sense, the tensions between global and local have privileged cross-cultural policies, extinguishing local cultures, knowledge and practices. These distinctions are fundamental to understand the relations between globalization and health and, furthermore, the relations among science, global policies and health.

Global Health: a dispute in the international arena

As we have described elsewhere^{7,1}, the definition of Global Health is disputed by several actors and institutions who defend its academic and political use and present different definitions linked to new health needs around the planet, as well as to the understanding that these needs and solutions constitute a common challenge to all countries.

Based on other authors^{8,9}, we understand that global health is a social construct of the scientific field^(d) and also of the political field that has been searching for stability to impose itself as a new paradigm in the international political-sanitary arena.

We will highlight below some definitions found in our studies which represent some political-epistemological positions about the theme.

In a recent paper published in a journal of large international circulation, Szlezák et al.¹¹ defined Global Health as a system, a constellation of communities, countries, governmental and non-governmental organizations, for-profit and non-profit institutions. The conception of this system presupposes harmony, stability and increment in social and sanitary justice to meet global health needs. Among them, disease prevention, equitable access to healthcare services, and health protection provided for all persons and populations.

The entrance of other institutional actors, independent of traditional institutions that support and manage national and international health, such as ministries of health and WHO, has expanded the rules and objectives of international cooperation. In addition, it has produced independent financial arrangements. One example of this realignment of resources can be found in the investment made by the Bill & Melinda Gates Foundation in health programs in the year of 2007, which equaled WHO's annual budget in that year, approximately three billion dollars¹¹.

In this sense, Global Health would identify a new arrangement among actors, Nation-States and health, impelled by the production of "new health needs", new independent actors and new standards of State regulation and intervention.

^(d) We understand the concept of scientific field, according to Bourdieu¹⁰, as a form of production and social relation in the search for recognition, resources and monopoly of knowledge.

Among the health needs, following the “example” of the reduction in child mortality rates in the world, initiatives to reduce and control other diseases and health risks have been encouraged, such as: non-communicable diseases like cancer, diabetes and neuropsychiatric disorders, as well as the continuity of the monitoring of communicable diseases such as AIDS, tuberculosis and influenza. Therefore, economic globalization has brought a set of challenges to the institution of new regulatory frameworks for the trade of goods and services in the area of health, generating new investments and influence on the national states. Another important element for the delimitation of global health needs has been climate change, its repercussions over disease vectors and its impacts on food security, water, environmental disasters and on the increase in population migrations.

In another perspective, Frenk¹² argues that health has three attributes with global repercussions: a key element for sustainable economic development; global security, effective governance and promotion of human rights; and flow of financial funds that involve the health sector. Global health would be a strategy to strengthen the national healthcare systems, a central element to the development of the global health system and a fundamental strategy to fulfill the health-related Millennium Development Goals^(e). That is, the construction of a global healthcare system depends on the alignment of the national healthcare systems, based on the strengthening of the attributes highlighted above.

According to Koplan et al.¹³, “The global in global health refers to the scope of problems, not their location”. Therefore, it is necessary to construct a criterion to locate priorities in global health, such as the construction of indicators like the global burden of disease.

Beyond its rhetorical use, the political phenomenon of Global Health represents the construction of a new agenda for the world’s health. The struggles and discussions about international health policy leave the geographic territory of countries and regions and try to impose a “cross-territoriality” on demands, evaluations and procedures. Discussions on primary care, disease control, and evaluation of healthcare systems start to constitute a panel for global planning and actions, based on the economic and technological interdependence of the Nation-States.

The title of a report of the Institute of Medicine of the United States National Academies illustrates the uses that this notion stimulates in the construction of opportunities and strategies within the hegemonic health scenario: “America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests”¹⁴.

^(e) In 2000, the UNO – United Nations Organization -, analyzing the world’s biggest problems, established 8 Millennium Development Goals - MDG, which, in Brazil, are called *8 Jeitos de Mudar o Mundo* (8 Ways of Changing the World): eradicating hunger and poverty; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating AIDS, malaria and other diseases; ensuring environmental sustainability; and developing a global partnership for development. (<http://www.objetivosdomilenio.org.br/objetivos/>)

In this report, globalization is described at the same time as a threat to the North American people, resulting from the expansion of international migration flows, which may cause the outbreak of diseases of high epidemic power, and as an opportunity to enlarge, in commercial and scientific terms, the North American influence on global health technologies.

Global Health also presents contradictions that are typical of the complexity of globalization processes. That is, on the one hand, it presents its hegemonic face; on the other hand, a position of counter-hegemonic struggle that starts from the capacity of new political and emancipatory strategies.

In another part of the globe, in Bangladesh, the First People's Health Assembly was held in 2000, based on a popular movement, the *People's Health Movement*, constituted by representatives of developing countries, non-governmental organizations and associations of healthcare professionals who claim a broad primary care action around the world, greater popular participation in health decision-making, free public health for all peoples and the monitoring of the activities of transnational companies and organizations in the market and in health policies¹⁵.

These and other initiatives clearly show the plural character of Global Health, which any hurried definition would reduce to the diversity of interests and struggles that are at stake in global health policies.

In this sense, different interests are at stake in the international health scenario, ranging from the problem of patent ownership to the expansion of large private health insurance companies in developing countries. The extension and mutual protection of large international economic interests fight together in a block to influence national healthcare models.

These and other initiatives aim to guide and influence national healthcare systems, mainly through information and communication tools to collect health data around the world and to organize international and local protocols to meet countries' demands.

"The Council works to ensure that all who strive for improvement and equity in global health have the information and resources they need to succeed."¹⁶

Therefore, Global Health indicates the construction of new political and epistemological strategies to manage, negotiate and offer ideas in the international arena, excluding the dimension of the Nation-States when it imposes their interdependence based on the imperatives of "global" needs. In this new type of negotiation, healthcare systems, indicators and the information they provide, the environment, the qualification to work in the field of health, access to services, inputs and other items are like "products" targeted at the expansion of the economy and of the markets, and also at national defense strategies against the epidemics that populate the poor nations and threaten the expansion of the health industries and the safety of the developed world.

In an attempt to organize some uses of Global Health in the surveyed literature, we identified three of its predominant meanings in the forms of hegemonic globalization, present in the political strategies of international agencies:

1 – A cross-national healthcare system that identifies health needs (or priorities), and has a set of actors and independent investors to help and strengthen national healthcare systems;

2 – A new regulatory framework in the relations between the market and health, involving healthcare goods, inputs and services;

3 – The identification of health problems, independently of their territorial/national location, which should be evaluated in a cross-national way, by means of the construction/application of demographic, economic and epidemiological indicators.

The last meaning of global health will be developed by means of an analysis of the construction and use of cross-national indicators of health, in light of the rhetorical strategy^(f) for the offer of ideas¹⁸, which has conducted to evidence-based policymaking.

Global Health indicators: from indication to determination

We argue that the term indicator can be defined as a measure-synthesis that is produced based on information captured in health information systems (which are usually digitized), and that it aims to promote the monitoring and evaluation of strategic health actions over time, as well as to evaluate and provide new information on different health attributes and dimensions and, also, on the performance of the healthcare systems as a whole.

In the literature, two forms of reference to the produced health indicators can be found: concerning purpose (efficiency, efficacy and effectiveness indicators) and concerning content (demographic, socioeconomic, mortality, morbidity and risk factors, resources, coverage, etc.). It is a fact that, with such comprehensiveness, given the reductionist seduction of homogenization, as well as its use in policies, this categorization ascribes to the indicators a great power of utility and problem-solving for different health issues.

However, it is not possible to overlook the fact that these are an indication and not a determination. In Brazil, according to *Rede Interagencial de Informação para a Saúde* (Ripsa – Interagency Network of Health Information), a set of health indicators aims to produce evidences about the sanitary situation and its tendencies, and also to document health inequalities¹⁹.

^(f) We have been using in our studies the perspective opened by Chaim Perelman¹⁷ about argumentation theory, or New Rhetoric, to analyze policies through the identification of the argumentation strategies undertaken by social and institutional actors present in documents, discourses and other materials. Boaventura Santos has also used these contributions to discuss the production and dissemination of scientific knowledge.

Nevertheless, it is important to emphasize once again that indicating is different from determining, and that evidence does not mean, exclusively, truth. In fact, regarding this second term, it is important to remember that one of its meanings is precisely clue, indication of the existence of something.

Fleming et al.²⁰, despite the fact that they agree with the idea that health indicators propose to produce evidences – or, in its rhetorical use, “production of truths” -, when they deal with the contribution that primary care promotes to monitoring in sentinel practice networks, presenting the possibility of detecting health inequalities through the use of indicators related to the targets designed in Agenda 21⁽⁸⁾, even so, they (carefully) highlight that:

“Addressing issues related to health inequalities, quality assurance in primary care and evidence-based policies for health intervention involves obtaining **appropriate information** to quantify them.”²⁰ [our emphasis]

Deckers et al.²¹ emphasize the use of indicators in primary care, and argue that health is the greatest concern of authorities and national governments, as well as the several data sources that can reveal the health and disease conditions of populations. However, they also state that it is understandable that there is inexistence of data sources, not to mention limitations and specificities in the existing sources.

Similarly, Murnaghan²² approaches the importance of health indicators for the conduction of cross-cultural studies, which are extensively employed in global health policies and research:

“...health indicators are an excellent means of promoting statistical comparability within and among health care systems. **Without some consistency and standardization in the more basic tools of measurement, one cannot examine differences and similarities and know whether or not changes are occurring.**”²² [our emphasis].

In addition, it should be observed that the indicators result from the composition of a set of data that were collected at some moment and which are integral parts of such moment. What we want to highlight through this statement, which seems to be rather obvious, is that, in order to compose a certain indicator, it is often necessary to have at least two sets of valid and consistent data (variables).

⁽⁸⁾ Agenda 21 is a broad-ranging action plan to be executed in a global, national and local way by organizations belonging to the United Nations, governors and influential groups, in each area in which human action impacts the environment. (<http://www.un.org/esa/dsd/agenda21/>)

Thus, it is important to highlight the countless differences that can occur in the way that concepts – apparently ordinary – are defined and measured in different countries, regions or contexts. Or, in other words, it should be remembered that conceptions, measurements and/or data collections, in the most varied places and spaces, are not performed in a standardized way; there are differences not only among regions of the same country, but also, and mainly, among countries. In fact, we should question, in a pragmatic way, not only these aspects, but also the pertinence, utility and costs involved in the collection of certain data in the national level. After all, this includes investment and expertise on the part of governments and health managers across the world, and it answers questions that were formulated locally and not globally.

Furthermore, it is necessary to approach the tools involved in the composition of these health databases. To save space, we will mention only the extremely common incompatibility among informatics systems (and software) used in data migration (absence of interoperability), as well as the formatting differences of the variables utilized in each database.

In view of what was discussed above, it seems that the expansion of the use of health indicators across the world is inexorable. However, there is also an underlying message that was highlighted above: these indicators should have, as basic premises, at least comparability and consistency. And the difficulties listed to capture and produce indicators in a cross-cultural way are numerous.

Despite all the reflections outlined above, the efforts made to compose, structure and delineate Global Health Indicators are uncontested – indicators that are induced, therefore, by globalization processes.

However, these efforts, which depend on premises that require a high degree of trust in the aspects mentioned above, seem to prefer a scientization, through their statements, findings and determinations, rather than by accumulation and complementariness among different types of knowledge. For example, findings from localized experiences or isolated surveys are rarely used as a supporting basis for health management or even for the promotion (or making) of policies.

It is important to mention that we do not propose, here, to deconstruct or demonize the use of health indicators. Rather, we want to alert to the possibility of incorporating, in the health arena, other experiences and types of knowledge that are also legitimate and which have equal magnitude and importance.

In addition, so that we can have an idea of what we mean here as absolute trust in what the indicators determine (instead of indicate), it is important to present the set of characteristics listed by Larson and Mercer²³ to select global health indicators:

“a) Definition: The indicator must be well defined, and the definition must be uniformly applied internationally.

b) Validity: The indicator must be valid (it must actually measure what it is supposed to measure), reliable (replicable and consistent between settings) and readily interpretable.

c) Feasibility: The gathering of the required information must be technologically feasible and affordable and must not overburden the system.

d) Utility: The indicator should provide information that is useful to decision-makers and can be acted upon at various levels (local, national and international)."

These authors also argue that the majority of the global health indicators used in developing countries focus on morbidity and mortality or on risk factors for both, while in developed countries, most of them reflect styles of individual life and behavior, such as physical exercise, smoking, diet, and abuse of alcohol or substances that are harmful to health.

This outlines, in a very categorical way, that the appropriation of indicators as "determinants" in decision-making for designing management models or for policymaking, or even for developing national healthcare systems, is fragile.

At this point, it is worth mentioning the remark that appears in the back cover of the World Health Statistics 2011 - Indicator Compendium, a publication that provides the methodological guidelines for the composition of more than one hundred global health indicators, available from the WHO website:

"All reasonable precautions have been taken by the World Health Organization to verify the information contained in this document. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use"²⁴.

That is, it seems that even international agencies aligned with a hegemonic form of globalization express ambiguity in relation to the utilization of cross-national indicators.

Moreover, there are many spaces where proposals for the aggregation of data and provision of health indicators proliferate. Only to exemplify some of them, we have: World Health Organization (WHO); Global Health Council; United Nations Children's Fund (UNICEF); US Centers for Disease Control and Prevention; National Center for Environmental Health; United Nations Development Programme (UNDP); Save the Children; and Statistics Canada.

In this text, it is worth highlighting WHO Statistical Information System (WHOSIS), so that we have an idea of the comprehensiveness that the international agencies intend to attribute to global health indicators. According to the WHO's website, WHOSIS is an interactive database that gathers basic sanitary statistics of its 193 Member States and more than 100 indicators that can be consulted in several ways (quick search, by categories, or by criteria defined by users). In addition, data can be selected, visualized graphically or downloaded to the user's computer.²⁵

This system has been incorporated into the Global Health Observatory²⁶, which aims to provide users with data, tools, analyses and reports on global health. It is basically constituted by a data repository, reports, country statistics, map gallery and indicator registry standards.

WHO's justifications to include an indicator in the World Health Statistics are:

- a) its relevance to public health;
- b) data quality and availability;
- c) the reliability and comparability of resulting estimates.

Thus, the list of selected indicators must provide a comprehensive summary of the current status of health and of national healthcare systems in nine areas (life expectancy and mortality; cause-specific morbidity and mortality; infectious diseases; health service coverage; risk factors; health workforce, infrastructure and essential medicines; health expenditure; health inequities; and demographic and socioeconomic statistics)²⁷.

It is worth presenting here one more warning of WHO regarding the data it provides:

"In many countries, statistical and health information systems are weak and the underlying empirical data may not be available or may be of poor quality. Every effort has been made to ensure the best use of country-reported data – adjusted where necessary to deal with missing values, to correct for known biases, and to maximize the comparability of the statistics across countries and over time. In addition, statistical techniques and modeling have been used to fill data gaps.

Because of the weakness of the underlying empirical data in many countries, a number of the indicators are associated with significant uncertainty" (WHO, 2011d).

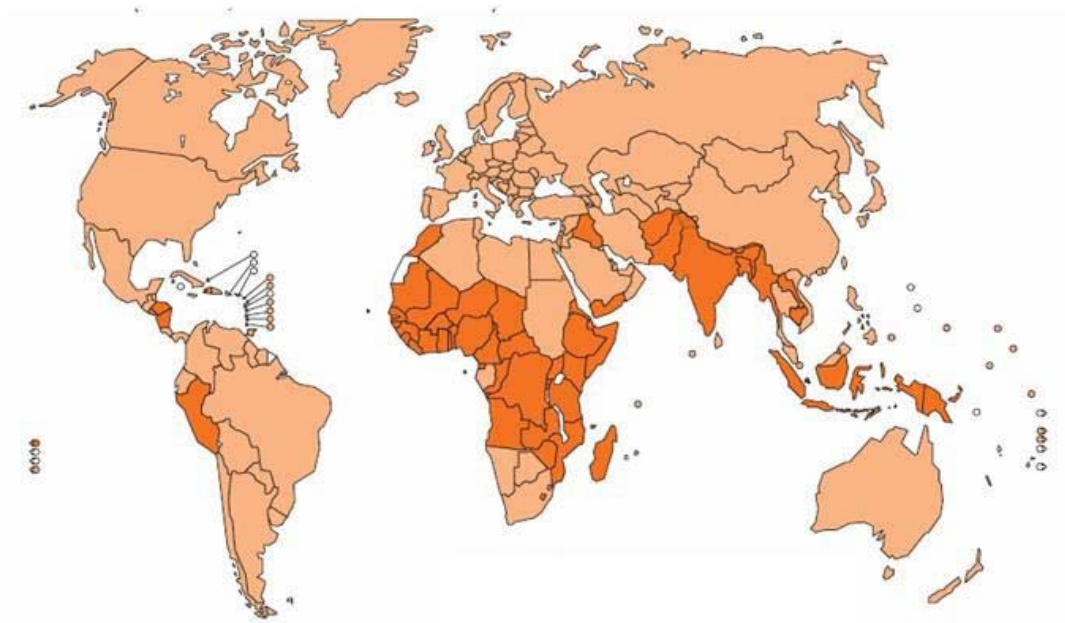
Generally speaking, it is possible to state that warnings like the one above not only denote the current technological incapacity to adequately capture and construct global health indicators, but also denounce the international agencies' intention to influence the construction of shared knowledge, when they deliberately dismiss information derived from empirical data – called underlying data above – but which might express local experiences that are indispensable to the understanding of the health status of a given population.

Based on the creation of these indicators, a rhetorical operation is put into practice in an attempt to persuade the international health community and potential donors about health demands and needs in the world. In this sense, the use of graphs, tables and maps is fundamental as a device of needs assessment and conformation. Scientific knowledge is employed in its regulatory and colonizing version, in a clear delineation of abyssal thinking, which identifies, on one side, knowledge, indicators, assessments and rankings of health needs, profiles of workers and national healthcare systems, and on the other side, specificities, actors, local policies and their

cultures, all of them deterritorialized, measured and hierarchized taking the hegemonic western thought as the parameter.

The map below exemplifies this epistemological and political process of construction that starts with the construction of indicators and culminates in the making of global health policies.

FIGURE 1. Countries with critical shortage of healthcare providers (doctors, nurses and midwives)



Source: World Health Organization. Global Atlas of the Health Workforce (<http://www.who.int/globalatlas/default.asp>) WHO²⁸.

The map above, which deals with the distribution of the health workforce across countries based on a density indicator, shows the reach and the methodology employed by global health proposals and policies. Using the map of the Earth as a needs assessment map, regardless of the comprehensiveness of healthcare systems (universal or not), of the compositions and functions of healthcare workers who aim to meet health needs, of the system's reach and access, of the public or private labor regime, a homogeneous system of health workforce distribution is suggested around the world, identifying weaknesses and investment needs. Therefore, this illustration is configured as an efficient instrument to induce homogenized actions and policies that consider

cross-cultural indicators that are not aligned with local needs. Figures like that were frequently found in the documents researched for this study; thus, they are typical of the argumentation strategies chosen by international agencies.

We are not depreciating the effort of worker empowerment within healthcare systems; rather, we want to identify their political, social, economic and cultural diversity, without treating them as equals. The measures used in global health intend to produce a perception of common objectives, means and results, presupposing harmony and absence of conflicts, depoliticizing their forms of struggle and social inclusion, remarkably in labor relations and in social inequalities in health.

In the case of Brazil, all the local investigative efforts point to inequalities and inequities in the distribution and conformation of the health workforce, and this indication cannot be captured in the figure above, as its construction is founded on a universalizing and cross-cultural perspective²⁹.

Final remarks

The contributions of Boaventura de Sousa Santos to the debate on the constitution and legitimation strategies of Global Health point to the complexity of the process that is under way, involving knowledge construction, health policy and the right to health.

The different uses of Global Health in the international health policies try to circumscribe a set of health needs/problems that are imposed on the Nation-States and which are intermediated by the use that resorts to the scientific imagery of cross-cultural indicators. This process reproduces the forms of hegemonic globalization, according to Boaventura Santos, such as the registry of regulation, in a colonizing perspective, silencing local traditions, knowledge, and modes of subjectivity.

The strategies of technological and scientific expansion aim to deregulate markets and the mechanisms of protection of national healthcare systems, opening space to the interests and investments of pharmaceutical industries, of health insurance plans and of different forms of public-private partnership that are currently at stake in the management and regulation proposals in different countries.

It seems clear, when we research the documents and literature of international agencies, such as WHO, that the theme of right to health is a priority of the global policies in the area of health, but in this sense, right is synonymous with access, in which the role of the national States is to regulate and ensure public or private access to health actions, services and inputs.

Paradigmatic themes of the sanitary reforms of the 1970s, which aimed to reduce social inequalities in the field of health, leave the territory of the social protection policies of the national States and emerge, deterritorialized, in the 21st century, through policies that should promote health equality, by means of actions of disease monitoring and control across the world.

The abyssal knowledge described by Boaventura assumes, in Global Health, shades that are strongly marked by the western biomedical knowledge and by the strategies of global government scanned by cross-cultural indicators of health. Both in the form of construction of these indicators and in their rhetorical appropriation – by the global health policies -, there are mechanisms that aim to homogenize data, methodologies and achievements that mischaracterize their local origins and territorial specificities.

The analysis of Global Health indicators is based on two dimensions that constitute devices that are associated politically, but form distinct epistemic and social communities. One is directed to the community of specialists who share values, rules and technologies for the construction and legitimacy of the indicators, and the other starts from the rhetorical/argumentative use that international agencies, governments and other institutions and political actors utilize to influence the adoption of health policies, programs and actions.

Therefore, we do not mean to say that indicators are a mere rhetorical construction; rather, we believe that their use has also the objective of persuading, mediating and intervening in an arena where the dispute over the direction, focus and funding of policies is very intense. Therefore, we consider that the construction and use of health indicators in policymaking is a social practice in which their alleged neutrality is one more strategy to persuade the communities that have, in their trajectory, the values of the technical-scientific imagery of modernity.

These processes reveal the need to respond to global imperatives, trying to identify, in the singularities of national struggles, forms, modes and strategies of translation that enable an ecology of knowledge, redescribing and updating the popular struggles to the right to health.

The shared production of knowledge, the establishment of networks of workers and users of healthcare systems, the sharing of experiences grounded on biomedicine and on other traditions and forms of care that are socially recognized are vigorous initiatives to the construction of counter-hegemonic globalization projects.

To conclude, the quotation below clearly represents the challenges and the possibility of epistemological and political paths of Global Health:

“In the perspective of the abyssal epistemologies of the global North, the policing of the borders of relevant knowledge is, undoubtedly, more decisive than the discussions about internal differences. As a result, a massive epistemicide has been occurring in the last five centuries, and an immense wealth of cognitive experiences has been wasted. To recover some of these experiences, the ecology of knowledge employs its most characteristic post-abyssal attribute, intercultural translation. Soaked in different western and non-western cultures, these experiences not only use different languages, but also distinct categories, different symbolic universes and aspirations to a better life.”⁶

Collaborators

The authors worked together in all the stages of the production of the manuscript.

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Translated by Carolina Ventura