



UK's evolving role in global health

The focus should be on equal partnerships and collaboration

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As an election year in the UK, 2024 is an auspicious time for the politics of health, with critical implications for the international as well as domestic space. What are the opportunities and challenges for the UK's position in global health? Over the past three decades, the UK has been an agenda setting and technical leader, as well as a major donor in global health activities. The national health service serves as a beacon for universal health coverage.¹ However, 14 years of austerity policies,² coupled with Brexit,³ have weakened public health infrastructure in the UK. Internationally, its contributions and impact, as well as reputation, are mostly in decline, because of substantial reductions in official development assistance since 2019, highlighted in recent Center for Global Development analysis.⁴

The UK government's global health framework for 2023-25,⁵ emphasises the sustainable development goals, the need to achieve universal health coverage globally, and adopting a One Health approach. It identifies four strategic objectives for the UK: strengthening global health security, reforming global health architecture, strengthening health systems around the world, and advancing the UK's leadership in global health science and research.

Although these goals are commendable, and for the most part in line with previous pronouncements, the devil is in the detail. Decisions on which countries to invest in and how policies are implemented is where stated ambitions to advance health globally are in tension with the UK's broader political and economic interests.

Credibility

In the wake of covid-19, global health security is central to many countries' strategies, but the UK has been criticised for being overly focused on technical capacities such as surveillance and laboratories. This criticism sits within broader tensions, including distrust of global health security, which many partner countries see as a neo-colonial project serving national security and economic self-interest.⁶

In terms of reforming the global health architecture, the UK has been a major donor for several global health institutions, such as the World Health Organization (WHO). However, alongside cuts to official development assistance, the UK undermined its credibility by championing WHO-led pandemic accord negotiations while also pushing for intellectual property protections for industry and vaccine equity to remain within the domain of the World Trade Organization. These contradictory positions have not gone unnoticed: the UN committee for ending racial discrimination recently singled out the UK and other high income countries for allowing

economic interests to trump human rights over access to pandemic countermeasures.⁷

While strengthening country health systems is emphasised in the UK's global health framework, the UK's stated priorities differ from implementation; the UK champions universal health coverage but fails (with others) to reform the substantial debt repayments that continue to undermine lower income countries' investment in health coverage.⁸ This has had a particularly detrimental effect on non-communicable diseases and mental health conditions, which, despite dominating disease burden in nearly every global region, have not been prioritised in successive UK global health strategies.⁴

The UK is well placed as a leader in science and research; it has one of the most comprehensive global research landscapes, with substantial health related benefits coming from its institutions.⁹ However, use of official development assistance budgets to support sustainable improvements in health and development overseas can be compromised by parallel objectives of promoting UK enterprise and subsidising its access into emerging markets.

Conspicuously absent from the global health framework is any meaningful reference to humanitarian relief and lifesaving funding for the world's most vulnerable people. Between 2020 and 2022, cuts in funding for humanitarian emergencies decimated health programmes in global hotspots, including Yemen (reduced from £221m to £77m), Syria (£181m to £63m), and South Sudan (£156m to £76m).¹¹

Staying effective

So where does this leave the UK? UK decision makers will no doubt be considering evolving power dynamics in global health—including the ascendancy of Germany¹² and China¹³ and regional bodies such as the Africa Centres for Disease Control and Prevention showing greater commitments to global health.¹⁴ The right choice of partner countries for global health activity is particularly important. In 2016, the UK pursued health partnerships with Myanmar (later abandoned) despite alarms being raised about the impending Rohingya genocide. More recently, continued support for Israel, which is also being investigated by the International Court of Justice for genocide,¹⁵ jeopardises the UK's international standing in global health.

Looking ahead, the UK should take a collaborative rather than competitive view of its role in global health and make co-creation and equal partnerships a focus of all activities. This involves learning from a more diverse range of countries in terms of approaches to health and societal resilience to emergencies. With resources for health and social

services seriously constrained, lessons from lower income settings on frugal innovation¹⁶ and building trust in health systems are valuable.

Limited resources for global health could be better used by diverting funding from specific health programmes in partner countries to focus more clearly on accountability in health systems, the prioritisation of health among policy makers and communities, and increased taxation to fund publicly financed health systems. Ultimately, the UK would do well to broaden its understanding of “enlightened self-interest” through a greater appreciation that equitable partnerships to improve health globally are beneficial to the UK.

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