In July 1944, hundreds of politicians, leading economists and diplomats from the Allied nations gathered in Bretton Woods, New Hampshire, to deliberate over a blueprint for a post-war global order. Proponents of an emerging school of thought maintained that market-driven service provision, and minimal state interference in the market, was the key to healthy economic growth and subsequent political stability. This approach became a defining feature of neoliberalism, which in turn would become the dominant political and economic philosophy of the twentieth century.

From the Bretton Woods blueprint also emerged the International Stabilisation Fund (later the International Monetary Fund) and the International Bank for Reconstruction and Development (later a component of the World Bank). The World Bank and the IMF formed the institutional front of the neoliberal endeavour, dispensing loans to states on the condition that they privatized state assets, stripped back social spending and minimized market regulation. The health sector was not free from the influence of neoliberalism; by the 1980s, the World Bank had become one of the largest funders of global health programmes worldwide.

In an attempt to expose the dominant underlying political and economic belief systems that continue to shape global health programmes, physician, anthropologist and Harvard professor, Salmaan Keshavjee documents the ascendency of neoliberalism, and its impact on global health, in his latest book, ‘Blind Spot: How Neoliberalism Infiltrated Global Health’. Keshavjee presents a succinct chronology of the key political events that have shaped global health policy in recent decades. Transition points are plotted from the Bretton Woods Conference in 1944 to the period of global economic turmoil and rising debt that deeply affected many low and middle income countries in the 1970s and 1980s, to the structural adjustment programmes imposed by the IMF and the World Bank that followed, and the subsequent Bamako Conference in 1987, at which many governments were encouraged to introduce user fees for basic health services.

Following the collapse of the Soviet Union a short time later, Eastern Europe and Central Asia became an experimental playground for development agencies. Drawing from anthropological research conducted in Tajikistan during the 1990s, Keshavjee details the collapse of a centralized health system developed during the Soviet era and the impact of the roll out of user fees shortly thereafter. Keshavjee intersperses interviews and anecdotes to cut through the political and programmatic rhetoric of the time; the introduction of user fees had a devastating effect on service utilization by citizens of Tajikistan, and elsewhere in the world, with a disproportionate impact on the poor. While easily treatable conditions such as malnutrition, respiratory infections and diarrhoea thrived in Tajikistan’s poorest regions, vaccination rates diminished, and by 2004 life expectancy had dropped to its lowest since the violent civil war that raged in Tajikistan during the early 1990s.

Keshavjee proposes that the governments and funding agencies that now dominate the global health landscape have chosen to ‘privilege the fiscal over the moral’ in an attempt to encourage economic transition. In so doing, patients have become clients, and health care as a social good has become a marketable commodity, granted to those with the financial means to pay for health services. In turn, good health, justice, dignity and equity are superseded by ideological conviction and ultimately fall into what Keshavjee refers to as ‘realms of neoliberal programmatic blindness’. As policymakers presently deliberate over a post-2015 vision for global development, and health activists rejuvenate the call for universal health coverage, we must challenge the dominance of neoliberalism in global health. This probing text acts as an overdue rallying cry; global health programmes must be urgently revaluated against the moral imperative of placing people before profit.

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