Global Health Governance's Colour Line: How Finance Has Shaped Global Health Disparities in African Countries

Lyla Latif[*]

Abstract:

The global health financing structure carries imprints of colonial-era power dynamics, perpetuating health inequities between the Global North and South. Tracing the historical origins of these inequities, this paper analyses how colonial policies and philosophies shaped early health systems to serve the interests of the European colonisers over indigenous populations in Africa. Consequently, this paper demonstrates how institutionalised racial biases from the colonial period echo in contemporary global health governance. The analysis shows the connections between historic prejudices, economic exploitation, and persisting disparities in the Global South. The author highlights how present-day inequities stem from systemic imbalances in global health financing and governance rooted in colonial mentalities. Furthermore, the author scrutinises how these colonial legacies have influenced global financial institutions and manifested in unequal resource allocation, priorities, and access—widening the global disease burden gap. The author also discusses the emergence of digital health apps and how their financing and data stewardship can risk perpetuating new forms of exploitation reminiscent of colonial extractivism. Therefore, the author argues that rectifying these structural flaws by realigning financing and governance is essential for equitable global health.

Keywords: Colonialism, Global Health Governance, Global South, Inequalities, International Finance

* * PhD, Lecturer, University of Nairobi, Faculty of Law (Nairobi, Kenya). latif.lyla@gmail.com

I. Introduction

The global health financing structure, with its intricate web of funding bodies, philanthropic endeavours, and policy dictators, is not insulated from the influences of major financial centres.[1] Historically, these centres have perpetuated a patron-client mindset, where regions, especially those once colonised, are often perceived as mere recipients awaiting directives, rather than stakeholders with a voice.[2] This patron-client dynamic is eerily reminiscent of colonial relationships, where the coloniser dictated terms and the colonised followed. Such a dynamic inevitably leads to a misalignment of resources and priorities. Often, the health challenges prioritised for funding and attention resonate with the worldviews and interests of the dominant financial territories, side-lining the urgent needs of the needy and vulnerable communities they claim to assist. For instance, despite bearing a significant burden of global diseases, African countries often grapple with constrained access to pivotal health resources. A poignant example of this sad reality is the HIV/AIDS epidemic. For years, while antiretroviral treatments were available in affluent parts of the world, many patients in Africa struggled to access these life-saving drugs due to financial constraints and patent restrictions, a situation aggravated by the global health financing dynamics.[3]

Additionally, there is a conspicuous skew when one observes the landscape of health research and development. Diseases that are rare yet prevalent in economically powerful regions might witness an influx of research funding, while ailments that wreak havoc in former colonial territories remain under-researched. To exemplify, tropical diseases like schistosomiasis or guinea worm disease,[4] despite affecting millions, are often termed as 'neglected tropical diseases'—reflecting not just the neglect in medical attention but also the neglect in global health financing. Furthermore, the disparities become even more evident during global health crises. The COVID-19 pandemic serves as a glaring example. While wealthier nations were quick to secure vaccine doses for their populations, many countries in Africa and other historically marginalised regions faced significant

1 Pearson JL, *The colonial politics of global health: France and the United Nations in postwar Africa*, Harvard University Press, Cambridge, 2018; Schrecker T, 'The power of money: Global financial markets, national politics, and social determinants of health' in KA Williams (eds) *Global health governance. International political economy series,* Palgrave Macmillan, London, 2009.

2 Cobbett E, *Gatekeepers of financial power: from London to Lagos,* Routledge, 2020.

3 Krikorian G and Torreele E, 'We cannot win the access to medicines struggle using the same thinking that causes the chronic access crisis', 23(1) *Health Hum Rights*, 2021, 119-127.

4 Viergever RF, 'The mismatch between the health research and development (R&D) that is needed and the R&D that is undertaken: an overview of the problem, the causes, and solutions', 10(6) *Glob Health Action*, 2013.

delays, not due to a lack of will or capability, but due to the financial and contractual power plays in the global health finance domain.

This cyclical architecture does not just perpetuate inequities; it embeds them even deeper. The underinvestment in health infrastructure in historically oppressed regions makes such regions perennially dependent on external aid. As health challenges intensify due to these inequities, it unfortunately reinforces certain stereotypes about the affected regions' capacities. This is not just a health matter; it is a matter of a broken system that was entrenched decades ago and continues to exert its influence today. Consequently, this paper aims to trace the historical roots of these inequities, analysing how global health governance structures have been intrinsically shaped by colonial-era philosophies and financial architectures.

By exploring the legacy of European colonialism in regions like Africa and Asia, this paper explains how institutionalised inequities in health systems were established during the colonial period and how that era's financial and ideological biases continue to echo in contemporary global health governance. The analysis demonstrates the deep connections between historic racial prejudices, economic exploitation, and persisting health disparities in the Global South. Ultimately, the objective is to highlight how present-day health inequities stem from systemic imbalances in global health financing and governance, which have origins in colonial-era philosophies and practices. Rectifying these structural flaws, therefore, is essential for building a more just and equitable global health governance.

Having delineated the historical contours of inequity, it is crucial to also point towards the contemporary landscape where digital health apps are at the forefront. This technological evolution, while promising to revolutionise healthcare, does not occur in a vacuum. It unfolds within the very fabric of the global health financing structures previously outlined, structures still carrying the imprint of colonial-era power dynamics. It is within this context that this paper also scrutinises the emergence of digital health solutions and their financing, understanding that without careful and conscious redirection, these advancements may inadvertently echo the patterns of the past.

This paper is structured into four main sections. The introduction explores the historical foundations of inequity in global health. The second section delves into the enduring imprints of colonialism on health systems. The third section examines contemporary health inequities and the persistent influence of colonial-era structures. The final section presents recommendations and concludes the discussion.

II. Historicising Health Inequities

Thandeka Cochrane argues that the historical legacy of European colonialism in Africa has left deep-rooted imprints on numerous facets of contemporary African societies, particularly in the realm of health systems.[5] According to George Ndege, establishing these health infrastructures during the colonial era was intrinsically interwoven with the racially charged ideologies of the colonisers,[6] and it is crucial to critically analyse their motives and methodologies to better comprehend present-day disparities. To fully grasp the extant disparities in African health systems, it is imperative to critically examine the motives and methodologies employed by the colonisers. Tayyab Mahmud argues that the racial ideologies that pervaded the colonial period were not merely passive beliefs but actively informed the strategies and approaches of European powers in Africa.[7] In Ndege's and Conklin's views, many European colonisers, driven by a sense of racial superiority, believed in their civilising mission, asserting that they were bringing progress and development to 'backward' societies.[8] This perceived superiority influenced their motives, as they sought to craft health systems that predominantly catered to the European settlers, often neglecting the healthcare needs of the native populations.

John Harrington's observations serve as a poignant extension of this argument. He highlights the colonisers' methodological flaws rooted in racial biases.[9] Their frequent dismissal and undermining of traditional African medicinal practices—labelling them as primitive or unscientific—speaks to their deep-seated ethnocentrism. Instead of seeking a collaborative integration that recognised the merits of indigenous knowledge, they opted to impose a Eurocentric medical model. This choice, while strategic, sowed seeds of disparity. Building on this narrative, Peter Duignan and Lewis Gann's scholarship intertwines the establishment of health systems with the overarching imperialistic strategy during the late 19th and early 20th centuries.[10] They underscore that Africa was predominantly perceived through the lens of untapped resources, waiting to be

---

5 Cochrane T, 'Colonial entanglements and African health worlds' 9(3) *Medicine Anthropology Theory*, 2022, 1-9.

6 Ndege GO, *Health, state and society in Kenya: Faces of contact and change*, NED-New edition, Boydell & Brewer, 2001.

7 Mahmud T, 'Colonialism and modern constructions of race: A preliminary inquiry', 53 *University of Miami Law Review*, 1999, 1219.

8 Ndege, *Health, state and society in Kenya: Faces of contact and change*; Conklin A, *A Mission to civilize: The republican idea of empire in France and West Africa, 1895-1939*, Stanford University Press, 1997.

9 Harrington J, *Traditional Medicine and the Law in Kenya*, Routledge, 2015.

10 Duignan P and Gann LH, *Colonialism in Africa 1879-1960*, Cambridge University Press, 1973.

extracted and exploited. The colonisers, motivated by both racial superiority and economic ambitions, sought to harness Africa's vast riches. Against this backdrop, this paper argues that the health infrastructures that were established were not just influenced by racial ideologies but were also a mechanism to sustain and facilitate resource extraction. Healthy European workers, administrators, and settlers were essential to maximise the exploitation of Africa's natural resources. Thus, health systems, while overtly showcasing a façade of development, covertly perpetuated a cycle of racial hierarchy and resource extraction, leaving a lasting legacy of inequality and exploitation in post-colonial African societies.

For example, Ndege confirms that in Kenya, the inception of the colonial health department had little to do with the welfare of the indigenous population.[11] It was fundamentally crafted to shield the European settlers from tropical maladies like malaria. Rather ironically, these settlers viewed the native Africans, who had lived in harmony with their land for millennia, as mere vectors of disease. While they sought refuge in well-established health facilities, healthcare services for the indigenous population were sparse and relegated to rudimentary care in remote mission stations.[12] The draconian segregation laws further accentuated this disparity, shoving Africans into congested reserves, away from European settlements, which invariably escalated their health vulnerabilities.

A similar narrative unfolded in Nigeria. Ibrahim Abubakar et al.[13] explain that Britain's primary interests lay in harnessing Nigeria's abundant resources and ensuring the smooth functioning of its local workforce. To this end, establishing a health system was merely instrumental, aimed more at preserving economic interests than fostering community welfare. While stringent quarantine laws ensured that no epidemic disrupted the mining and production sectors, the overall health infrastructure remained skeletal at best. Hospitals, few and far between, primarily catered to British functionaries and a handful of local elites, leaving the masses largely neglected. Zimbabwe, according to Makambe,[14] also witnessed a health infrastructure largely tailored to support its burgeoning mining industry and the European agrarian settlements. Africans were ousted from their ancestral lands by rampant land grabs and cornered into native reserves where the only semblance of healthcare came from missionary-run clinics. Meanwhile, in urban

11 Ndege, *Health, state and society in Kenya: Faces of contact and change.*

12 Latif L, 'Can you reap what you don't sow? Health finance in Kenya's progress towards universal health coverage' 1(3) *Financing for Development*, 2009, 41-67.

13 Abubakar I, Dalglish SL, Angell B, et al, 'The Lancet Nigeria Commission: Investing in health and the future of the nation', 19(399) *Lancet,* 2022, 1155-1200.

14 Makambe EP, 'The exploitation and abuse of African labour in the colonial economy of Zimbabwe, 1903-1930: A Lopsided Struggle Between Labour and Capital' 23 *Trans African Journal of History*, 1994, 81–104.

centres, well-furnished hospitals were erected, exclusively catering to the white settlers. In stark contrast, the rural clinics, aimed primarily at the indigenous population, had a singular objective: ensuring a steady supply of healthy black labour for the colonial enterprise.

Across the Mediterranean in Algeria, under French rule, the narrative was not remarkably different. Hannah-Louise Clark reports that the French colonial administration, with its eyes firmly set on promoting settler agriculture, crafted health policies that overwhelmingly favoured white farmers.[15] Arabs and Berbers found themselves subjected to an array of stringent health laws, from quarantines to mandatory vaccinations, all designed to preserve the health of the settlers. The chasm between the settlers and the indigenous population was vividly reflected in the healthcare facilities too. The settlers enjoyed access to state-of-the-art hospitals, while the natives had to make do with rudimentary mobile clinics.

Shifting gaze to Southeast Asia, in Burma and former Malaya, the British colonial narrative, although geographically distinct, echoed similar motifs. As waves of Indian labour migrated to these regions, it became increasingly evident that their health was not just a humanitarian concern but intertwined with economic imperatives. Amarjit Kaur has pointed out that while Burma's bustling factories and Malaya's expansive plantations depended heavily on Indian labour, establishing the health sector was more about ensuring the continuity of this labour force than genuinely addressing their health needs.[16] The racial dynamics at play ensured that the Indian labourers, despite their critical contributions, remained on the periphery of the colonial health matrix.

Across these diverse colonial landscapes, be it Africa or Southeast Asia, the establishment of health systems was not an act of colonial benevolence. It was, more often than not, a strategic move driven by racial prejudices and economic ambitions. The health of the indigenous and migrant populations was inextricably linked to their utility in the colonial machinery, and their welfare was secondary to the overarching imperial objectives. These examples demonstrate that the very establishment of these systems was marred by the racial prejudices of the time, which viewed Europeans as inherently superior and Africans as inferior – and, more detrimentally, as carriers of diseases.[17] Therefore, to ensure the safety and well-being of European settlers, strict health measures like quarantines,

---

15 Clark HL, 'Expressing entitlement in colonial Algeria: Villagers, medical doctors, and the state in the early 20th century,' 48(3) *International Journal of Middle East Studies*, 2016, 445–72.

16 Kaur A, 'Indian labour, labour standards, and workers' health in Burma and Malaya, 1900–1940' 40(2) *Modern Asian Studies*, 2006, 425-475.

17 Tilley H, 'Medicine, empires, and ethics in colonial Africa', 18(7) *AMA J Ethics*, 2016, 743-753.

mandatory vaccinations, and even unsanitary settlements were enforced on the African populace.[18]

This dual standard was evident everywhere. Ann Beck demonstrates that while European enclaves had sophisticated medical facilities and swift responses to health threats, African settlements had to make do with rudimentary services, which were more focused on ensuring they remained productive workers rather than genuinely healthy individuals.[19] The blatant racism of the colonial era was evident in the vast discrepancies in health spending. It is telling that small outbreaks among European populations would trigger immediate and extensive interventions, whereas large-scale epidemics in African communities were met with apathy, seen as mere natural occurrences rather than tragedies that required action. Furthermore, the introduction and imposition of Western bio-medical models often side-lined and belittled indigenous medical practices and knowledge.[20] Instead of harnessing local expertise or trying to integrate indigenous and Western practices for a holistic healthcare approach, colonial health policies were characterised by a top-down, coercive approach.

Beyond just the establishment of health systems, the attitudes and strategies employed in their deployment were emblematic of the broader colonial ethos. Europeans' self-proclaimed civilisational superiority not only guided economic and political policies but also deeply influenced sectors like healthcare. What was promised as the spread of 'civilisation' was, in fact, the imposition of a racially biased system that viewed healthcare not as an intrinsic right for all, but as a tool of control and differentiation.[21]

While many African nations have achieved political independence, the shadows of their colonial pasts still loom large, especially in critical sectors like healthcare. The systems and policies, originally crafted with racial biases, have often persisted, requiring modern African nations to grapple with these legacies as they endeavour to create health systems that are truly inclusive and equitable. In essence, the colonial health systems of Africa, while draped in the rhetoric of welfare and development, were, in reality, manifestations of the racial prejudices of the era.

---

18 Vaughan M, *Curing their ills: colonial power and African illness*, Stanford University Press, 1991, 288.

19 A Beck, *A history of the British medical administration of east Africa, 1900-1950,* Cambridge, Massachusetts, 1970.

20 J Iliffe, *East African doctors: A history of the modern profession,* Cambridge University Press, 1998.

21 Latif L, *Islamic wealth taxation and financing of public health in Kenya: An interdisciplinary analysis of human rights law, Islamic law and constitutional law*, Ethics Press, 2023.

The analysis of the historical legacy of European colonialism in Africa reveals a stark and consequential inequity in health finance, highlighting how the priorities of the colonisers did not extend to the well-being of the indigenous populations. This is evident in the case of Kenya, where the colonial health department was established to protect European settlers from diseases. This racially charged approach translated into a lack of investment in the health of the native population. The colonisers left health financing predominantly in the hands of local native councils,[22] reflecting their disregard for the wellbeing of the local populace. The colonisers' emphasis on economic exploitation over humanitarian concerns resulted in a systemic imbalance in health funding. While the European enclaves enjoyed access to well-funded and advanced medical facilities, the indigenous settlements were left with meagre resources and underfunded clinics.[23]

This financial divide was a direct consequence of the colonial agenda, which viewed the health of the native population as secondary to maintaining a productive workforce for their economic interests. Thus, the colonial legacy of inadequate health financing remains an enduring challenge for modern African nations striving to rectify historical injustices and create truly equitable health systems. Global health finance, to a significant extent also reflects the biases and structures established during the colonial period. The ecosystem of global health financing is complex and composed of diverse actors including governments, multilateral agencies, bilateral partnerships, non-governmental organisations (NGOs), private sector entities, and philanthropic foundations. Each actor brings its priorities, strategies, and forms of governance to the table, influencing how resources are allocated and what health issues are addressed on a global scale. This complex ecosystem is characterised by power imbalances and funding streams that can be seen as reflections of a colonial mindset. The next section discusses this in detail.

III. A Transition from Colonial to Global Health Inequities

The foundation of today's global financial infrastructure (GFI), as described by Michael Barr in his work,[24] reflects an era post-World War II, distinguished by the creation of the International Monetary Fund (IMF), the World Bank Group, and the General Agreement on Tariffs and Trade (GATT), which later

[22] Ndege, *Health, state and society in Kenya: Faces of contact and change*

[23] Cavanagh E and Veracini L, *The Routledge handbook of the history of settler colonialism*, Routledge, 2017.

[24] Barr MS, 'Who's in charge of global finance', 45(4) *Geo. J. Int'l L*, 2014, 1027.

evolved into the World Trade Organisation (WTO). Rooted in response to the financial crises of the 1930s and informed by the protectionist barriers that arose during the Great Depression, the Bretton Woods conference yielded institutions committed to liberalising trade. John Keynes was instrumental in crafting this vision, primarily centring on economic stabilisation, reconstruction, and growth.[25] However, beneath the progressive façade of these institutions lay inherent flaws. Ha-Joon Chang makes it evident that while these institutions were framed as universal platforms for economic cooperation, their operations were deeply entrenched in the imperialistic ambitions of the dominant Western powers.[26] In his seminal work 'Kicking Away the Ladder: Development Strategy in Historical Perspective,' Chang provides a nuanced critique of these international financial institutions. He argues that developed nations, after having benefited from various protectionist measures during their developmental phases, now advocate for free-market policies in developing nations, effectively 'kicking away the ladder' that they had used to climb to prosperity. This perspective can be seen as an extension of imperialistic ambitions, where former colonial powers, through these financial institutions, seek to maintain their dominance and continue extracting value from their former colonies.

Despite their stated objectives, the IMF, World Bank, and WTO often advanced policies that were in line with the interests of the Western powers. Structural Adjustment Programs (SAPs), for instance, which were enforced by the IMF and World Bank in many developing countries during the 1980s and 1990s, mandated a slew of liberalisation and privatisation reforms. While these reforms were purported to stabilise economies and ensure debt repayment, they often led to the erosion of local industries, increased economic dependence on the West, and the diminishment of public welfare systems, including health and education. Furthermore, these institutions' governance structures inherently favoured the Western economies. Voting rights in the IMF and the World Bank are determined by financial contributions, ensuring that wealthier, predominantly Western nations have a disproportionate say in decision-making processes. Such an arrangement invariably places the priorities and interests of these mighty nations above those of the developing world. While advocating for free trade, the WTO has often been criticised for advancing the interests of Western multinational corporations. The trade-related aspects of intellectual property rights (TRIPS) agreements, for example, have often been seen as tools that

[25] Keynes JM (1919), *The economic consequences of the peace*, Springer International Publishing, 2019.

[26] Chang HJ, *Kicking away the ladder: Development strategy in historical perspective*, Anthem Press, London, 2004.

limit the ability of developing nations to access essential medicines or develop indigenous industries, thereby perpetuating their economic subservience.

Clearly, despite representing a vast spectrum of economies, the influence within the IMF, World Bank (and later the WTO) is disproportionately skewed towards larger Western economies and against the historically marginalised communities. The fact that both the IMF and World Bank decision-making were heavily influenced by contributions from member states, with the USA's unprecedented economic size allowing it the largest voice, meant that policies and financial decisions often mirrored Western, especially American, interests.[27] While the system was ostensibly successful in revitalising post-war economies, notably in Europe and Japan, it subtly entrenched a paradigm where the 'developed' West was seen as the norm and other economies were measured against this yardstick. Barr's observation on the crisis of legitimacy in institutions like the IMF and World Bank is particularly enlightening here.[28] Though these institutions purportedly represented numerous countries, the power dynamics heavily favoured a select few economically powerful, predominantly Western Nations. Such imbalances in representation and decision-making often resulted in policies favouring these dominant countries. The side-lining of nations in Africa, Asia, and Latin America—regions with diverse racial and ethnic groups—underscores the racial architecture of these institutions, where non-Western countries often found their voices diminished. This bias indicated deeper issues of transnational accountability and legitimacy. It became evident that while these bodies, in theory, served numerous countries, in practice, only a select few, the economically dominant, were steering the ship.[29]

This asymmetry in representation and influence has deep-rooted implications that extend beyond economics. It perpetuates a paradigm where the Western 'developed' model is held as the gold standard, against which other nations are compared and often found lacking. The side-lining of nations from Africa, Asia, and Latin America further illuminates the racial and ethnocentric underpinnings of these institutions. The challenges and voices of these non-Western nations, representing diverse racial and ethnic groups, are often overshadowed by the priorities of the dominant Western countries. This raises crucial questions about transnational accountability, representation, and the very legitimacy of these institutions.

---

27 Barr, 'Who's in charge of global finance', 1027.

28 Barr, 'Who's in charge of global finance', 1027.

29 Hickel J, Dorninger C., Wieland H, et al, 'Imperialist appropriation in the world economy: Drain from the global South through unequal exchange, 1900-2015' 73 *Global Environmental Change*, 2022, 102467.

A. *Global Health Financing*

Translating these financial and political imbalances to the realm of global health reveals a landscape riddled with disparities. For instance, while the WHO's prioritisation of diseases with pandemic potential is essential for global health security, it can be perceived as reminiscent of colonial-era policies that emphasised the protection of European settlers over the health of local populations.[30] This dynamic is legally encapsulated in the International Health Regulations (IHR 2005), which focus on preventing the spread of disease internationally, akin to the quarantine laws of the colonial period.[31] Additionally, the centralised decision-making process of the WHO often sees wealthier member states exerting significant influence, potentially overshadowing the voices of less affluent countries, a structure that can be regarded as analogous to colonial governance systems. In resource allocation, the pattern of directing funds towards specific projects instead of bolstering national health systems bears similarity to the colonial approach, favouring elite health services over comprehensive public health infrastructure.[32]

The global health law further reflects these disparities, particularly in the protection of intellectual property rights through agreements like the TRIPS which has been criticised for favouring pharmaceutical companies in high-income countries at the expense of accessible healthcare in the Global South.[33] Moreover, deploying universal guidelines without adequate consideration of local contexts may perpetuate a one-size-fits-all approach, potentially marginalising indigenous knowledge. Emergency response and international aid, often framed as humanitarian assistance, can sometimes create dependencies that echo the paternalistic 'civilising missions' of colonial powers rather than empowering local health systems.[34] Moreover, the occasional deficiency in cultural competency within health interventions can be traced back to the colonial disregard for indigenous customs, which were integral to community health practices.

Furthermore, global health is not merely influenced by natural epidemiological factors but is significantly intertwined with the policies and priorities of global financial institutions. For instance, health programs funded by the World Bank often mirror the health priorities of the West, side-lining

30 Bhattacharya S, 'Colonialism/postcolonialism and global health', *Lancet*, 2021.

31 Fidler D, *SARS, governance and the globalization of disease*, Palgrave Macmillan, 2004.

32 Mackey T, 'Global health diplomacy and the governance of counterfeit medicines' *Journal of Health Diplomacy* 2013.

33 Hoen E, *The global politics of pharmaceutical monopoly power*, AMB Publishers, 2009.

34 Pearson, *The colonial politics of global health: France and the United Nations in postwar Africa.*

pressing health challenges endemic to regions like Africa or Asia. Consequently, countries might be nudged towards adopting Western health financing models, which might not resonate with their socio-cultural and economic contexts. This misalignment risks creating health systems that do not cater to the unique needs and contexts of their populations, potentially widening health disparities. For instance, donor countries might earmark funds for high-profile diseases such as HIV/AIDS, tuberculosis, and malaria, which, while undeniably critical, can overshadow basic healthcare services, maternal health, and non-communicable diseases that represent a growing burden in low-income regions. This situation can perpetuate a form of dependency where recipient countries tailor their health agendas to fit donor preferences, a dynamic that is not dissimilar to colonial economic systems where local economies were restructured to serve the interests of the colonisers.

Paul Farmer's work also offers a compelling critique of this dynamic, emphasising the structural violence embedded in global health systems.[35] Farmer highlights how global economic policies, predominantly influenced by the West, exacerbate health inequalities, especially in resource-limited settings. Global health financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and GAVI, the Vaccine Alliance, represent significant efforts to channel funds towards specific health crises. However, while successful in many respects, these vertical funds may contribute to health system fragmentation as they sometimes bypass national systems, creating parallel structures that can undermine the sovereignty of domestic health policy planning. Another manifestation of the influence of these global financial institutions on health is seen in the Structural Adjustment Programs (SAPs). Designed with economic objectives, these programs inadvertently led to diminished public health spending in many developing countries. The outcome was a beleaguered health infrastructure, leading to increased preventable diseases and deepening the divide in health outcomes.

The disparities in global health, influenced by the policies and biases of major global financial institutions, are evident in empirical data. According to the WHO, health spending starkly contrasts between economic strata; low-income countries allocated a mere sixty-three US Dollars per capita on health in 2021, whereas high-income countries spent four thousand four hundred and ninety-one US Dollars.[36] This is further accentuated by the effects of SAPs, leading several low-

[35] Farmer P, *Pathologies of power: Health, human rights, and the new war on the poor*, University of California Press, 2003.

[36] WHO, *Global expenditure on health: Public spending on the rise?* 2021 <https://www.healthdata.org/research-analysis/gbd> on 21 January 2025.

income nations to curtail public health expenditures. The 2019 Global Burden of Disease Study illustrates a pronounced gap in life expectancy, with countries like Japan boasting a figure over eighty-three years while nations like Sierra Leone lag sit at a meagre fifty-five years.[37] Similarly, under-five mortality rates, as indicated by UNICEF,[38] remain alarmingly higher in low-income nations, a testament to the differential health system performance. The pervasive influence of SAPs has been detrimental, with countries under these programs experiencing diminished health infrastructure and personnel, particularly in sub-Saharan Africa during the 1980s and 1990s.

A study by Brown et al. further serves as a compelling testament to the continued entrenchment of systemic racism and social exclusion in what one might assume to be universally accessible sectors, such as water and sanitation, even in high-income countries (HICs).[39] This deeply embedded disparity offers insights into the way global financial architecture has evolved. Rooted in a racist understanding of health, these financial systems inadvertently perpetuate health inequities across the globe, leading to a vicious cycle where health disparities, in turn, influence economic decisions.

In the modern era, with centuries of investment behind them, HICs have realised the profound public health benefits associated with universal access to water and sanitation. Yet, as Brown et al. aptly underscores, the journey towards achieving these fundamental human rights has been tumultuous, mired by systemic exclusion of marginalised communities.[40] These disparities cannot be divorced from the broader tapestry of global financial systems. The architecture of such systems, largely defined by HICs, often reflects the biases and inequities inherent within these countries. For instance, the dominant discourse in global water, sanitation, and hygiene (WASH) focuses predominantly on low and middle-income countries. Such a narrow focus, stemming from the global financial blueprint, overlooks the underlying challenges even in HICs. Instances like the water crisis in some areas of the United States of America, serve as stark reminders that even nations with abundant resources can falter, primarily

---

37 See: <https://www.healthdata.org/research-analysis/gbd> accessed on 21 January 2025.

38 UNICEF, *Under-five mortality*, 2023 <https://www.unicef.org/reports/under-five-mortality> on 21 January 2025.

39 Brown J, Acey C, Anthony C, et al, 'The effects of racism, social exclusion, and discrimination on achieving universal safe water and sanitation in high-income countries' 11(4) *The Lancet*, *Global Health*, 2023, E606-E614.

40 Brown et al, 'The effects of racism, social exclusion, and discrimination on achieving universal safe water and sanitation in high-income countries'.

due to systemic racism and exclusions deeply woven into their socio-economic structures.[41]

Furthermore, the global financial architecture, which plays a pivotal role in shaping health priorities and investments worldwide, is influenced by these racial underpinnings. Suppose only a minute fraction of the population in HICs remains excluded from basic services like water and sanitation due to systemic barriers. In that case, it brings into question the fairness and equity of global financial institutions in addressing broader health disparities. Persistent disparities in HICs, as Brown et al. emphasise, are not merely about lack of resources but are intricately linked to environmental discrimination, systemic racism, and social exclusion.[42] The global financial landscape, heavily influenced by these HICs, inadvertently becomes a conduit for these biases. It moulds policies, funds, and resources in a manner that may perpetuate these disparities, rather than alleviate them. By orienting more towards economic growth and less towards equitable health access, this architecture may further widen the gap between the haves and the have-nots, both within nations and on a global scale.

The analysis by Brown et al. underscores the grim reality that historically marginalised groups—encompassing minority racial and ethnic populations, indigenous peoples, migrant communities, and people of colour—are frequently found on the peripheries of essential amenities such as water and sanitation. The repercussions of systemic racism manifest in these glaring disparities, an issue that remains largely underacknowledged due to the dearth of comprehensive data stemming directly from these marginalised communities. The intricate interplay between housing development and infrastructure disparities in some HICs further illuminates the depth of this issue. Many communities with subpar housing and neighbourhood infrastructure, or those confined by policies that hinder property ownership, invariably grapple with compromised water and sanitation services. This complex web of systemic exclusion is especially palpable in the U.S. context, where the archaic practice of redlining has left indelible marks on urban landscapes. This policy, sanctioned and perpetuated by state apparatuses, ensnared cities in cycles of stark inequality, resulting in disparities that encompassed not just housing, but extended to crucial infrastructure, subsequently influencing health, economic status, and overall quality of life.

---

41 Ruckart P, Zeitz E, Hanna-Attisha M, et al, 'The flint water crisis: A coordinated public health emergency response and recovery initiative', 25(1) *J Public Health Manag Pract*, 2019, 84-90.

42 Brown et al, 'The effects of racism, social exclusion, and discrimination on achieving universal safe water and sanitation in high-income countries'.

Through the example of Flint, a city in Michigan, USA, it is evident how the repercussions of past decisions ripple into contemporary times as discussed by Carla Campbell et al..[43] The once-prized centralised water systems now bear witness to their glaring inflexibility. As cities like Flint experienced demographic shifts, typified by job losses and subsequent reduced demand for water, coupled with the demolition of housing units, the resultant water quality deteriorated. Crucially, this decline was most pronounced in the most depopulated areas, which were also the poorest. Thus, the ramifications of historical systemic racism and social exclusion, particularly in housing, came full circle, adversely affecting water quality and thereby impacting health. Campbell et al.'s scholarship demonstrates that the tentacles of systemic racism extend beyond just infrastructure.[44] They infiltrate the very core of civic participation, evident in strategies like gerrymandering, under bounding, and voting rights restrictions, to name a few. The water crisis in Jackson, another city in Mississippi, USA also serves as a case in point. A city with a majority Black populace was thrust into a prolonged water supply disruption, a culmination of years of underinvestment. This underinvestment is often perceived by locals as being intrinsically linked to state policies, which appear to divert available federal funds preferentially to predominantly white communities.

In essence, revisiting Brown's analysis paints a grim reality of the enduring legacy of systemic racism.[45] It is not just about denied access; it is about a historically embedded pattern of exclusion, perpetuated by both overt and covert means, that continues to disenfranchise marginalised communities, even in sectors as fundamental as water and sanitation. The analysis rendered by Brown et al. not only sheds light on the contemporary manifestations of systemic racism in high-income countries but also pulls back the curtain on the larger, more intricate web of historical colonial legacies that have underpinned such systemic inequalities. These legacies have dictated and delimited fiscal spaces for health and the potential for robust research and development within these historically oppressed communities.

As has been discussed, the roots of these glaring disparities can be traced back to the colonial era, when dominant powers, driven by a mix of economic and ethnocentric motivations, moulded governance structures in their colonies. These structures were predominantly designed to perpetuate an inequitable status

---

43 Campbell C, Greenberg R, Mankikar D, et al, 'A case study of environmental injustice: The failure in Flint', 13(10) *Int J Environ Res Public Health*, 2016, 951.

44 Campbell et al, 'A case study of environmental injustice: The failure in Flint', 951.

45 Brown et al, 'The effects of racism, social exclusion, and discrimination on achieving universal safe water and sanitation in high-income countries'.

quo, concentrating wealth and access to essential resources in the hands of the colonisers while simultaneously depriving and disenfranchising local populations. As colonies achieved independence and transitioned into sovereign states, the economic and structural remnants of these oppressive regimes persisted. Many of these newly independent states grappled with inadequate fiscal spaces dedicated to health, and their capacities for innovation and research and development were stunted.

The colonial imprints are not confined merely to national governance and economic structures; they have also bled into global health governance. Global health institutions, although universally mandated, often reflect power dynamics that echo colonial-era hierarchies. Decision-making processes, allocation of funds, setting of health priorities, and research orientations are often influenced by these historically dominant entities, which unfortunately means that global health agendas are, at times, more reflective of the interests of the powerful rather than the needs of the most vulnerable. Furthermore, it means that while many global health initiatives might be lauded for their ambitious mandates and impressive scope, they can inadvertently reinforce and perpetuate health inequities that have their roots in colonial practices and structures. The design and operation of these institutions can lead to a system where resources, both in terms of knowledge and finance, flow predominantly to concerns that align with the interests of historically dominant entities. Consequently, issues faced by marginalised communities, which may be more pressing, often remain on the periphery of global health agendas.

B. Global Health Disparities Following COVID-19

While the WHO and the World Bank appear as democratic multilateral entities the concentration of power often lies with a few dominant member states, usually the largest financial donors. This imbalance not only marginalises voices from low and middle-income countries but also erodes the very ethos of global partnership. Furthermore, this asymmetry extends to fiscal matters. Wealthy nations, often rooted in former colonial powers, tend to steer the direction of global health funding. Such control sometimes skews attention towards diseases prevalent in high-income regions, side-lining conditions that majorly affect poorer nations. It is a scenario reminiscent of colonial days when the interests of the colonisers took precedence over the colonised. For instance, the past neglect of certain tropical diseases, despite their high prevalence, can be

seen as a reflection of this historical bias.[46] There is also the domain of research and development—a realm significantly dominated by the global North. HICs, with their advanced infrastructure and financial muscle, often take the lead in medical research. A recent case in point discussed by Sara Stevano et al. is the COVID-19 pandemic, where vaccine development and initial distribution were heavily monopolised by richer nations, leaving many poorer countries waiting in line.[47]

The global health landscape, historically entrenched with myriad disparities, stands today at a critical juncture. The interplay between health inequities and the underlying financial structure of our modern world underscores a deeply troubling narrative. In this regard, the United Nations (UN) in its report on poverty eradication, cast a spotlight on the pervasive nature of poverty and illuminated the stark contours of global health disparities. By underscoring the 'existential crossroads' of the contemporary time, encompassing pandemics, economic downturns, and movements challenging systemic racism, Alston set the stage for a more profound scrutiny. The onslaught of the COVID-19 pandemic revealed more than just the vulnerabilities of the health systems. It became a mirror reflecting the failures of a global capitalist regime. Whereas prior crises of the century were rooted predominantly in financial collapses, COVID-19 emerged as a multifaceted monster, underlining the interconnectedness of health, economic, and social sectors. This virus, in its rampage, exposed the inefficiencies and exploitations inherent in global capitalism, particularly how it has leaned heavily on the gendered, racialised working classes across the globe.[48]

One might argue that at the heart of these exploitations are the remnants of a colonial past, glaring through the lens of contemporary capitalism. The very systems that govern the contemporary world, while technologically advanced and globalised, still harbour the residues of age-old inequities. Moreover, the pandemic has redefined the understanding of the state's role, compelling one to re-evaluate its position not merely as a facilitator but as an active player within the capitalist system. While affluent countries rediscovered the potency of fiscal interventions, countries of the Global South grappled with constraints, further widening the chasm between the Global North and South. The stark inequality became palpably evident in the vaccine distribution crisis, with wealthy nations

[46] Ndege, *Health, state and society in Kenya: Faces of contact and change*

[47] Stevano S, Tobias F, Dafermos Y et al, 'COVID19- and crises of capitalism: Intensifying inequalities and global responses,' 2)42) *Canadian Journal of Development Studies* / Revue canadienne d'études du développement, 2021, 1-17.

[48] Stevano et al, 'COVID19- and crises of capitalism: Intensifying inequalities and global responses,' 8-5.

monopolising vaccine stocks, thereby exposing the darker underbelly of global capitalism.[49] But what underlies this disjunction? Is it mere coincidence or the symptom of a larger, more insidious malaise rooted in the global financial architecture?

The catchphrases for COVID-19 mitigation—'stay home, socially distance, and wash hands'—underscore this discrepancy. For those cushioned by affluence, it seems a small price to pay. But for countless individuals entrenched in poverty, this mantra becomes an ironic taunt. How does one socially distance in overcrowded slums? How does one incessantly wash hands without access to clean water? This crisis, rather than being the 'great leveller', has intensified the chasm between the haves and the have-nots. The COVID-19 pandemic, as the UN succinctly noted, accentuated the systemic neglect of those living on the fringes of prosperity.[50] It is here that the underpinnings of the global financial architecture come under scrutiny. The post-colonial world order, undergirded by structures established by the Global North, often perpetuates economic hegemonies and continues the legacies of extraction and exploitation.[51] These structures, whether through debt mechanisms, trade policies, or intellectual property regimes, often prioritise capital over humanity. They are not merely neutral by-products of economic evolution but, in many ways, are emblematic of an architecture that has its foundations in racist ideologies and Eurocentric paradigms.

From a financial standpoint, the pandemic starkly highlighted the disparity in available resources for health emergencies. Western countries, with their considerably larger economies, were able to allocate unprecedented funds towards pandemic response. For instance, the United States passed relief packages totalling trillions of US Dollars,[52] and the European Union established a seven hundred and fifty billion Euros recovery fund.[53] In contrast, many African nations,

---

[49] Ning C, Wang H, Wu Jing et al, 'The covid-19 vaccination and vaccine inequity worldwide: An empirical study based on global data' 19(9) *Int J Environ Res Public Health*, 2022, 5267; Li Z, Lu J and Ly J, 'The inefficient and unjust global distribution of covid-19 vaccines: From a perspective of critical global justice', 58 *Inquiry: Journal of Health Care Organisation*, 2021.

[50] UN, *The parlous state of poverty eradication – report of the Special Rapporteur on extreme poverty and human rights*, UN A/HRC/44/40, 2001.

[51] Latif L, 'The lure of the welfare state following decolonisation in Kenya,' in G Bhambra and J McClure (eds) *Imperial Inequalities*, Manchester University Press, 2022.

[52] Sheth S and Roig J, 'House passes $1.9 trillion stimulus package, paving the way for Biden to sign it into law later this week,' Insider, 2021 https://www.insider.com/house-passes-biden-covid-19-relief-package-stimulus-checks-2021-3 on 21 Jan. 2025.

[53] Boffey D and Rankin J, 'EU leaders seal deal on spending and EUR750bn Covid-19 recovery plans,' The Guardian, 2020 <https://www.theguardian.com/world/2020/jul/21/eu-leaders-reach-deal-on-750bn-covid-19-recovery-fund> on 21 January 2025.

already grappling with debt and limited fiscal space, found it challenging to mobilise similar levels of resources. Although international bodies like the IMF and the World Bank have provided emergency financial assistance to several African countries, the quantum often pales in comparison to the self-financed packages of the West.

The financial constraints faced by African nations had direct implications for health disparities. For instance, while Western nations rapidly scaled up their health infrastructure, conducting millions of tests and establishing makeshift hospitals, many African nations struggled to access even basic testing kits in the pandemic's early stages. The disparities became even more pronounced with the rollout of vaccines. Wealthier Western countries pre-ordered billions of doses, ensuring a significant stockpile for their populations.[54] In contrast, many African countries have been largely reliant on the COVAX initiative, a global effort to ensure equitable access to vaccines. However, as of mid-2022, while many Western countries had achieved substantial vaccination coverage, a significant portion of the African population remained unvaccinated due to supply constraints and logistical challenges. Furthermore, the pandemic's economic fallout has had a disproportionate impact on African nations. With limited financial buffers and a heavy reliance on sectors like tourism and exports, which were severely affected by the COVID-19 pandemic, the economic repercussions for many African nations were profound. In contrast, many Western countries, with more diversified economies and substantial fiscal stimuli, have shown signs of robust economic recovery.

The narrative of global inequities, especially when viewed through the lens of fiscal capacities and health disparities, paints a tale of two worlds. In one, the gleaming hospitals of high-income nations stand tall, bolstered by strong fiscal capacities that give them the edge in times of crisis. The Global North, with its expansive coffers and access to low-interest loans, is not just financially affluent—it is medically privileged. When pandemics strike, they can swiftly channel resources, bolster their medical infrastructure, and launch vast public health campaigns. Yet, travel a little south, and the picture shifts dramatically. The Global South, with its constrained fiscal pockets, grapples with a dual challenge. On the one hand, there is the immediate health crisis, demanding funds, resources, and attention. On the other, there is the looming shadow of long-term economic instability. Their limited borrowing capacities do not just

[54] UN, Unequal vaccine distribution self-defeating, WHO chief tells economic and social council's special ministerial meeting, ECOSOC/7039 (2021). <https://www.un.org/press/en/2021/ecosoc7039.doc.htm> on 21 January 2025.

signify economic constraints; they are a glaring emblem of health inequities. In essence, these nations are often forced into an unenviable choice: immediate health response or future economic stability.

C. *Global Health, Digital Health Applications and International Finance*

The global health inequities that have persisted throughout history have found new expression in the realm of digital health, particularly through the development of health apps in the wake of digitalisation and the COVID-19 pandemic. During the pandemic's peak, the disparity in funding allocation for health apps illustrated a divide reminiscent of colonial-era power dynamics. Wealthy nations, leveraging their considerable resources, were able to rapidly develop and implement technologies for tracking and tracing the virus. In contrast, lower-income countries faced significant challenges due to limited financial and infrastructural capacities, highlighting a continuity of the imbalance in global power and resource distribution that has its roots in colonial history. These health apps, vital in the efforts to control the spread of COVID-19, became instruments that inadvertently mirrored the extractive practices of colonialism. The urgency that once propelled the investment in these technologies has subsided, yet a pressing concern emerges: the extensive data amassed by these apps.[55] The management and use of this data present a risk of perpetuating a new variant of colonialism—'data colonialism'.[56] This contemporary form of exploitation echoes the extractive nature of traditional colonialism through the accumulation and control of data by entities in high-income countries, often without equitable benefit to, or consent from, the populations of lower-income countries who are the subjects of the data.[57]

Data colonialism has the potential to exacerbate global health disparities by enabling the continuation of unequal power dynamics. HICs could utilise this data to advance their healthcare systems and economic interests, thereby reinforcing their dominant positions. Meanwhile, lower-income nations, already disadvantaged by the digital divide, may experience further marginalisation as they are denied the benefits and insights derived from their data. This situation

[55] Wongsin U, Wannasri A, and Iqbal U, 'Data Privacy, Regulations and Legal Issues on COVID-19 Tracking Apps: A Scoping Review' 289 *Stud Health Technol Inform*, 2022, 388-391.

[56] Couldry N and Mejias U, *The Costs of Connection: How Data is Colonising Human Life and Appropriating it for Capitalism*, Stanford University Press, 2019.

[57] Couldry and Mejias, *The Costs of Connection: How Data is Colonising Human Life and Appropriating it for Capitalism*.

threatens to widen the gap in global health outcomes, with data becoming the new commodity through which inequalities are perpetuated and entrenched. Thus, the forthcoming research that will follow from this paper will critically examine the stewardship of health data and address the mechanisms of data control that continue the legacies of colonialism. By acknowledging and tackling these issues, there is the possibility to redirect the course away from data colonialism and towards a more equitable distribution of the wealth of data. International finance has a pivotal role in this redirection, offering the potential to reshape global health equity. Without the fetters of its current colonial undertones, it can catalyse a shift where investments are made transparently, democratically, and with a deliberate focus on enabling lower-income nations to have sovereign control over their data.

IV. Conclusion

This analysis of the historical contours of health inequities elucidates the colonial underpinnings of contemporary global health financing and governance. Tracing the discriminatory establishment of health systems during colonialism reveals how institutionalised prejudices became entrenched. The transition into today's complex ecosystem of global health actors shows continuity in power imbalances that disadvantage the Global South. The data on health expenditures and outcomes spotlight the ongoing disparities arising from these systemic biases. The COVID-19 response exposed wider fissures between the capabilities of wealthy and poorer nations, precipitated by underlying financial architectures traceable to colonial origins. As technological innovations like digital health apps rise to prominence, retaining the structural status quo risks perpetuating new forms of data exploitation that echo colonial extractivism. Fundamentally reshaping the orientation of global health financing is integral to overcoming persisting inequities. This requires confronting the historical origins of biases, consciously channelling resources equitably, and empowering leadership from marginalised regions to rebalance global health governance. Only by acknowledging and rectifying these systemic flaws can there be a just global health ecosystem.

To build a more just global health ecosystem, concrete policy steps must be taken to realign financing and governance. Firstly, representation and decision-making in multilateral health institutions should be restructured to elevate marginalised voices from the Global South. Leadership selections should diversify beyond historically dominant nations to encompass perspectives from communities bearing the greatest disease burdens. Secondly, health financing

must actively prioritise strengthening national health systems holistically, not just vertical interventions. Fund allocation should be needs-based, channelling greater resources towards countries with the most glaring capacity gaps and health indicators lagging behind global targets. Thirdly, research and innovation must be reoriented towards neglected diseases impacting poorer nations. Equitable access frameworks for new technologies should be instituted to ensure that lifesaving medicines and vaccines reach vulnerable populations concurrently with wealthy countries. Fourthly, local knowledge and cultural contexts should be integrated into policymaking to avoid one-size-fits-all approaches. Finally, equity impact assessments should evaluate all financing and programmes to ensure they progressively reduce disparities. Shifting incentives and mindsets is indispensable for dismantling systemic biases.

Also, the proliferation of digital health technologies like mobile applications warrants careful governance to prevent exacerbating inequalities. Policies must tackle the emergence of data exploitation through data colonialism where countries and companies in the Global North amass and benefit from the health data of populations in the Global South without their consent. Stronger data protections, ownership frameworks, and benefit-sharing agreements are needed to empower low-income nations to control their data sovereignty. Investments should build national capacities for secure data stewardship and advanced analytics to unlock the insights required for strengthening local health systems. Regulatory standards could ensure health apps meet privacy, and equity requirements prior to deployment. Regional cooperation can pool resources for shared data repositories and technology tools tailored to local needs. Ultimately the aim should be catalysing leapfrogging innovations that do not widen digital divides but enable equitable access and health system enhancement. With thoughtful governance, these technologies can disrupt, not reinforce, historic inequities.