Achieving healthy societies - ideas and learning from diverse regions for shared futures

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Executive summary

Within and across countries different ideas have emerged over time on what is meant by a healthy society and what determines it, with implications for the policies and actions implemented to achieve it. Ideas have become dominant, whether by force or consent, influenced by military, material, socio-political, institutional and ideational forms of power, but also by what is embraced by society.

This paper recognises this diversity of thought and experience and seeks to present evidence and reflections to contribute to dialogue and inquiry on our understanding of healthy societies and how we achieve them.

We explore the trajectory and content of frameworks on healthy societies from the 1970s onward, while also bringing in relevant information on historical paradigms that predate the 1970s, but that continue to inform contemporary agendas. Based on a desk review of published documents, we examine this at global level, with its influences from Europe and the United States of America, and in Latin America, East and Southern Africa and India. The paper does not explore how far these policies were implemented or the factors affecting it, as this is a separate and important area for follow-up analysis.

Section 2 describes the main features of those paradigms that had a wider or more sustained policy influence, with their contextual, institutional and social drivers and examples of their policy influence at global level and for each of the geographical regions covered, shown in the table below. These paradigms have had different periods of dominance and policy influence, emerging in new spaces and forms as political and economic conditions evolve.

European, North American and global	Latin America	East and Southern Africa	India
The pathogenic, biomedical paradigm	The pathogenic, biomedical paradigm	Post-colonial biomedical approaches	'Nehruvian' paradigm; commodification of health
Social medicine and a social determinants wellbeing paradigm		Social determinants and resource nationalism	Gandhi's mind, body, soul, community health paradigm
Rights-based paradigm	The social medicine paradigm		People's health in people's hands
Planetary health as an ecological wellbeing paradigm	Buen vivir and intercultural health	Reciprocity in traditional health systems, *ubuntu*	Traditional paradigms
A biosecurity-focused paradigm		Colonial pathogenic approaches	Colonial imposition of allopathic medicine

Section 3 draws on this evidence to outline key features and insights. The regions demonstrate common and different features of compelling discourses about healthy societies. Both a pathogenic/biomedical paradigm and the contrasting social determinants paradigm have existed for centuries in all regions, albeit with unique features in different regions, and with rights approaches interfacing with both.

There has, however, not been a singular idea of healthy societies, and we suggest that neither should one be imposed. While values may be shared, health is as much socio-cultural and political as it is technical and material, and ideas about healthy societies are embedded in histories, polities, and alliances within and across countries. Listening to wider voices and learning from a diversity of thinking and approaches brings new values, ideas and practices to work on healthy societies, which are vital to address the many still unresolved health challenges.

A pathogenic paradigm and increased biomedical knowledge informed an optimistic expectation in global and northern discourse that the causes of disease could be eradicated by a technology-driven 'modernisation'. Biomedical approaches have contributed to improved population health for societies where medical services and health technologies are accessible and delivered universally as a right.

The imposition of the pathogenic paradigm during colonial expansion, however, suppressed local knowledge and cultures, and with a colonial expropriation of natural resources has generated a legacy that still needs to be addressed in today's global interactions on healthy societies. In all three southern regions, this has implied reclaiming and respecting indigenous cultures and local ecologies (such as in Intercultural health or the Gandhian paradigm); recognising rights (such as in 'people's health in people's hands'); re-asserting collective interests and reciprocity (such as in *ubuntu*) and addressing equity and justice in the domestic and global political economy (such as in social determinants and social medicine approaches, in Buen vivir and resource nationalism).

In its extreme form, a singular connection made between disease and individual biology in eugenics enabled racist, discriminatory discourses in all regions covered, highlighting the need to embed ethical principles, solidarity and collective rights and benefit in public health thinking.

Evidence on and attention to social determinants of health have grown globally, with associated ideas for inter-sectoral action, 'whole-of-government', 'health in all policy' approaches to integrate social determinants in policy and practice. A growing experience and critique of the inequities and harms to healthy societies from commercial determinants in a neoliberal globalisation have motivated a shift in focus beyond individual determinants to social determination and to integrate the structural, global and commercial determinants of health. The liberalisation, resource extraction and commodification of public systems have been more intense and prolonged in the southern regions, generating demands for rights and justice within countries and more radical demands for change in the global political economy from the three southern regions than those currently accommodated in global platforms.

Yet this is changing globally, in part reflecting alliances across technical, socio-political actors, movements and institutions, including within high-income countries. Global rights frameworks have given new attention to the right to development, and global processes have called for global collective action to address powerful commercial forces that work to counteract health. The social determinants paradigm has extended to an integration of ecosystems, intergenerational equity and collective global responsibilities in articulation of planetary health. Ideas of reciprocity and a location of health within holistic ecosystems that existed centuries ago in southern regions are obtaining new profile in global thinking.

The paradigm trajectories outlined in this paper suggest that ideas do matter in producing change and that there are diverse ideas on and pathways to a healthy society. A 'battle for ideas' has infused debates on how to improve population health, calling for spaces to engage with their proponents across regions, disciplines and constituencies. The flow of ideas in new international collaborations and alliances in a multipolar world also suggest that a 'model of circulation' may better suit the development of paradigms on healthy societies, with greater horizontal exchange across regions to build global ideas.

Section 4 discusses the implications for future framings, action and inquiry. The confluence in 2020 of a prolonged COVID-19 pandemic, climate change, environmental degradation and biodiversity loss, and extreme inequality, and the current Gramscian moment of old and new ideas, highlight our need to develop paradigms that will serve us better in tackling such crises and building healthy societies globally. This raises a question of which research practices can generate knowledge that supports such change. At one level, this relates to how to build a more values-based, transdisciplinary, comprehensive inquiry and practice on healthy societies, one that is more self-determined and embedded in lived experience, with spaces to raise alternative ideas and raise questions to the present hegemony, and more strategic understanding of the relationships, interests and power that affect how ideas gain influence. It also suggests a research practice that links more directly to the processes and actors producing change towards healthy societies.

The experiences in the paper point also to the critical nature of politics and the public mindset. A paradigm shift that advances health in its comprehensive framing depends on populations and countries who see the unhealthy status quo as no longer acceptable, and who have the consciousness, ideas and confidence to act collectively to produce change. Without such collective interest and self-determined agency, can we really talk about healthy societies?

1. Introduction

What do we mean by healthy societies and how do we achieve them? While the question may sound simple, the answer is not. Different disciplinary and institutional lenses, knowledge and political discourses and systems, ideologies, cultures and regions would have different responses. It would certainly have been answered differently at different times in history.

As the WHO Constitution recognised more than 70 years ago, health implies more than absence of disease and length of life. It involves also collective physical, social, mental wellbeing, and not just the quantity but the quality of life (WHO, 1948). Health is affected by the living, working and socio-economic conditions that shape day-to-day realities. This is the reality that people experience. Much work on healthy societies is centred on how to address these determinants of health, particularly the inequalities that lead many to live without safe water, clean air, adequate food and shelter, decent work or with violence and other forms of deprivation.

These conditions, population health equity outcomes and the wellbeing of current and future generations are influenced by socio-cultural, economic and political determinants from local to international level. They are now increasingly affected by different dimensions of a transnational, neoliberal globalisation, including in relation to climate, biodiversity and other ecological conditions. The inter-connectedness of and balance between these different determinants and their delivery for people within and across countries are affected by values, ideologies, knowledge, politics, power relations and rights that influence policies, services, institutions, technologies, capabilities and actions.

The way healthy societies and their drivers are conceptualised within countries by socio-political actors with different degrees of power and influence plays a role in shaping the policies and actions implemented to achieve them. Within countries and internationally, different ideas co-exist and some assume dominance or hegemony for various reasons, whether by force or consent. In a constructivist analysis, the hegemony of particular ideas is a consequence of many factors, including production relations and the use of material power to dominate others, socio-political forces and relations, and institutions, rules and procedures used to impose, negotiate, build convergence and maintain consent around particular ideas, and to suppress others (Ravenhill, 2008; Schmidt, 2018).

A social constructivist analysis brings the public into this analysis, arguing that hegemonic power is exercised when dominant ideas are embraced by society. It is thus not only the ideas advanced or imposed by socio-economic elites and states that matter, but also those that are promoted by social actors and that exist in the public mindset (Schmidt, 2018).

Different paradigms underlying the explanations, knowledge, policy and action on healthy societies have thus existed across time and across countries, rooted in histories and political economies and arising from competing interests and ideas. Different concepts have emerged and exist in different regions and at global level. Van Olmen et al. (2012:1) argue that such frameworks:

> *are products of their time, emerging from specific discourses. They are purposive, not neutrally descriptive, and are shaped by the agendas of their authors. The evolution of thinking over time does not reflect a progressive accumulation of insights. Instead, theories and frameworks seem to develop in reaction to one another, partly in line with prevailing paradigms and partly as a response to the very different needs of their developers.*

A recent international meeting on healthy societies noted that there is no global consensus on how to achieve them (HSHPG, 2020). One reason is because, as noted above, not all social actors and states share common interests and experiences, and not all polities share the same thinking on what constitutes a healthy society, or how to attain it. If a global 'consensus' on healthy societies is not to simply reflect an imposed global hegemonic perspective, we need to have a better understanding of the nature, trajectory, drivers and policy influence of the different paradigms that have emerged on healthy societies, not only at international and global levels, but also those that have emerged and influenced policy from different regions globally.

This paper recognises this diversity of thought and experience and seeks to present evidence and reflections to contribute to dialogue and inquiry on our understanding of healthy societies and how we achieve them.

We explore the trajectory and content of frameworks on healthy societies from the 1970s onward, while also bringing in relevant information on historical paradigms that predate the 1970s, but that continue to inform contemporary agendas.

We examine this at global level, with its influences from Europe and the United States, and in Latin America, East and Southern Africa and India.

The paper focuses in *Section 2* on the main features of those paradigms that had a wider or more sustained policy influence, with their contextual, institutional and social drivers and examples of their policy influence. The paper does not explore how far these policies were implemented or the factors affecting it, as this is a separate and important area for follow-up analysis.

In *Section 3* we draw on the evidence of the paradigms and their trajectories in the different geopolitical regions and levels covered to outline shared and different features and insights for the framing of healthy societies.

In *Section 4 we* discuss the implications for future dialogue and inquiry on healthy societies.

The paper, developed in late 2020, draws from a desk review of public domain published documents. We covered European and USA influences and the three geopolitical areas, which we term 'regions' in the paper, given their significant share of the global population, drawing on literature in English and Spanish. We focused on paradigms that were more dominant, persistent or influential post-1970, and exemplify policy events that signal their uptake, without claiming to be exhaustive. While the 1978 Alma Ata Declaration on Primary Health Care (PHC) is the entry point for the paper, the timeline in *Appendix 1* shows a longer history that has contributed to post-1970 paradigms in all regions covered. We used a shared definition of paradigms as systems of beliefs, ideas, values, and actions that are models of thinking about the real world and of a healthy society as one that does not wait for people to become ill.

Recognising the need for a level of epistemic pluralism to address the key areas of focus, the paper is written by authors with personal experiences of the regions covered and drew on diverse rather than singular disciplinary sources, albeit with population health a key entry point. We used a broad analytic framework to document the goals, ideas and approaches within the paradigms and the cultural, socio-political, material and knowledge systems that they drew on. We implemented a grounded thematic analysis of the materials sourced to identify the key themes. A review meeting involving people with experience in the area from the regions covered and at global level contributed to the validation of and review feedback on the findings.

We recognise various limitations: The paper does not cover *all* regions, and excludes countries or regions that we consider to be important, such as China, Russia, North or West Africa, parts of Asia-Pacific or the Middle East. This was due to limitations of time, resources and language, and we encourage follow-up work to similarly document the paradigms in these other parts of the world. In drawing on available published information covering significant time periods and geographical scope, it excludes detail. The evidence is deliberately qualitative and intends to make no associations between paradigms, policies and their health impact.

Notwithstanding these limitations, the regions covered demonstrate common and diverse features of compelling and influential discourses about healthy societies that have emerged and have had policy influence within and across regions and globally. Exploring this evidence of shared and different features and their drivers enables us to reflect more deeply on how we can build more inclusive spaces and processes for better engaging with these historically produced and context-dependent ideas of 'healthy societies', in negotiating and framing paradigms and policy agendas and in generating knowledge and action, including at global level.

2. Paradigms on healthy societies and their policy influence

Within this broader context, this section describes for the global level and its European and North American influences, and then for each of the three regions covered, the trajectories of the most dominant and persistent paradigms on healthy societies in the past half century, and their policy influence. The descriptive presentation in this section of the histories, contextual factors and features *within* each region is deliberate, to ground analysis and insights from their common and different features in *Section 3. Figure 1* below provides a visual summary of the regions covered and, broadly, the paradigms covered within them.

Figure 1: Regions and paradigms for healthy society covered in the paper
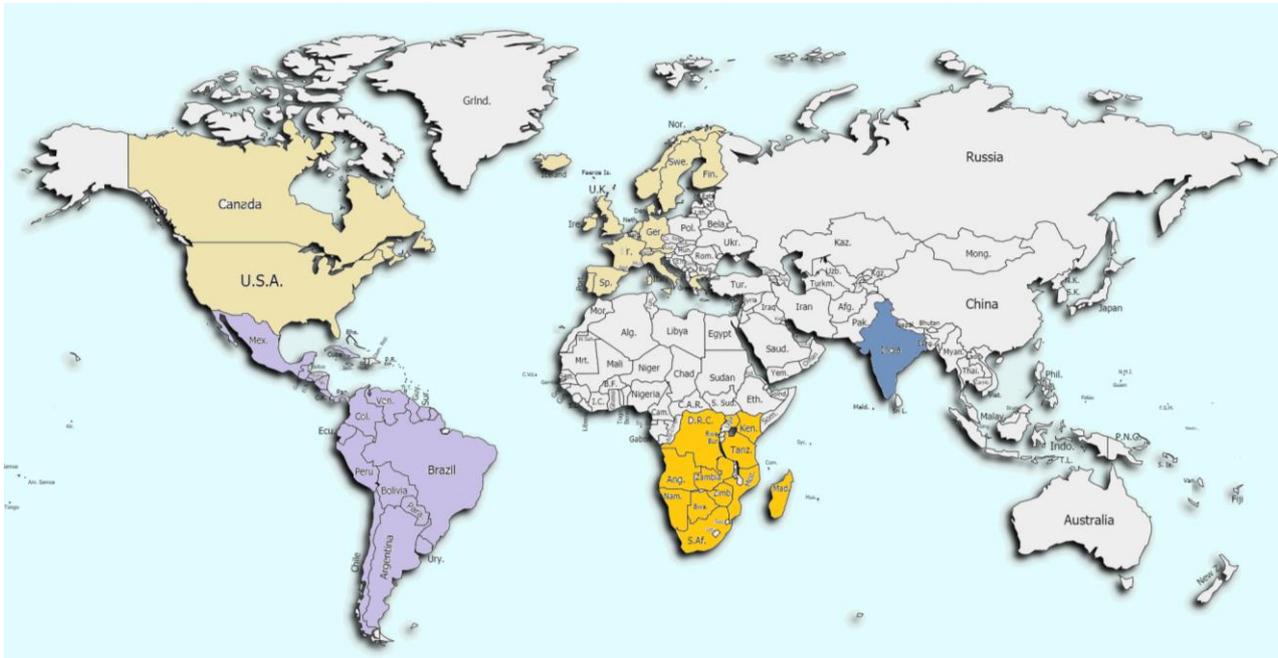
Key:

Europe, North America and global	Latin America	East and Southern Africa	India
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Social medicine and a social determinants wellbeing paradigm		Social determinants and resource nationalism	Gandhi's mind, body, soul, community health paradigm
Universal rights and a rights-based approach	The social medicine / social determination paradigm		People's health in people's hands
Planetary health as an ecological wellbeing paradigm	Buen vivir and intercultural health	Reciprocity in traditional health systems, *ubuntu*	Traditional paradigms
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2.1 European, North American and global frameworks

European countries and the USA have had a historical impact on international and then global health frameworks, although there have been wider influences in recent decades. Two major paradigms are evident and a further three linked to them. The 1978 Alma Ata Declaration, the entry point for the analysis, reflected a *social medicine* and *social determinants and wellbeing paradigm* focusing on socio-political and economic determinants of health equity and wellbeing. A second paradigm was, however, generally more dominant in the period: in a *pathogenic or biomedical paradigm,* healthy societies were characterised by how far immediate disease risks could be reduced or eliminated. A *rights-based approach* has generated claims in and interfaced with both the social determinants and the biomedical paradigms. In the 2000s, the social determinants paradigm evolved to integrate the international co-operation needed to protect key ecosystems for sustained, intergenerational wellbeing, as a *planetary health paradigm*. In the

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same period, a *biosecurity-focused approach* has intensified the biomedical response to cross-border health and economic threats from pandemics and emergencies. Each of these are discussed in this subsection.

2.1.1 A social medicine and social determinants wellbeing paradigm

A *social determinants wellbeing* paradigm emerged in Europe as early as 300BC, when Aristotle framed wellbeing as an outcome of material and non-material dimensions, where successful societies (excluding slaves) shared common principles on what is important for collective wellbeing (Giovanni et al., 2011). In the late 1800s and in the industrial revolution in Europe, reflecting working class political and union organisation, Rudolf Virchow and Frederik Engels raised the social origins and structural causes of illness, including in the economic and political relationships between different social classes (De Angulo and Losada, 2014). As activist scientists, their *social medicine* approach integrated the socio-economic and political causes of health problems to motivate socio-political change (Carter, 2019). In a more moderated technical manner, the League of Nations Health Organization (LNHO) applied this approach in identifying health risks, as did the International Labour Organisation (ILO) in identifying workplace risks to set fair labour standards (Carter, 2019). In a context of ideological conflict between capitalism and socialism, not all western countries bought into the approach. The USA remained outside the LNHO and ILO and used its influence to promote separate international health and labour organisations for the Americas, while also placing individuals from the USA on LNHO advisory committees, with the Rockefeller Foundation supplying about 30% of its budget (Carter, 2019).

Maintaining hegemony of approach was one feature of a Cold War context. In the 1930s, as independent governments and political movements in Latin America became more important in international health, the USA-allied Pan American Sanitary Bureau (PASB) and the Rockefeller Foundation reached out to these countries. They promoted social insurance and selected state regulation of certain markets, such as for food, but resisted critiquing the deeper political economy causes of ill health (Carter, 2019). Nevertheless, the more radical political lens of Virchow and Engels was adopted in many Latin American countries, as discussed in *Section 2.2.2.*

The Cold War context and contestation around ideas continued to Alma Ata. Rising incomes and consumption in high-income countries presented opportunities for improved health, with wider benefit from a post-war social contract with labour. However, increasing inequality, a 1973 oil crisis, economic shocks in 1968-1971, nuclear escalation and conflict also stimulated growing social movements in these countries, including anti-war and civil rights movements (Brown et al., 2006). Cold War tensions affected how civil and political rights were seen relative to social and economic rights, discussed in *Section 2.1.3*. Experiences of socialised access to jobs, incomes, living conditions and services in some Eurasian countries and in Cuba, and pressures for social justice from liberation, nationalist, social justice and rights movements, generated a perception that injustices demanded deeper systematic change and that this was possible, including through a more just international economy. Widening alliances converged around development theories that emphasised long-term socio-economic growth, fairer terms of trade and more generous development finance, spearheaded by international institutions such as the Non-Aligned Movement, the Group of 77 and the United Nations (UN) Conference on Trade and Development (UNCTAD), leading to a 1974 UN General Assembly resolution calling for a New International Economic Order (Brown et al., 2006).

While many of these processes were taking place at state level, non-state organisations working at grassroots-level generated health innovations from countries with differing political systems, such as China's barefoot doctors, contributing new ways of improving population health (CSDH, 2005). A worldview built on a positivist, reductionist knowledge was seen to inadequately account for the multiple subjective interconnections in dynamic social systems. Social epidemiology proponents identified deeper social-pattern factors affecting health and illness, proposing that if the determinants of health are economic and social, the remedies must be too (De Angulo and Losada, 2014). Halfdan Mahler, WHO director general from 1973-1988, responded to these international pressures and local innovations, noting that "the imperatives of contemporary history", called for new approaches in health (Chorev, 2012:1). 'Health for All in the Year 2000' recognised the pressures for equity and justice, and the 1978 Alma Ata Declaration framing of

comprehensive primary health care (PHC) integrated the multidimensional and socio-political nature of health development (Brown et al., 2006).

While *Section 2.1.2* describes how global political economy and institutional trends rowed back on comprehensive PHC, its socio-political framing was sustained in some regions and international processes. The 1986 Ottawa Charter for Health Promotion promoted intersectoral/ multisectoral action for health (IAH/MAH), recognising peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as fundamental conditions for health. It posed health as both a right and a resource for social, economic and personal development and quality of life. In contrast to a view that improved wealth alone would improve health, these proponents argued that health was essential to create wealth. The approach was thus operationalised by integrating health promotion in public policies, laws, fiscal measures, tax and organisational measures across diverse sectors. For the health sector, this implied supporting, partnering or leading actions across different sectors to improve *health* outcomes as a key contributor to economic outcomes (Rasanathan et al., 2017; Kickbusch, 2008). A significant body of research added evidence to this policy dialogue, such as from the 1990 WHO publication of *Social Determinants of Health: The Solid Facts*, providing evidence on social determinants that IAH/MAH could address to improve health, such as the social gradient, stress, early life, social exclusion, addiction, jobs, food, and transport (De Angulo and Losada, 2014).

The end of the Cold War in the late 1980s marked the end of a bipolar world framed around the military interests of USA and USSR. Rather than a 'unipolar' western-dominated world, the emergent global influence of China and other Asian countries, India and Latin America opened up a more multipolar world. Increased global trade and transnational organisation of production generated global interdependencies across countries. A growth in social media and communication widened opportunities for information flow and socio-political connections. New institutional and social configurations emerged as drivers of ideas and co-operation. They included the Brazil, Russia, India, China and South Africa (BRICS) forum and transnational social rights movements, discussed later (Loewenson et al., 2014). The context in which states constructed their national interests changed, challenging notions of national sovereignty, raising collective interests, and opening space for non-state actors in international relations.

A neoliberal form of globalisation generated contexts for the development and articulation of ideas for a healthy society. A growth in technological development, consumer goods, and information technologies reinforced arguments that improved wellbeing could come from science and technology and through free markets, reinforcing and generating commercial interests around the biomedical paradigm discussed in *Section 2.1.2*. Intensified extraction of land, mineral wealth and other local resources and rising socio-economic inequality generated challenges, political tensions, conflict in many countries, however, as well as cross-border migration (CEPAL, 2015b; EQUINET, 2012; PAHO,WHO, 2019; Shukla and Phadke, 1999). The rise in global wealth together with a rise in precarious employment, household insecurity, and worsening living, working and community environments fuelled perceptions of injustice and challenged the notion that a neoliberal economic growth would guarantee improved wellbeing. International perceptions and pressures from the global south grew on the wider international insecurity generated by these trends and the limits of macroeconomic growth as a measure of economic and social progress. For example, the 2009 Sarkozy Commission on Measurement of Economic Performance and Social Progress called for a multidimensional understanding of development that would address wellbeing, inequalities and protect future generations (Fidler, 2009; Brown et al., 2006).

Within this context, the 2001 Macroeconomic Commission on Health took up the ideas raised in the 1986 Ottawa Charter to locate investment in health as a contributor to poverty reduction, while the 2008 Commission on Social Determinants of Health (CSDH), using the analytic framework shown in *Figure 2*, provided evidence of social determinants driving inequalities in health and the actions to address them. This was further taken up in the 2008 World Health Report and the 2011 World Conference on Social Determinants of Health in Brazil, with champions from Chile, Brazil and UK. With IAH/MAH having limited uptake, a further way of operationalising these ideas was articulated in a 'Health in All Policies' (HiAP) approach that placed responsibility on all sectors across government to do no harm to health and to advance

health outcomes. It was championed globally by the EU Finnish presidency and in the 2010 Adelaide Statement on HiAP (Howard and Gunther, 2012; Bert et al., 2015). The 2014 Global Health Promotion Conference on Health Promotion and Helsinki Statement on HiAP pointed to opportunities to achieve health and *wellbeing* goals through 'Whole of Government' approaches. These pronouncements recognised leadership for action from outside the health sector, such as in the role of mayors and urban local governments in the 99 cities in the WHO European Healthy Cities Network that integrates health and wellbeing in urban planning (WHO Euro, 2014).

Figure 2: The WHO CSDH conceptual framework on the social determinants of
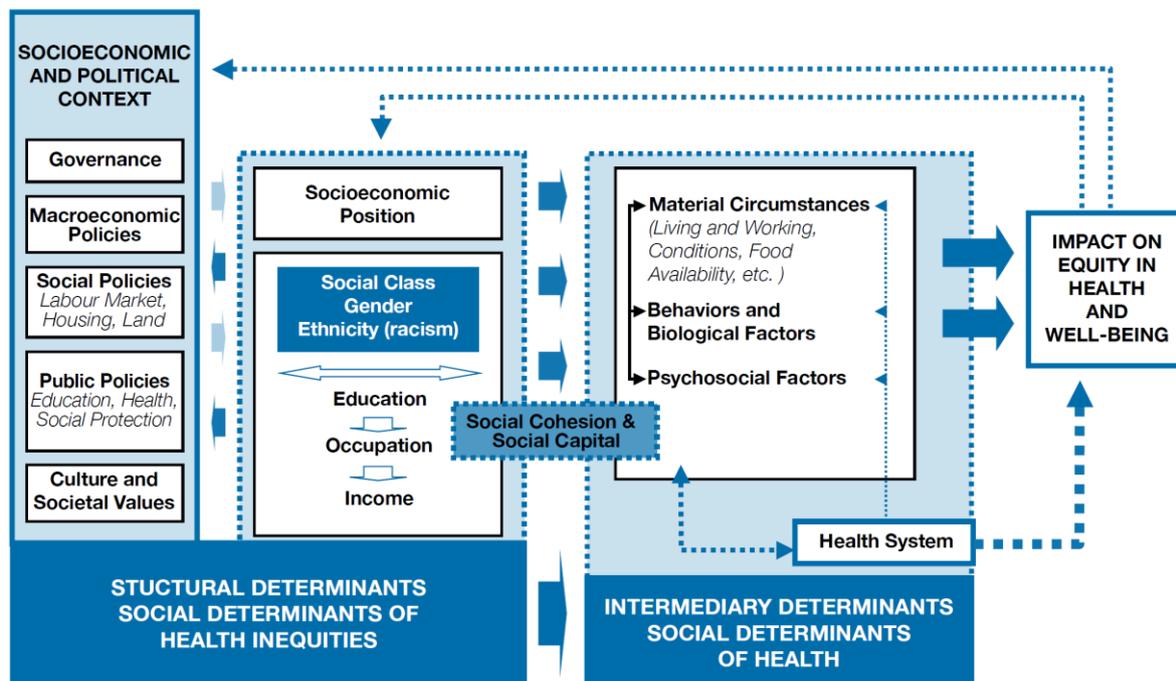
health *Source:* Solar and Irwin, 2010.

While acknowledging global determinants of health, such global processes continued to focus primarily on country-level roles, notwithstanding the increasing influence of global trade, finance, extractive activities and transnational actors in national conditions. In 1998, WHO's Yach and Bettcher in the 'The Globalization of Public Health' identified how global-level social determinants may harm or improve health, both from the diffusion of ideas, values, rights and knowledge, and through the practices and products from transnational actors. Rising food prices, a 2008 energy and financial crisis, conflict, population displacement, environmental and biodiversity degradation added evidence of such global determinants and their harms to health, including in rising levels of chronic diseases, pandemics and social deprivation (Fidler, 2009; Commonwealth Secretariat, 2016; Agyepong et al., 2017). Without a systemic challenge to the global political economy model, the WHO at global level lacked a persuasive role in *preventing* these environmental, energy, food, and economic crises, focusing rather on engaging on their more immediate harms (Fidler, 2009). The call for *global* responsibilities, for 'reciprocal maintenance' for all people and countries, and international co-operation and intervention thus came from some countries and civil society (Brown et al., 2006; De Angulo and Losada, 2014; WHO Euro, 1986). For example, the People's Health Movement, a global health civil society movement launched in 2000, in its 'People's Health Charter' and advocacy coalesced civil society in different regions around the right to health, comprehensive PHC and economic alternatives to a neoliberal globalisation as fundamental to achieving healthy and sustainable societies (Brown et al., 2006; Fidler, 2009).

WHO's role in these processes is the subject of a significant, separate body of literature. The organisation faced a challenge when policy norms affecting health sectors shifted to the Bretton Woods institutions, discussed in the next subsection, and from member states protesting over WHO policy challenges through budget withdrawals, as for example, the USA did over WHO's Essential Drugs Programme. In response, "WHO began to refashion itself as a coordinator, strategic planner, and leader of global health initiatives" (Brown et al., 2006:69). In the early

2000s, various global measures were passed to protect health across borders and to limit free markets and trade practices that were shown to be harmful to health. They included the updated International Regulations (2005) and the Framework Convention on Tobacco Control (2003). Notably, there have not been such global-level regulatory conventions since then. The 2000 Millennium Development Goals (MDGs), discussed later, set health related goals that were more focused on encouraging global development aid for health, education and social services in low-income countries than around wider global economic reforms, stimulating and giving policy influence to a range of new global institutions and funds and global private foundations (Buse and Hawkes, 2015).

The debates in and framing of the 2015 Sustainable Development Goals (SDGs) reveal the voices in and debates over global determinants of health and the global level processes that build hegemony. From early 2011, UN-initiated consultations over the Post-2015 Development Agenda sought to develop a successor agenda to the MDGs and the Rio+20 UN Conference on the Environment and Development. A working group took input from a range of sources, constituencies and regions. Led by the UK, one 'post-MDG' stream continued the international aid and technical development focus. A second, with strong voices from southern countries, environmental and equity actors, challenged the current development trajectory and its inherent inequalities as a socio-political issue (Fukuda-Parr, 2019). Inequality was recognised by both streams, but with different perspectives on whether it implied tackling the distributional inequality of power and wealth between social groups and countries, or whether it implied focusing only on the exclusion of vulnerable and marginalised populations. The debates around these perspectives crystallised around whether to include a specific goal on inequality, promoted by the G77 and China and opposed by the Western countries (Fukuda-Parr, 2019).

The World Bank advanced the concept of ending extreme poverty and promoting 'shared prosperity', through sustained income growth of the bottom 40% of the population. It was widely contested for not addressing the widening of inequality through a growing concentration of wealth in the top 10%, within and across countries. This challenge was avoided in a manner that masked political influence and exerted hegemony by shifting the debate to a technical committee and focus on how to 'frame' and measure the goals (Fukuda-Parr, 2019). When the UN General Assembly set the 17 environmental, social and economic SDGs, while goal 10 did address inequality, its framing and targets and the call to 'leave no-one behind' reflected the social exclusion and poverty reduction perspective, with indicators that narrowly focused on features of gender, age, disability, and location and were silent on structural features such as wealth/income, ethnicity, religion or race (Fukuda-Parr, 2019).

In their multi-sectoral commitments, including those related to food security, gender equality, safe water and sanitation, safe inclusive cities and peaceful inclusive societies, the SDGs integrated key issues affecting healthy societies and located their resolution as a duty of governments (Commonwealth Secretariat, 2016; Ridgway et al., 2019). Yet the debates in their framing suggest that while they asserted hegemony of one set of ideas, they left unaddressed many of the expectations from countries and social actors that they would address the global determination of these conditions for healthy societies. In a context of the neoliberal crises, social inequality and protest described earlier, it was the 2016 9th Global Conference of Health leaders' 'Shanghai declaration' that took a more challenging global position on the structural, commercial and global determinants and the duties of different actors and sectors to address them, calling for a whole of *society* engagement and 'global collective action' to advance equity, and to address 'powerful commercial forces that work to counteract health' (WHO, 2016). In doing so it highlighted a continued demand for global, political economy determinants of health to be addressed, further taken up in the debates on planetary health, discussed later.

2.1.2 The pathogenic, biomedical paradigm
The social determinants paradigm discussed previously has had a developing trajectory, but it is a pathogenic, biomedical paradigm that has generally been more dominant in health in modern history. As early as 460BC, written records report Hippocrates' proposal that external agents cause disease, with the primary relationship to achieve a healthy society a therapeutic one between individuals and physicians (Franco et al., 2014). These ideas were given impetus during and after the European Renaissance and in the Industrial revolution as scientific advances

identified 'germs' and other immediate factors in disease causation, albeit without identifying their societal origins (Giovanni et al., 2011; Ridgway et al., 2019). The 'germ theory' led to a range of 'sanitary' public health reforms in countries. These approaches informed the international co-operation in the Americas, through the 1902 International Sanitary Bureau, later renamed the Pan American Sanitary Bureau (PASB), a precursor of the Pan American Health Organisation (PAHO), and in the LNHO international commissions and intelligence reports on disease control (Fidler, 2009; Brown et al., 2006). While these sanitary measures improved health where they were applied in Europe and the USA, they were not universally applied in the colonies, as discussed later in the experiences of other regions.

The pathogenic paradigm informed an optimistic expectation that the causes of disease could be eradicated by technology. This idea fitted well with USA Cold War efforts to promote modernisation with limited social reform. The 1958, WHO 'Global Battle Against Disease' took on this paradigm and a successful vaccination campaign to eradicate smallpox gave succour to it. The failure of a similarly technologically driven malaria eradication campaign in 1955-1969, however, led the 1969 World Health Assembly to declare eradication to be infeasible in many parts of the world (Brown et al., 2006).

When the 1978 Alma Ata Declaration on PHC promoted a more holistic, political and social determinants approach to population health, as noted earlier, what followed Alma Ata reinvigorated the biomedical focus. A second oil crisis in 1979, a global recession in the early 1980s and a debt crisis in many countries were used by the Washington consensus of right-wing governments in the USA and Europe and the Bretton Woods institutions to deepen neoliberal reforms favouring free trade, deregulated financial and labour markets, and reduced social budgets as a necessary response to crisis. Structural adjustment programmes were implemented in many low- and middle-income countries (Fidler, 2009). Protecting neoliberal ideas that the free global movement of capital and trade was essential for growth, the Washington consensus argued that the wealth from macroeconomic growth would 'trickle down' and improve population health. Social deficits caused by these measures were said to be transitional and addressed by targeted social schemes with aid for low-income countries.

The dominance of this consensus and its associated demands for fiscal constraints and economic efficiency in the health sector gave momentum to US agency, World Bank and UNICEF pursuit of biomedical approaches, overshadowing WHO in their application of institutional resources and power to their ideas. Without challenge to the argument that growing wealth was a precondition for improved health, comprehensive PHC was argued to be infeasible. *Selective PHC* was thus developed at a 1979 Bellagio meeting sponsored by the Rockefeller Foundation and World Bank. It proposed a set of technical, low-cost interventions, operationalised under the acronym 'GOBI' (*G*rowth monitoring to fight malnutrition in children, *O*ral rehydration techniques to defeat diarrheal diseases, *B*reastfeeding to protect children, and *I*mmunisations) (Brown et al., 2006).

Global attention in health focused on managing high mortality 'emergencies', notwithstanding their socio-economic determinants (Fidler, 2009). The surge of HIV in the late 1980s and resurgence of malaria, tuberculosis and other infectious diseases added further impetus to global efforts and funding to move from comprehensive PHC and public health towards diagnostic, medicine and vaccine technology-driven measures for specific diseases, with growing policy influence in the Global Fund for AIDS, TB and Malaria (GFATM) as a funder of medicines, the Global Vaccine Alliance (GAVI), and the Gates Foundation for its role in health technology development. The 2001 Report of the WHO Commission on Macroeconomics and Health provided economic arguments for which diseases and cost-effective programmes to prioritise to improve population health, implemented through essential benefit packages (Brown et al., 2006). Treatment activism and policy engagement in the World Trade Organisation and the TRIPS Doha Declaration in 2001 engaged on access to these health technologies where needed as a right. These presented important claims on economic actors, but left control over their patenting and production largely in high- and middle-income countries and low-income countries dependent on development aid to obtain them, and thus continued global debate on control over patents, research and development (Fidler, 2009; Howard and Gunther, 2012).

The 2000 MDGs to a large extent reflected this understanding of a healthy society being achieved through reductions in morbidity and mortality for high-burden conditions through cost effective interventions, specifically for children under 5 years; mothers; HIV, tuberculosis and malaria; and for low- and middle-income countries. Having global goals did widen responsibility for their achievement, reasserting the role of states and their duties for the health of populations, in part in response to HIV and disease/treatment activism (Marten, 2018; Brandt, 2013). However, the MDGs did not challenge the biomedical paradigm, narrowing the focus to specific 'priority' disease or mortality challenges, as selective PHC had done earlier. They shifted the focus from what was technically and scientifically feasible for population health to what was affordable and could be funded through bilateral aid and global institutions such as GAVI and GFATM. This left many health challenges unmanaged, including those causing rising chronic conditions (Marten, 2018; Buse and Hawkes, 2015). While the SDGs integrated many of the social conditions affecting health, it located the health sector role within the goal of universal health coverage (UHC), with this goal given profile in the 2018 Astana declaration commemorating PHC (Rifkin, 2020). UHC has enabled a rights-based approach to universal access to healthcare, but has also been framed in many countries in terms of what services can be met from insurance financing, leading to greater focus on biomedical services than the wider determinants and actions raised in Alma Ata and subsequent international policy processes. The implications of adopting a dominant biomedical approach to achieving healthy societies for emerging challenges such as pandemics is discussed later.

2.1.3 Integrating human rights
A human rights-based approach has interfaced across the years with both the social determinants and the biomedical paradigm, and been applied in both. The 1948 Universal Declaration of Human Rights (UDHR) established a human rights foundation that has informed global policies, situating health under the right to an adequate standard of living, including food, clothing, housing, health and social services and social protection (Gostin et al., 2018). The WHO operationalised the UDHR in health through its constitution, *creating a rights-based foundation for global health governance…* that *… represented the world's most expansive conceptualisation of international responsibility for health* (Gostin et al., 2018:2731). The UN Economic and Social Council Commission on Human Rights highlighted both medical care and underlying determinants of health, encompassing both patient and population health rights.

In the Cold War, the Western states embraced civil and political rights and the Soviet Bloc emphasised economic and social rights. This divided the comprehensive framing in the UDHR into two separate rights covenants: the International Covenant on Civil and Political Rights and the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR). These two framings carried implicit tensions between individual and collective rights, resonating respectively with values asserted in capitalist and socialist ideologies. US opposition to socio-economic rights and its strong promotion of individual rights resulted in a narrow definition of the right to health and health determinants in the ICESR as the right to the highest attainable standard of physical and mental health. At the same time, WHO observed "people are beginning to ask for health, and to regard it as a right" (Gostin et al., 2018:2732). Social and economic rights were highlighted in the call for the New International Economic Order, and in the 1978 Alma Ata Declaration in calling for participatory, broad-based socio-economic development to achieve comprehensive PHC. A rights approach and a social determinants lens resonated *as different yet overlapping measures of human wellbeing and self-actualisation* (Kenyon et al., 2018:1).

In the late 1980s, civil society and treatment activists across countries, but particularly in the United States, Brazil, India and South Africa, developed a strong social movement with global influence on the right to medicines for HIV, locating advocacy on both political and economic rights within a biomedical paradigm (Nunn et al., 2012; Brandt, 2013). WHO also integrated this link between healthcare and human rights in its 1987 Global Programme on AIDS, led by Jonathan Mann, as a rights-based framework for global health (Gostin et al., 2018). The movement contributed to the establishment in 1994 of UNAIDS. These developments suggested that social activism using a human rights-based approach could overcome some of the powerful interests impeding health action. It pointed to ways to anchor health development in claimant and duty bearer capacities and in systems for implementing rights and obligations as a matter of law, policies and processes. It thus sought to move action from the optional realm of benevolence and

aid into the mandatory realm of law, positioning people as active claimants of rights, rather than passive beneficiaries of policies, placing attention on the mechanisms and processes for exercising claims and holding duty bearers accountable (WHO, undated; Loewenson, 2012).

Partly enabled by a post-Cold War context, a 1993 World Conference on Human Rights affirmed a perspective that all human rights are universal, indivisible, interdependent, and inter-related. Bringing socio-economic rights and civil/political rights into one framework highlighted the role of power in how rights are realised and of collective agency and participation as determinants of health equity (Kenyon et al., 2018). For example, strong social movements for gender equality informed the 1994 International Conference on Population and Development and the 1995 World Conference on Women that both linked civil and political rights with economic and social rights as a foundation for sexual and reproductive health. Such initiatives further strengthened the activism in and focus on the rights-based approach in health, and in 1997, the WHO enlisted its first human rights advisor to operationalise a rights-based approach in its programmes and collaborate with the UN human rights system. The UN added General comment 14 to the ICESCR, extending in its authoritative interpretation of the right to health not only preventive and curative healthcare, but also as rights to determinants of health such as food, housing, work, education, non-discrimination, and equality. While the right-to-healthcare—as an entitlement, not a market commodity—linked delivery on rights to a biomedical paradigm, the many other areas covered linked the health rights framework to the social determinants paradigm. The WHO covenants cited earlier reinforced this. For example, the 2005 revision of the IHR included "full respect for the dignity, human rights and fundamental freedoms of persons," as a pillar, minimising restrictions on individual freedoms and prohibiting discrimination in health measures (Gostin et al., 2018). The 2008 WHO CSDH elaborated how rights related to social determinants could be implemented to promote health equity (Chapman, 2010).

With shortfalls in realising health rights, even for healthcare services, the concept of progressive realisation has become a key issue. Linked to it is the adequacy of public and tax revenues, resources and capabilities to deliver duties and the opportunities and political space to claim rights and to hold the state – and private actors - accountable for delivering on health rights (Kenyon et al., 2018). At global level the Human Rights Council provided new mechanisms for public health accountability, including periodic reviews, with a role for civil society to hold governments accountable for implementing health-related human rights. Health featured in nearly a quarter of all recommendations made under the first cycle of these mechanisms, with particular attention to gender-based violence (Gostin et al., 2018). The later discussion on the southern regions covered in this paper highlight that while social actions over health rights have taken on different issues in these regions, they have consistently integrated a demand for justice and exercise of social power in systems that are seen to skew against marginalised social groups and classes.

2.1.4 The emergence of planetary health as an ecological wellbeing paradigm
By the second decade of the 2000s an emergent *planetary health paradigm* has emerged, building on social determinants to raise the key ecosystems essential for wellbeing and the resources, policies and actions that harm or enable sustained, intergenerational survival and wellbeing. Climate and earth sciences exposed ecological determinants of wellbeing, showing both their immediate and intergenerational impact on health and emergencies. Further evidence showed that policies such as those promoting more sustainable dietary choices, zero carbon energy, and transport systems can improve health and mitigate climate change (HSHPG, 2020). Planetary health linked health, wellbeing and equity goals to the impact of human systems on nature and to the safe environmental limits within which humanity can flourish. Departing from a mechanistic, hierarchical cause-effect understanding of life, it applied new ways of understanding complex processes and interdependency (De Angulo and Losada, 2014).

The 1992 UN Conference on Environment and Development in Rio had already posed sustainable environments as an intergenerational global issue (Ridgway et al., 2019). Two decades later, the Conference of the Parties (COP) in 2011 set 20 global Aichi Biodiversity Targets to guide national and international efforts to conserve biodiversity, all with some link to health and wellbeing. A COP Secretariat Joint Work Programme on Biodiversity and Health with the WHO produced a Strategic Plan 2011-2020 for Biodiversity (Whitmee et al., 2015).

Planetary health brought a more structural, global analysis of ecosystems and health to earlier 'One Health' and 'EcoHealth' concepts, discussed in the section on ESA countries. It was framed by Horton and Lo (2015) as an evolution of public health and critical for achieving the SDGs, with the evidence and discourse amplified in a new, *Lancet Planetary Health* journal and initiatives supported by the USA-based Rockefeller Foundation and the UK-based Wellcome Trust (Pongsiri et al., 2019). As an emergent and still developing paradigm, it has applied a social determinants paradigm to ecosystem issues at planetary scale (Lerner and Berg, 2017).

At the same time, climate strikes - many led by youth - social protest and debates called for a more profound transformational change, challenging economic and austerity policies, the privatisation of public services and the depletion of biodiversity (Mersmann et al., 2014). The degradation of environments, biodiversity and threat from climate change have intensified demand and focus on global determinants of health, including inequalities in burdens, benefits, capacities and risks to wellbeing within the current global political economy and in power within global rule-making institutions. Following the path of the 2016 Shanghai Declaration, proponents of planetary health, such as in the 2015 Lancet Commission on Planetary Health, have called for measures to tackle the vested interests and power imbalances that undermine more sustainable and equitable patterns of consumption (Whitmee et al., 2015).

2.1.5 The escalation of a biosecurity-focused paradigm
As these new ideas locating a healthy society within a healthy planet were gaining attention, the pathogenic paradigm and its focus on technical interventions also took on a new momentum in a *biosecurity paradigm*, in response to recurrent emergencies and pandemics.

As early as the 14th century, European foreign policy interactions sought to contain cross-border health risks to trade and to economic and security interests, including in the planning of colonial settlements and in quarantining social groups seen to pose a risk to health (Loewenson et al., 2014). In 1919, following the 1918 flu pandemic, the US established an International Bureau for Fighting Epidemics, and in 1920 the LNHO administered international sanitary agreements and the rapid exchange of public health information, a task later taken up by the WHO in the IHR (Spinney, 2020; Brown et al., 2006). The 1918 flu epidemic also gave profile to eugenic theories that pointed to 'inferior' genes rather than poor environments to explain workers' risk in the epidemic. The same explanations of the biological inferiority of colonised groups informed colonial *biosecurity-focused approaches* segregating and quarantining people seen to harbour disease (Spinney, 2020). Eugenic theories enabled a discourse on race and ethnicity that found a place in the virulent nationalisms and fascism of the 1930s in Europe (Carter, 2019).

The post-Cold War period in the 1980s and end of the bipolar system opened space for countries to re-conceptualize 'security' to include threats beyond those emanating from military action by enemy states. While this included the concepts of human and collective security, noted earlier, challenges such as pandemics and antimicrobial resistance in the 1990s and 2000s were given higher profile as threats to national and international security (Fidler, 2009; Reich et al., 2011). The US launched its Centers for Disease Control and Prevention (CDC) to respond to what it identified as "global infectious disease threats". The 1997 US Institute of Medicine International Health report, the CDCs 1998 Strategy for the 21st Century and the 2001 US Department of Defence Global Emerging Infections Surveillance and Response System all sought to protect local people and economic interests from pathogenic threats (Fidler, 2009; Brown et al., 2006).

Biosecurity has become even more pronounced in global policy-making in the 2000s, responding to pandemics, biological weapons, biotechnology and bioterrorism (Fidler, 2009). The September 11 terror attack in the USA may have given even greater impetus to the already increasing USA focus on external threats to health, noted earlier. WHO has defined biosecurity as the prevention, detection and response to infectious disease threats of international concern to limit trans-border morbidity and its impacts (WHO, 2007) There is, however, a yet unresolved debate on how biosecurity relates to global health security and whether the latter is limited to biosecurity or should be used to raise the global profile of a wider range of health and human security issues, such as in the UN Security Council's recognition of HIV as a threat to peace and security (Snowden, 2019; Kamradt-Scott and Wroczynski, 2016). While different actors have given

different meaning to the term 'global health security' and used it in different ways, the focus on infectious diseases has intensified following the series of pandemics in the 2000s (SARS in 2003, MERS in 2012 and Ebola in 2014-2016) (Rushton, 2011; Heymann et al., 2015). In 2014, a Global Health Security Agenda, launched with support from the USA, included 69 countries, international organisations, non-government organisations, and private sector companies seeking to respond to 'global health threats posed by infectious diseases' (GHSA, 2020, online).

The COVID-19 pandemic provides a still unfolding lens on how these paradigms are being applied at global level. While it is not possible to address this comprehensively within the framework of this paper, and while the pandemic has led to a wide mobilisation of different responses across countries and regions, the most dominant appears to have been a biosecurity-focused approach, largely driven by the quarantining and control principles that have been applied for centuries. It has triggered many authoritarian, reactive, centrally led and coercive responses, unresponsive to local conditions and communities. It has also been associated with national protectionism in and stockpiling of essential health technologies, despite UN appeals for collective security and advocacy for these to be global public goods, critique of potential harms to public health from these approaches and concern that they leave unaddressed intensifying political economy and ecosystem determinants of pandemics (Paul et al., 2020; Loewenson et al., 2020; Wallace et al., 2020).

As a prolonged pandemic still underway at the time of writing this paper, COVID-19 has also exposed critical features of the current political economy that undermine or enhance wellbeing from local to global levels, including in terms of the socio-economic inequality in risk and vulnerability and the socio-economic inequality and insecurity generated by the responses to it. It has generated debate on the global response. For example, while many high-income countries have hoarded essential health products and pre-purchased available global vaccine stocks, there have also been calls from national to UN levels for COVID-19 to be treated as a global, collective responsibility and for a lifting of WTO rules that are a barrier to health technologies being made available as global public goods. The pandemic has triggered comprehensive, solidarity driven responses in some settings, and reactive, authoritarian and sometimes militarised responses in others. It has intensified populist responses, with rights violations and privatisation, even while it has also opened new debates about public rights and state obligations from local to global levels (Loewenson et al., 2020). The implications of these debates are further discussed in *Section 3.*

2.1.6 A global context of colonial expansion affecting the three southern regions
The next sub-sections explore the paradigms and their policy uptake in the three southern regions covered. While the post Alma Ata focus of the paper post-dates colonial expansion in these three regions, their current paradigms all reflect to some extent the diversity of ethnicities, cultures and indigenous knowledge systems in their precolonial histories and the impact of colonialism. In all three regions colonial capitalist expansion brought new military, material, institutional, scientific and ideational power, using this to suppress local production modes, knowledge and cultures, and to establish extractive modes of production that brought significant racial and ethnic inequalities in legal and social status, in access to production resources, employment and incomes, and in living and social conditions that disadvantaged and marginalised indigenous people (Maldonado, 2010; Cornia and Mwabu, 1997). Colonial expansion brought epidemics of new diseases from previously unknown microbes into all regions, and together with enslavement and forced movement of millions of Africans, decimated local populations (Caceres, 2003). Eurocentric knowledge introduced new technologies, institutions and infrastructures, but also suppressed local languages, cultures, systems and resources. While colonialism generated significant resources for high-income country economies, it left a legacy of high levels of morbidity and mortality from preventable disease and injury in all three regions (Cornia and Mwabu, 1997; WHO AFRO, 2014; Maldonado, 2010). While the context in the three regions differed, improving health and social wellbeing was thus seen to be important for political legitimacy and electoral support in post-colonial society in all three.

2.2 'Buen vivir' and social medicine in Latin America

Latin America includes countries with different political and governance systems and histories and diverse social groups. Different countries have thus had a range of approaches, such as a pathogenic approach by the Catholic missions segregating population groups, or social security and health insurance approaches (*obras sociales*) promoted by trade unions in Argentina and Uruguay. In this paper we focus on two paradigms for healthy societies that have been persistent, widespread and with policy impact across many countries post 1970. These are a *Buen Vivir paradigm*, associated with *Intercultural Health* (summarised as 'BV/ICH'), and a *social medicine (SM) paradigm*. Following the colonial application of the pathogenic paradigm, described earlier, both were shaped within the region before Alma Ata, but had political or social support and policy influence after the 1970s, coexisting with or confronting pathogenic/biomedical approaches. Both continue to have relevance to current challenges.

2.2.1 Buen vivir and intercultural health restoring respect for cultures and nature

Buen vivir (BV) was based on Andean indigenous beliefs, linked to respect for nature ('mother earth' or Pachamama), hygiene practices and to the common features of precolonial norms across different Andean cultures and ethnicities (Monteverde, 2011). BV, or *Sumaq Kawsay* in Quechua, the local language, means 'life in fullness' or 'full existence'. Life is centred on community, collective interests, complementarity, and reciprocity, in harmony and equilibrium with nature and spiritual cosmic forces. Human beings are seen to be a simple strand of a wider ecology (Maldonado, 2010).

BV or Sumaq Kawsay ideas emerged during the colonial period with chroniclers (*cronistas*) of precolonial traditions like Felipe Huaman Poma de Ayala and Garcilazo Inca de la Vega. More recently, the further development of BV by scholars such as Acosta, Gudynas, Mamani, Huanacuni contributed to its rising prominence and policy influence, So too did its promotion by contemporary indigenous movements and by the anti-colonial and anti-neoliberal political movements that brought left-wing governments to power from the 1980s in numerous countries, including Bolivia, Ecuador, Peru and Venezuela. Ideas of collective wellbeing and a balance with nature resonated socio-politically, given the expropriation and extraction of land and other natural resources, the wide social deficits and racism described earlier, particularly for marginalised indigenous and mestizo (mixed indigenous-Spanish) people (PAHO,WHO, 2019).

Indigenous people's organisations, such as CONAIE in Ecuador, integrated BV in their social justice, human rights and environmental campaigns. In confronting the negative local consequences of globalisation and supporting holistic approaches to social wellbeing, BV resonated with the political and social justice aspirations of left governments and the constituencies that elected them in the 1980s and 1990s. It was integrated into Venezuela's Alianza Bolivariana para los pueblos de nuestra America (ALBA) ideologies in 2004, and in 2008 in the Brazilian sponsored UNASUR covering 12 countries (Hidalgo-Capitán and Cubillo-Guevara, 2017). It was explicitly included in the Ecuadorean and Bolivian constitutions as a framework for policy-making (Hermida, 2011; Barie, 2014). These measures responded to the intention of left-wing governments and social movements to promote social justice in health, integrating in environment protection, cultural diversity, national and people's sovereignty and anti-colonial and anti-imperialist perspectives (Rodriguez, 2013).

These ideas motivated implementation of social policies that generated improvements in health, education and in reduced poverty and social inequality (CEPAL, 2015a). Nevertheless, these governments faced many challenges in implementing the economic policies implied by BV, particularly given the lack of effective transformation away from a dependence on a foreign, privately owned extractive sector that was resistant to social and environmental reparations and terms of trade that were deeply integrated with the global economy. This brought conflict between the governments and the same indigenous movements that had brought them to power.

The more dominant expression of BV was thus less in its confrontation with structural determinants in the economy and more in its integration of respect for cultural diversity. Reflecting this, a concept of 'pluri-national' states explicitly and legally recognised the multi-ethnic nature of and indigenous people's rights in these states. In countries such as Ecuador and Bolivia, the concept integrated recognition of the diversity of indigenous cultures, knowledge and

people and their co-ordination and inclusion in social and economic policies (Fernandez, 2010). In health, this was expressed as an *intercultural health* (ICH) approach. ICH confronted the socio-cultural alienation from colonialism, globalisation and the deep inequities and racism experienced from both. It established the 'right to be different', to participate and to coexist at all levels (Fernandez, 2010).

ICH integrated traditional indigenous health, organic farming, food knowledge and practices and natural herbal therapies that had continued to be accepted and used. It was given contemporary form in the 1950s in the *Programas de Salud en la Situacion Intercultural* (Health programmes in an intercultural situation) in the region (Aguirre, 1955). These programmes integrated biomedical knowledge with respect for cultural and gender diversity, community power and roles within a comprehensive PHC approach (Salaverry, 2010).

PAHO/WHO and the Andean Regional Health body (ORAS-CONHU)ICH promoted these approaches in the 2000s. They were given further impetus and wider uptake in the region by UNESCO, the ILO in Convention 169 and the UN in their Declaration on Indigenous Peoples and their right to health (PAHO, WHO, 2017a). PAHO linked ICH to the equity, rights and mutual respect for different people and their natural environments required for universal health outcomes and, more recently, for achieving the UN SDGs (PAHO, WHO, 2017a). The 2017 Pan-American Sanitary Conference further consolidated ICH in the PAHO Ethnicity Health Policy (PAHO, WHO, 2017a). PAHO established technical work on ICH, involving indigenous people's organisations, technical experts and some governments in the region, building a body of theory, tools, training and inter-governmental agreements to operationalise the ICH approach (PAHO,WHO, 2017b). Nevertheless, implementation of BV/ICH remains more limited than the transformational aspirations of its ideas, particularly after the election of more conservative, pro-market governments. It continues, however, to be advocated by indigenous groups, leftist parties and progressive organisations in the region and to resonate with wider international movements raised earlier, such as those on planetary health and PHC*.

2.2.2 The social medicine/social determination paradigm influencing politics and policy
As raised in *section 2.1.1*, European SM promoted a social determinants approach, linking health outcomes with their social, political, and environmental causes. In Latin America, SM resonated with struggles for social justice and a critique of health deficits being dealt with through philanthropic care, rather than through public health services as a right (Waitzkin et al., 2011).

SM ideas in the region can, in fact, be traced back to the late 1700s, when Eugenio Espejo, an Ecuadorian doctor involved in that country's independence struggle linked health with wider socio-political wellbeing. In the early 1900s, followers of Virchow, such as Max Westenhofer, emigrated to Latin America and established academic courses on SM, training many SM activists involved in workers' struggles. They explicitly rejected the biomedical framing of risks to health being advanced by the Rockefeller Foundation at the time and proposed a countervailing SM *proceso salud-enfermedad*, linking health to factors in the political economy (Waitzkin, 2011). Rather than reducing risk-health relationships to individual and demographic factors, they linked them to social class and its role in the labour process. Rather than seeing health as a 'state', health is viewed as a dynamic process. They viewed reductionist biomedical interventions as masking significant inequities and organised evidence on the working, living, housing, education and other social conditions affecting health, calling for political and socio-economic responses, including strong rights-based, public sector health systems (Boron, 2015; Waitzkin, 2011). SM approaches resonated with Paulo Freire's recognition in the 1960s of knowledge as a source of oppression or power, with knowledge from lived experience and self-determined conscientisation a source of social power, including in health.

Salvador Allende was one of the students of a SM course in the University of Chile Medical School in 1908 and took the ideas forward when he became a health minister and subsequently Chile's President in1970. Allende's book *La realidad Medico Social Chilena* captured key features of SM, linking common health problems to work processes and social conditions of debt, dependence and underdevelopment and their resolution to economic transformation (Allende, 1939). Allende applied SM in socialist economic policies and in creating a tax-funded, universal Chilean National Health System (Waitzkin, 2011). In Argentina, Ramón Carrillo and Juan Justo

as SM advocates, promoted investments in nutrition and living conditions to improve workers health. Argentine-born physician Ernesto (Che) Guevara heavily influenced SM thinking in the region, including in the Cuban Revolution in 1959 and its introduction of radical, comprehensive socio-economic change, including to address the determinants of wellbeing (Quijano, 2018). The structural changes in Cuba, its achievements in health from the efforts of multiple sectors, the expansion of primary care and investment in health technology, medical education and international health co-operation inspired public health activists and scholars throughout the region and in many parts of the world (Waitzkin, 2011).

The Cold War and the proximity and influence of the USA led to confrontations with the leftist movements, governments and policies promoting SM, and the rise of military dictatorships noted earlier. In Chile, Salvador Allende's death and Augusto Pinochet's military regime in 1973 profoundly switched policy towards introducing neoliberal policies, supported by the US. Military-led political changes in other countries in the region led to repression, torture, murder and exile of many SM activists between the 1970s and the 1990s and the introduction of market-led reforms in health (Montano, 2018; Waitzkin et al., 2011). Those in local struggles and in exile sustained SM policy debates and development. By the 1970s, right-wing military juntas governed many South American countries, with mainly military personnel in government delegates from the region to the 1978 Alma Ata Conference (Waizkin et al., 2011).

When political movements and elections ended the military regimes in the 1990s, many of the new governments implemented redistributive, pro-poor social programmes that again drew on SM approaches. The approaches were influenced and had support from PAHO, academic networks, such as the SM unit in the UAM Xochimilco in Mexico, and researchers such as Maria Isabel Rodriguez, Asa Cristina Laurel and Jaime Breilh (Nunes, 2015). Chile implemented redistribution programmes in key areas of social security (Chile Solidario), employment (Chile Emprende) and early child development (Chile Crece Contigo), mainstreaming social determinants and equity in its health ministry and playing a key role in the global WHO CSDH (Bedregal et al., 2014). In Brazil, where SM is referred to as 'collective health' health and constitutional reforms established health and many of its determinants as rights, creating the publicly funded Sistema Unico de Saude (SUS) in 1990 and setting a range of policies tackling social determinants such as income and freedom from hunger (Paiva and Teixeira, 2014; Rodrigues, 2014). Within its health diplomacy, Brazil has promoted a rights-based and structural social determinants approach internationally since 1990, together with the universal, rights-based approach applied in its own primary healthcare system. Under the presidencies of Lula da Silva and Dilma Rousseff, Brazil promoted solidarity-based south-south co-operation as a means of addressing northern economic hegemony, including in the BRICS consortium of emergent economies noted earlier. The country engaged in technical assistance to break dependencies on high-income countries; contesting intellectual property barriers to distributed health technology development and production in global platforms; and playing a convening role in the Global Conference on the SDH in 2011 (Padilha, 2011; Russo and Shankland, 2014).

The Latin American SM Association (ALAMES), created in 1984 as a network of activists, scholars and decision-makers, provided a sustained mechanism for intellectual debate on and political leadership for SM, both critiquing and influencing health policy in the region. It also introduced a regional SM lens into global policies and in the positions of the global Peoples Health Movement (PHM) (REDSACOL-ALAMES, 2017). SM and social determinants analysis and policy was thus not only advanced in the region, but also in the engagement with global policies from a Latin American perspective, discussed further in *Section 3*.

2.3 Contesting and coexisting paradigms in East and Southern Africa
In the ESA region, three paradigms for healthy societies coexisted, reflecting the wider political economy in the region. The first pre-existed colonialism in different forms of traditional health practice and in ideas of *ubuntu*. While often marginalised, it persists and resonates today with emergent concepts of psychosocial and ecological wellbeing. A *pathogenic/biomedical model* was applied during colonisation and in some post-colonial development policies, with many of the features described in *Section 2.1.2.* The third paradigm covers efforts to address *structural and social determinants of health,* linked with the aims of liberation struggles, PHC, developmental states and *resource nationalism* as a matter of social justice. Each is discussed below.

2.3.1 Reciprocity in traditional health systems and ubuntu

Pre-colonial ESA society was pre-capitalist. While it had gender and other forms of inequality, survival was based on reciprocity, or _ubuntu_ (a South African term that has been used across Africa, with other terms for similar ideas in other countries). _Ubuntu_ applies the dictum "I am, because you are", where the person is the 'product' of their fellow community members and ancestor spirits (West, 2006; Lebese, 2013). Illness is regarded as a result of disturbed relationships with fellow community members. Biological, social, cultural, psychological, spiritual and supernatural evidence and concepts of empathy and sharing are all used to explain and remedy problems or to promote wellbeing, which depends on reciprocity, co-operation and interdependence (Prinsloo, 2001). Traditional society thus gave more weight to the rights and interests of the community than of the individual. The different traditional health systems in the region reflected this, focusing beyond the body to the person and their ties with others in the community, with nature and with the spiritual world and using diverse practices, plant and social remedies to address imbalances leading to ill health (Prinsloo, 2001). They drew on a knowledge of plants, such as the 1,200 plants with therapeutic benefit in Kenya (Gakuya et al., 2020).

In the 18th-20th centuries, colonial governments implemented laws and interventions to discredit traditional health and medical practices, labelling it as 'witchcraft' and passing 'witchcraft suppression' laws that were only reversed after the mid-1900s. At the same time, African medicinal plants were harvested, sold and in many cases patented by colonial and western systems and further depleted by habitat destruction (Gakuya et al., 2020). Land and resource expropriations, social disruption, competing knowledge systems and services significantly impacted on and undermined both traditional and _ubuntu_ paradigms (Ichoku et al., 2013).

Nevertheless, _ubuntu_ concepts of collective and reciprocal liabilities and traditional health systems persisted, and many in ESA countries use them today, often together with western systems. Unity and reciprocity informed solidarity in liberation struggles, post-independence policy harmonisation and cross-border collaborations in regional initiatives across ESA countries and in unified African approaches in global diplomacy. _Ubuntu_ was invoked by Nelson Mandela to promote social cohesion and solidarity around HIV/AIDS. Concepts of reciprocal liabilities have informed local-level community solidarity to address vulnerability - such as in absorbing orphans from AIDS into extended families or refugees into local communities, or more recently in solidarity-driven community responses to COVID-19 (Sambala et al., 2020; AMREF, 2015).

In recent decades greater attention has been paid to protecting the knowledge in traditional health systems (Gakuya et al., 2020). In the 2000s, and with a herbal medicine industry alone estimated to have a global value of US$250 billion, intellectual property rights, the control of bio-piracy from the region and the equitable sharing of benefits of biodiversity and genetic resources with local communities have thus emerged as key themes for healthy societies. These issues have been debated in the 1992 Convention on Biological Diversity (CBD), the Convention on International Trade in Endangered Species (CITES), the International Protocol on Trade (IPT), the Trade-Related Aspects of Intellectual Rights (TRIPS), the OAU model for and the UN Declaration of the Rights of Indigenous People (Gakuya et al., 2020), as discussed later.

2.3.2 Colonial and post-colonial pathogenic, biomedical approaches

Africa's colonisation, mainly by European countries, sought to conquer, occupy, trade and draw benefit from the resources of the continent. European pathogenic paradigms, discussed earlier, were developed into a field of 'tropical medicine' to protect and care for European settlers and the labour necessary for production. The spread of western religion and medical systems intended to weaken African explanations and systems (Mokaila 2001; Loewenson et al., 2014).

Land expropriations and tax measures used to establish extractive, commercial production and poor social conditions led to undernutrition and communicable disease in local populations (Ichoku et al., 2013). Most ESA countries had a settler population, and public health law and practice in the 1920s sought to prevent the spread of disease through segregated settlements and quarantine of infected people, with limited attention to ensuring healthy living and working conditions (Chatora and Tumusime, 2004; Loewenson et al., 2014; Ichoku et al., 2013). These conditions made comprehensive PHC relevant to liberation ideas and to post-independence

nation building, discussed later. However, new governments also needed to show rapid gains through selective PHC interventions and the spread of medical services (Streefland, 2008).

From the mid-1990s, post-independence decolonisation was reframed as a pursuit of 'development', invoking a 'catch-up' of models and technologies used in high-income countries, with support from 'development aid', particularly in the health sector (Mkandawire, 2005; Ichoku et al., 2013). Disease and public health emergencies were used to trigger policy attention and to motivate external funding, with more affirmative 'healthy society' goals less effective in generating aid (Mkandawire, 2005; Loewenson et al., 2014). Vertical programmes for specific health problems proliferated in the 1990s and 2000s, often applied top-down, in ways that did not always take on board local health cultures or priorities. They often focused on technologies such as bednets and prophylaxis to manage exposure, rather than the conditions generating risk.

The Bretton Woods institutions' structural adjustment programmes (SAPs) introduced after the 1970s and the targeted 'safety nets' in the Poverty Reduction Strategy Programs gave limited attention to the structural determinants of health, arguing that the health sector could improve health if it used existing resources more efficiently and in a more targeted manner, despite evidence of the worsening health outcomes and inequality from the SAPs (Streefland, 2008; Cornia and Mwabu, 1997). The World Bank 1993 Report: Investing in Health presented ratios of cost and effect for different health interventions in terms of the unit cost of disability-adjusted life years (DALYs) for each intervention, promoting a cost-effective package of basic services that largely excluded upstream and structural determinants (World Bank, 1994).

As the real costs to health emerged from rising unemployment and food and service costs, some agencies, like UNICEF, promoted 'adjustment with a human face' through targeted initiatives to minimize the more glaring social and health inequalities arising from SAPs, not as a right, but as targeted, temporary philanthropy. This further shifted the discourse from 'development' to 'poverty reduction' with a residual role for social policy to address 'transitional' economic harms that were in fact long lasting. The paradigm shift was substantial: A healthy economy, seen as rising GDP, increased exports and fiscal restraint, set the parameters within which any measures for a healthy society should be achieved. It privileged individual responsibility and a limited role for the state. Universal reforms were replaced by targeted approaches (Mkandawire, 2005).

Political concern over lack of progress towards 'health for all' led to the Bamako Initiative in 1987, intended as a strategy for accelerating PHC but implemented largely as efficiency-led minimum service packages, applying cost sharing through user fees, with selected safety net measures for particularly vulnerable populations (WHO Afro, 2008; Mkandawire, 2005; EQUINET, 2012). Wider social solidarity, universalism and deeper structural interventions were seen to only be feasible after crossing a certain threshold of economic development (Mkandawire, 2005). Some ESA countries adoped community-orientated primary care (COPC) , particularly South Africa and Botswana, as a "continuous process by which PHC is provided to a defined community on the basis of its assessed health needs, by the planned integration of primary care practice and public health, including through community health workers". Primary care is seen as the key focal point, notwithstanding significant limitations in access to primary care, the workforce being only a fraction of the size needed and funding inadequate (Mash et al., 2018).

The MDGs in the 2000s, discussed earlier, prioritised issues that were health burdens in ESA countries. However, they also reinforced targeted approaches, potentially introducing a bias away from covering more marginalised populations in efforts to reach minimum targets. This risked leaving many aspects of healthy societies poorly addressed, including those from commercial, workplace, urban, employment conditions, or from the gender-based violence and other social determinants associated with rising levels of NCDs (Cornia and Mwabu, 1997; EQUINET, 2012). Concerns were raised in the WHO AFRO Harmonization for Health in Africa initiative, the International Health Partnership+ and the 2017 Lancet Commission on Health in Africa that multiple aid flows, agencies and interests in diverse biomedical programmes were weakening the wider health systems, and the co-ordination of the HiAP and multi-sectoral approaches needed to address social determinants like access to safe water, to prevent and control NCDs and other population health problems, or to implement global initiatives such as the WHO FCTC (WHO AFRO, 2014; Agyepong et al., 2017).

In the 2000s, recurrent epidemics and pandemics and the challenges of antimicrobial resistance stimulated a 'One Health' response, giving more focus to the interconnectedness of risk between animal and human populations (Roger et al., 2016; Gebreyes et al., 2014). While this has widened the scope of risks addressed in healthy societies, it too is largely framed within a biomedical paradigm, focussing on environmental and medical surveillance, clinical diagnostic methods and medical interventions to control zoonotic diseases (Gebreyes et al., 2014). A pathogenic approach to epidemics has catalysed important early-warning alert and response systems, diagnostic laboratories and surveillance systems, but, as evidenced during COVID-19, it has also raised significant challenges in accessing essential health technologies for these measures, and has sometimes led to authoritarian disease control measures and quarantines that have generated their own health and food insecurity harms for poor communities and low-income countries (Gebreyes et al., 2014; Sambala et al., 2020).

2.3.3 Social determinants approaches and resource nationalism

From the 1960's, nationalist movements in the ESA region invoked a liberation ethic of decolonisation, linking improved health to economic and political justice, socio-economic rights and self-determination (Youde, 2007; Loewenson et al., 2014). This lens gave priority to social and economic rights, linking rights to socio-economic justice and equity within and between countries. Post-independence policies sought to provide universal health services, but also to address inequities in social determinants of health through education, food subsidies, public works programmes for expanded employment, housing developments and, in some ESA countries, redistribution of land and other natural resources (Loewenson et al., 2014). Improving health was seen to be a key contribution to nation building, led by developmental states that would promote equity in access to key domestic resources for health (Mkandawire, 2005). Over the last five decades, the African Union and ESA countries have promoted policies on resource nationalism, to give greater domestic control over the minerals, biodiversity, land, seed and other resources needed to promote economic inclusion, food sovereignty and equity. 'Reclaiming the resources for health' was, for example, a shared agenda of government, parliament, professional and civil society activists in EQUINET (a regional health equity network) (EQUINET SC, 2007). The first goal of the African Union's Agenda 2063 development plan focuses on inclusive growth and sustainable development, through ensuring a high standard of living, food and social systems for a quality of life, sound health and wellbeing (AU, 2015).

The 1978 Alma Ata Declaration and its vision of comprehensive PHC described earlier resonated with these political and policy intentions. Post-independent ESA countries incorporated it into their national policies and strategies (Chatora and Tumusime, 2004; Streefland, 2008). Coming at a time when many ESA countries were becoming independent enabled the adoption of comprehensive PHC as a strategy to resolve historical injustices affecting health, to guide health development and to involve people in community health. PHC services addressed health and nutrition through interventions such as the promotion of nutritious local food crops and community gardens, expanded access to safe water and sanitation, gender parity in education and environmental health (Chatora and Tumusime, 2004; Streefland, 2008). Domestic efforts to apply comprehensive PHC also led ESA countries to engage on global policies on medicines access, migration of health workers, control of breastmilk substitutes, food security, debt cancellation and fair trade (Loewenson et al., 2014). For example, the negotiation of the 2001 WTO Doha declaration on TRIPS Agreement and Public Health covering access to medicines was stimulated by the Africa Group of diplomats, to confront a global trade system that undermined access to antiretrovirals for people living with HIV. The declaration was adopted, notwithstanding intense contestation from some high-income countries, with Article 4 on WTO Members' right to protect public health and, in particular, access to medicines for all a landmark decision on the precedence of protecting public health in trade (EQUINET SC, 2007).

To support this, and building on histories of *ubuntu*/reciprocity outlined earlier, ESA countries built regional co-operation and integration through regional organisations, including the Southern African Development Community, the East African Community and the Africa group of diplomats in Geneva (Anyaoku, 1999; Loewenson et al., 2014).

In ESA countries, public expectations of improved socio-economic conditions and widening access to health and education services was seen to be necessary for nation building, yet structural adjustment reforms and a neoliberal context diminished the resources for this (EQUINET SC, 2007). ESA countries participated in various forms of south-south co-operation, such as in the Non-Aligned Movement; and have engaged on reforms of the UN Security Council and Bretton Woods institutions to include greater southern voice (Gottschalk, 2016). ESA countries have engaged in the BRICS bloc on public health flexibilities related to research and development on neglected diseases; and in the China-Africa Forum on local production of health technologies. These engagements grew in the 2000s as a means for south-south international health co-operation and for securing more voice and more beneficial terms for the region in global negotiations on structural determinants of health (Anyaoku, 1999; Loewenson et al., 2014; Harmer and Buse, 2014). For example, South Africa joined with other emergent economies to call for more inclusive representation in global institutions and lobbied the G20 for a third board chair for sub-Saharan Africa in the International Monetary Fund (IMF) (Landsberg, 2005).

These efforts to address structural factors affecting healthy societies pointed to social determinants within the region and at global level. With natural and financial net resource outflows from extractive sectors, economic and trade conditions undermining resources for health, and intersectoral collaboration weakened by underfunded public sectors and powerful economic actors, obtaining fairer returns from the global economy and greater power in global processes were often seen as critical for delivery on healthy societies at national level (Ichoku et al., 2013; EQUINET, 2012; Vearey et al., 2019; Agyepong et al., 2017). As raised by Dr. Makaziwe Mandela, Nelson Mandela's daughter, "how long is Africa, we Africans, going to depend on help from outside? What will it take really to create, truly, a sustainable development in Africa so that the solutions for Africa's problems are within Africa, and we just get support and a boost from outside?" (AMREF, 2015).

This has become even more pronounced as climate change, pandemics and other global processes affecting population health have become more evident, whether in relation to ecosystem resources (land, water, biodiversity, air) or harms (pollution, consumption, pandemic and other) (Roger et al., 2016). Resonant of elements of early traditional health system ideas and more recent global planetary health ideas, EcoHealth has linked public health to natural resource management and livelihoods. As for other areas, while challenges such as climate emergencies and pandemics raise social determinants within countries, they also expose global determinants affecting the region and have connected discussions on ecological, socio-economic and political goals in sustainable development with issues of fair collective benefit, improved livelihoods and citizen participation (Roger et al., 2016).

2.4 India's trajectory of paradigms for healthy societies

India is a vast country, with 29 states and seven union territories that cover different cultures, religions, ethnicities and conditions. While generalisations in such settings lose detail and diversity, four paradigms for healthy societies have had a deeper and more persistent presence and policy influence, that is: *traditional, Nehruvian, Ghandian and rights-based approaches*, while recent years have seen elements of some used within a *populist nationalism*.

2.4.1 Traditional paradigms and the imposition of biomedical, allopathic medicine

Pre-colonial ideas of a healthy society in India were interwoven with plural traditions and practices that integrated the supernatural, moral, spiritual and material worlds. Various dietary, herbal, spiritual and religious remedies across the country co-existed with codified Ayurvedic, Siddha, Unani and Tibb systems. Ayurvedic texts linked the Hindu scriptures and vedic science as a 'science of life' providing guidance on how to sustain health and prolong human existence (Arnold, 2013:81). Siddha shared common roots with Ayurveda. Unani, originating from the Middle East, emphasised the relationship between diet and health.

British colonialism appropriated techniques and therapies from these traditional systems, while at the same time seeking to delegitimise them. Traditional systems had internal divisions over whether to engage with western medicine. Some Ayurvedic practitioners sought to protect a separate practice, aligning with nationalist movements, but many skewed their systems towards

colonial interests (Arnold, 2013). This and the wider power relations led to a dominance of allopathic medicine (Ganesan, 2010; Kumar and Basu, 2013).

Allopathic medicine and its biomedical paradigm were institutionalised through medical colleges and hospitals, focusing largely on curative care and using quarantine and isolation to segregate people suffering from problems such as leprosy, tuberculosis and mental illness, or to manage epidemics of plague and malaria that threatened commercial activities. The 1897 Epidemic Diseases Act gave local authorities powers to forcefully inspect, detain and segregate infected persons and to disinfect, evacuate and even demolish 'infected places', enforced where needed by militaries (Mushtaq, 2009). As in ESA countries, a European pathogenic paradigm expressed as 'tropical medicine', with scientific discoveries, such as of mosquito vectors for malaria, triggering chemical and environmental controls (Ramanna, 2013). While this brought technology to risk prevention, Indian Medical Service doctors trained in this dominant biomedical, curative approach became a powerful post-colonial influence in health service policy.

2.4.2 Nationalism, the 'Nehruvian' paradigm and commodification of health
The Indian National Congress was one of the leaders of the nationalist movement, and its leader, Jawaharlal Nehru, subsequently became India's first Prime Minister. He set a post-independence model of state-led capitalism, industrialisation and planned development, styled on the Soviet lines (Baru, 1998). This aspiration for modern capitalism competed with India's key role in the Non-Aligned Movement and its promotion of peace, self-reliance and global equity.

In relation to health, Nehru had no major scientific differences with the western biomedical paradigm. A Bhore committee, set up prior to independence, provided a health service blueprint that privileged public sector allopathic services (Baru, 1998). Universality, equity and comprehensiveness were central in the framing of public health services, given high levels of social poverty, as was the integration of preventive, promotive and curative services. While the policy was public-sector focused, it accommodated rather than nationalised the large private curative sector and producers of pharmaceutical and medical equipment (Baru, 1998).

Viewing the traditional practices noted earlier as irrational and unscientific, the Nehruvian paradigm emphasised technological solutions to eradicate disease, such as chemicals and medicines for malaria, and pesticides for farming (Banerji, 1985). This biomedical, technological focus was reinforced by a growing and influential private medical sector able to resist state regulation, as local doctors became investors in private healthcare and in the pharmaceutical industry (Baru, 1998). Even when the resurgence of malaria in the 1970s demonstrated the limitations of this approach, it did not significantly shift policy, but gave more emphasis to its application in screening and treatment (Zurbrigg, 1992). With poverty attributed to family size and population growth, a family planning programme in the 1960s aimed to control fertility and reduce population size using contraception and sterilisation. It had political backing, and health services were forced to fulfil sterilisation targets (Rao, 2010). It peaked in Indira Gandhi's declaration of emergency, coercive measures to sterilise men and women from marginalised and religious minorities in 1975. These measures provoked resistance from civil society and opposition parties and contributed to the Congress party's electoral defeat in 1977 (Rao and Sexton, 2010).

The trajectory of this state-led paradigm was contested by structural adjustment reforms that gave momentum to liberalisation and privatisation in health. The World Bank Report 'Investing in Health' included the proposal to split the health system into 'private and public goods', with the state responsible for preventive services and primary-level care as a public good and the market responsible for curative services at secondary and tertiary levels as a private good (World Bank, 1993). Policy uptake of these proposals further strengthened the private health sector and large corporate involvement in pharmaceuticals and technology in a medical industrial complex, and weakened public health (Baru, 2018). India deepened its integration into the global economy, embedding neoliberal reforms in domestic policy. Use of the state of a language of rights and entitlement masked the large-scale privatisation of social services accompanied by targeted 'safety nets' (Qadeer et al., 2001).

These developments triggered counter-campaigns from civil society groups involved in disease control, health, environment, education, livelihoods, micro-financing, agriculture, water and other

areas of health determinants, discussed later, allying with international civil society and foundations and using lobbying and litigation to manage periods of shrinking political space and countervailing corporate power (Baru and Kapilashrami, 2019; Qadeer and Baru, 2016). Civil society also engaged *within* the biomedical paradigm, without addressing deeper structural determinants. By showing the impoverishment from costs of medical care, civil society triggered state and national policies for health insurance schemes to include poor households, even while the focus on insurance intensified the biomedical approach and provided public subsidies to private services (Baru, 2018; Baru et al., 2010).

2.4.3 Gandhi's paradigm of mind, body and soul and community health

Mahatma Gandhi, the lawyer and anti-colonial nationalist, while playing an equally significant role as Nehru in the independence struggle, promoted a very different vision of people's dignity and self-sufficiency through transforming the rural economy and small-scale industrialisation. He opposed discrimination, including of the lowest caste, and promoted health through food, fasting, labour and exercise, hygiene, sanitation and safe water. The paradigm linked the physical body to nature, reflecting the Hindu cosmological understanding of the five physical elements - earth, water, fire, air and space. Health was viewed as an outcome of the balance between the physical, mental and soul or spirit (Iyengar, 2017).

Gandhi was critical of biomedical approaches, but also saw limitations in traditional healing systems. He saw hospitals as a 'symptom of decay', and called for more focus on prevention of diseases and on mental, physical and spiritual health (Iyengar, 2017:28). Rather than the top-down application of technological approaches, he perceived that achieving health depended on living healthy lives, starting at the village level, as a form of a social determinants approach. He advocated for community health workers, or *Arogya Samrakshan Samiti,* and for primary health centres that promote healthy lifestyles and family care, advise on diets and healthy foods, promote safe water and sanitation and apply herbal therapies using local plants (Iyengar, 2017).

This approach made the community and primary-care level key for health services and healthy societies. The Gandhian paradigm was taken up by many grassroots groups and movements in the 1980s and 1990s, forming coalitions around specific issues between political parties, leftist trade unions, Gandhian, Dalit, Adivasi and feminist groups. The United Progressive Alliance coalition government formed in 2004 included left-wing parties in the coalition. In 2005 it established the National Rural Health Mission (NRHM), giving greater attention to 'bottom-up' planning and seeking a more active partnership with civil society in health. This led to innovations in design, local-level implementation, training and monitoring of rural preventive, promotive and curative services, some including indigenous systems and applying participatory processes in different states, although still largely within a service-centred approach (Gill, 2009).

2.4.4 'People's health in people's hands': Rights, justice and social determinants

After India's independence in 1947, nation building was pursued through state-led industrial growth, poverty alleviation and social sector interventions. Health rights were articulated in constitutional provisions related to the right to life and in its directive principles of state policy setting state duties to raise the standard of living and nutrition. By the time of Alma Ata, however, there were evident shortfalls on delivery of these policy goals (Baru, 1998; Shah, 1990). Social deficits energised non-partisan social movements around socio-political, living, working and environmental conditions, with a demand to recognise that the, "…the struggle for liberation (was) not just from alien rule but also from internal decay" (Kothari, 1984:220). These movements stimulated grassroots community health projects across different Indian states, connecting health with larger social concerns and with a claim for social justice and local democratic control (Shah, 1990; Shukla and Phadke, 1999).

In the 1970s, social movements challenged state shortfalls in addressing inequality and poverty and implemented innovations at grassroots level, including community health projects. The projects reflected a mix of Gandhian, Christian and Marxist ideas, often a hybrid of the three. The Chinese idea of barefoot doctors changed the idea of a 'health worker' and promoted the idea in India of 'people's health in people's hands', a popular slogan that influenced many community health organisations that focused on social determinants of health and health systems (Shukla and Phadke, 1999). These social movements viewed that only an equitable, sustainable and just

society can ensure health for all. Health action was seen to call for a struggle against harms such as pollution, poor living, dietary and psychosocial conditions and for promotion of an alternative, healthier pattern of development. While many actions for this lie outside the healthcare system, they saw health services as the most visible determinant of health, calling for a public system that is responsive to people's needs and socially accountable. They rejected the blame placed on poor people, women and other marginalised groups for their own ill health, seeing this as a consequence of elite dominance in decision-making, in and beyond the health sector (Shukla and Phadke, 1999).

These ideas and the community-level innovations described earlier contributed to the principles and design of comprehensive PHC in the 1978 Alma Ata Declaration. While they were implemented in limited local settings, alliances formed on specific issues in the 1980s and 1990s that gave them stronger policy visibility and influence. Women, consumer and other movements, doctors and social activists converged on issues such as the promotion of essential medicines, breastfeeding, local traditional farming and food security, and on the protection of medicinal plants and traditional therapies. For example, the Medico Friend Circle formed in 1974 by a group of doctors and social activists drew on Gandhian and socialist ideologies to critique technology-determined disease control programmes, calling for IAH (NHRC, 2006). A civil society coalition in western India led a campaign on the 'right to food' through school-feeding programmes, universal pre-school child care, employment and food security for vulnerable social groups (Srinivasan and Narayanan, 2007). The women's movement engaged on hazardous contraceptives like EP drugs, Net En, Norplant, Depo-Provera, sex selective abortions and coercive state population control policies, and on domestic and state-sponsored gender violence. They took their campaigns to the courts, leading to new laws on these issues (NHRC, 2006).

Comprehensive PHC and rights-based approaches to health were further advanced by social movements, especially by the Indian Peoples' Health Movement, termed Jan Swasthya Abhiyan (JSA). Formed in 2000, JSA is a coalition of about 20 national networks and more than a thousand local organisations across India working on health, science, women's issues and development. It has opposed commercialisation of medical care and argued for pro-people changes in the health sector. It has taken up research, advocacy, legal action and alliances on the right to health and social determinants of health (NHRC, 2006). It has highlighted inequities in health outcomes and access to health services, pointing to a social gradient that has led some parts of the middle class to also experience declining health (Baru et al., 2010). Following the 2008 WHO CSDH Report, JSA energised PHM branches in Asia to form a south-south alliance to profile the inadequacy of state policies on social determinants, with different networks covering issues such as equitable social development and migrant health (CSDH- PHM-India, 2005).

2.4.5 Intensified commodification and nationalism
In recent years, inequality and deprivation have fueled a rise in nationalist populism and identity politics. The discontent from social deficits was channeled in part into Hindu nationalist politics, with the 2014 electoral victory of the Bhartiya Janata Party (BJP), while also suppressing civil society and social action on social rights and justice (Gudavarthy and Vijay, 2020). In contrast to widening social movement advocacy on rights and PHC, the post-2014 rise of Hindu nationalism deepened the liberalisation and commercialisation of health services, expanding social welfare and insurance schemes for poor households. It promoted a biomedical paradigm, commodifying health inputs and giving weak attention to living, working and social conditions (Baru, 2015).

Hindu nationalism has celebrated and supported Ayurveda and yoga as vedic science rooted in Hindu scriptures and texts. In 2014, the BJP-led government created a separate ministry for the indigenous systems of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH). The ministry gave indigenous systems greater visibility. However, it did not address the historical dominance of allopathic medicine over these indigenous systems, the unequal power relationships between these two systems or the commercialisation of indigenous systems within the neoliberal economy. Within a nationalist intention to consolidate the idea of a united Hindu nation, traditional systems had a symbolic value in indicating that other religious/ethnic groups are not full citizens and that belonging requires acceptance of Hindu belief systems. This undermines the secularism of the Nehruvian era, and intentions of universality, equity and comprehensiveness in public health. In contrast, fear and discrimination have been used to justify exclusion and new

narratives and propaganda used to withdraw welfare and explain institutional functioning "…reinforcing a language of obligation and security over that of rights, law, citizenship and institutional-procedural liberalism" (Gudavarthy and Vijay, 2020:468).

The COVID-19 epidemic demonstrates the fault lines of this current paradigm and its integration of a pathogenic, technology-driven biosecurity focus, in contrast to the holistic, rights-based, determinants-focused paradigms. It has generated a humanitarian crisis around urban migrant workers in the lockdown; used fear of the virus and disease to instill compliance in the population; and used digital technologies to track people's biometrics and movement. A 1897 Epidemic Act has been used to 'police' COVID-19, applying colonial coercive measures in the 21st century.

3. Insights from across diverse ideas of healthy societies

Section 2 outlined the features of discourses about healthy societies that have emerged and had policy influence globally and within the selected regions covered, while noting as before the limitations of brief descriptions of half a century of changing ideas and their application in dynamic and complex contexts. This section explores common and different features of these ideas and their policy uptake and captures some of the insights from the evidence.

Globally, with historical, albeit not always complementary, influence from Western Europe and the USA, the pathogenic/biomedical and disease-focused paradigm and the contrasting social determinants and health/wellbeing-focused paradigm have over centuries had policy influence, with different material, socio-political, ideational and institutional and social means used to impose or limit the scope of ideas, and contestation between them. Both are dynamic and evolving. A rights-based approach has advanced claims and raised duties in both approaches. Within the three southern regions, there are features of these global paradigms and trends, particularly where colonialism and globalisation have influenced the transmission and dominance of ideas, policies and political economies. However, there are also unique and different features in the regions and evidence of pressure from southern regions for greater reflection of their realities within international framings. There is evidence that ideas of reciprocity, collective interests and wider ecosystems that existed centuries ago in the southern regions are obtaining a new profile in global thinking and a flow of ideas that is not unidirectional.

3.1 Paying greater attention to the plurality of ideas
What is clear is *that there has not been a singular idea of healthy societies. We would suggest that neither should one be imposed*. There has been significant effort to impose a singular, often Western-centric, hegemonic view on how to achieve healthy societies as superior to and more 'realistic', 'technically correct' and feasible than all other thinking (Escobar, 2020). However, the notion of a singular idea is problematic for various reasons. First, while values may be shared, health is as much socio-cultural and political as it is technical and material, and ideas about healthy societies are embedded in different histories and polities. Second, ideas have changed over time, and while some paradigms may have dominated in discourse and policy influence internationally and within regions at some points in time, new ideas emerge or previous ideas resurface in new spaces, feeding into and affected by changing political and economic developments. Shared ideas are applied in different ways in different contexts.

Keeping open to these changes, listening to wider voices and learning from a diversity of thinking and approaches brings 'another possible' of new ideas and practice to work on healthy societies. The WHO director general did this in the 1970s in relation to comprehensive PHC. New ideas are influencing debates on the plurality of culture in health and in addressing collective interests around global and commercial determinants.

Third, a contestation of different ideas links not only to plural realities and forms of knowledge and evidence, but also to different values and interests. A competition over which ideas become hegemonic is not disconnected to wider contestations over political and economic hegemony. Different ideas need to be given space. They play a vital role in advancing thinking on the many still unresolved health challenges, including how collective interests and interdependency can be

addressed within and across countries in a manner that produces sustained and equitable wellbeing.

3.2 Overcoming the consequences of an imposed biomedical paradigm

The biomedical/pathogenic paradigm, largely problem driven and reductionist, flourished with advances in positivist scientific knowledge and technology development. It has contributed knowledge and health technologies for population health, from vaccines and medicines to water treatment plants. By reducing disease it has improved population health, more so for those where medical services and health technologies are accessible, appropriate, affordable and delivered universally as a right. In post-war Europe, for example, this made mandatory tax/insurance-funded public sector national health services a key feature of the state commitment to building a post-war healthy society.

As evident in the trajectories in all three southern regions, the same was not the case in the colonies. There, the pathogenic paradigm was imposed with dominating intent during colonial expansion and the Cold War to promote an idea of modernisation and improved health through medical technologies and therapeutics, in a manner that did not demand social reform or allow challenge to colonial economic power. An expansion of allopathic medicine went along with the expropriation and extraction of key natural resources, the political, economic, racial, and social marginalisation of local populations and the suppression of indigenous health systems.

While some of these experiences pre-date the time frame of this paper, they carry legacies that need to be addressed in today's framing of and global interactions on healthy societies.

First, an imposed pathogenic paradigm disconnected people from their local cultural understanding of health, even while appropriating techniques, herbs and therapies from these traditional systems. ***It implies an understanding of healthy societies that is linked to reclaiming cultures for dispossessed countries and people, recognising the deep link between health, identity and justice.*** This is articulated in various ways in the approaches described in *Section 2*, such as: in the intercultural health paradigm, the integration of respect for cultural diversity and indigenous remedies, and in the promotion of local production systems and the agency of rights holders. It has been a matter of particular concern for indigenous people, but has also been promoted by governments in Latin America; in the Gandhian reconnection with local cultures and economic activity in India; and in ESA country protection of its own biodiversity and herbal knowledge. This rooting of healthy society in local identity is not unique to these regions or to middle- and low-income countries. For example, in the Ngāti Porou Hauora indigenous health system in New Zealand, the health service, not the community, is seen as the 'external party' with the onus to participate as an equal partner in community processes and settings led by community elders, not health personnel (Matheson and Matheson, 2017). Not addressing past cultural and other forms of dispossession in health may leave societies and indigenous practice susceptible to manipulation, as for example was observed in the use by Hindu nationalism of traditional Ayurvedic practice to drive forms of ethnic exclusion and a discourse of obligation and security over that of rights, law and citizenship.

Second, ***defining 'tropical medicine' as the science and practice of the pathogenic approach in the colonies created a superiority for the approach and an exceptionalism in how healthy societies are achieved in the south, raising a wall that needs to be explicitly overcome between a mutually useful exchange of knowledge and learning south-north and between regions on shared problems in population health.*** The application in the three regions of tropical medicine enabled approaches that were different to those being applied at the same time in Europe, such as in the coercive quarantine and segregation of local populations into the mid-1900s or in a focus on selective interventions for particular diseases with universal comprehensive national health systems seen to be feasible only after crossing a certain threshold of economic development. The spread of allopathic tropical medicine was portrayed as a form of 'catch up' with western development and modernisation, asserting a superiority of approach and discounting, suppressing and even criminalising local systems.

There is evidence, however, that when imposed measures paid weak attention to local realities, ideas and knowledge or failed to see the implications of applying technologies in highly stratified

unequal societies they brought costs to health, such as in failed malaria control programmes, forced sterilisations, antimicrobial resistance and inadequate attention to a rising level of chronic conditions. Discounting lessons learned from southern regions as irrelevant to high-income countries has blocked useful positive learning on local food and dietary practices; community health systems; on cultural and psychosocial integration in health; or on the harms of commodifying and privatising health services or of implementing coercive models in public health. In contrast, the learning and experience from the southern regions, for example on barefoot doctors and community health workers, has informed comprehensive PHC, and the application of such ideas in the unequal, multi-cultural societies in high-income countries. The ICH movements in Latin America have informed the framing of global instruments and measures to integrate the rights of and respect for different people and their natural environments in the many multi-ethnic societies that now exist in most countries globally. Such experiences are opening minds to what is termed 'reverse innovation', and the need to more explicitly address the language, process, spaces and resources that instinctively draw global ideas from institutions in high-income countries and not from more mutual horizontal exchange between regions.

Third, a ***singular connection made between disease and individual biological determinants, articulated in the most extreme form in eugenic theories, has enabled racist or discriminatory discourses in health that have persisted into the 2000s.*** Eugenic theories promoted in the 1930s in Europe and in the regions during colonialism that explained health outcomes as a result of biological inferiority inherently stigmatise particular groups. It has led to racism, ethnicism and other social rights violations, masking the conditions generating susceptibility and vulnerability. In *Section 2.4* its use is described in the late 1900s in India in the coercive sterilisation of 'lower caste' groups and its associated abuse of sexual and reproductive rights. It is emerging as an ethical issue in the growing ability of genetic technologies to engineer human modifications or fertility choices (Lombardo, 2019). Unless ethical principles, solidarity and collective rights and benefits are embedded in public health thinking, particularly given new developments in personal prevention and biogenetics, there is a continuing potential for approaches to healthy societies to inequitably segregate or exclude from care those with poor health or particular social status as a means of improving the outcomes of others, whether in relation to elderly age groups, race, or other social features (Tilley, 2020). We have only to witness the recent anguish of elderly people dying alone and away from families in care homes during COVID-19 in high-income countries to understand the continued presence of such thinking and the need for dialogue and learning on this issue for healthy societies.

3.3 Engaging with determinants of a deepening neoliberal globalisation

From the early 1900s there were many drivers of demands to act on the deeper determinants of health in all regions and globally. They included political ideas on socialism and social democracy, post-war social contracts in Europe; anti-colonial struggles for justice; cyclical energy, financial and food crises in the global economy, and surging preventable diseases. There is a resonance across social medicine and social determinants paradigms in different settings to look beyond disease and commodified biomedical approaches to promoting health, wellbeing and quality of life, integrating material, political, psycho-social and economic determinants of health, in asset-, solution- and rights-based approaches.

Different regions vary in how this has been expressed, departing from global paradigms and policies in ways that have implications for understanding healthy societies. This is possibly also the case in countries we were not able to cover, such as China and Russia. In Latin America, 'social determination' was preferred over 'social determinants' to ensure that the political character of determination is understood and to avoid fragmenting it into individual determinants. In India, the articulation by social movements of 'people's health in people's hands' linked population health improvements to struggles for social rights, an alternative development path and an accountable state. In ESA countries, liberation movements linked health to socio-political justice and self-determination, articulating that wellbeing requires more inclusive economies and fairer returns from the global economy. In all regions, however, ***there was explicit claim to social power and rights and an understanding that overcoming the inequities undermining health required radical political and economic transformation towards systems that promote equity and inclusion, that address commercial determinants of health and that do not commodify or subject healthcare to market rules.***

These ideas from the regions have made more radical demands than those expressed in many global platforms. For several decades, early global ideas that combined socio-economic, civil and political rights in one collective framework were disrupted by Cold War ideological conflict and economic interests. While there is agreement that the improvement of people's living and working conditions are key signs of progress in health, the view that a growth in wealth itself would achieve this subjugated health improvement to the neoliberal markets, production, trade and financial systems that largely served existing wealth. Technical, political, institutional and financial resources have been applied to avoid linking social inequality to determinants in the global political economy, as reflected for example in the discussion on the framing of inequality in the SDGs. Yet globally this is changing, in part reflecting alliances across technical, socio-political actors, movements and institutions, including within high-income countries. From the 1998 exposure of global, commercial determinants, in the widening understanding of the rights to health in general comment 14 of the ICSER and the new attention to the right to development, in the 2008 WHO CSDH identification of power as a determinant, the focus has increased on structural determinants of health. By 2016, the Shanghai Declaration call for "global collective action" to address "powerful commercial forces that work to counteract health" explicitly implies that framing a paradigm and programme of work on healthy societies needs to address these commercial determinants and what this means for the global political economy.

This implies that any paradigm for healthy societies needs to engage with drivers from a neoliberal globalisation, including for how it integrates restorative, intergenerational and ecological justice. The experiences in the three regions suggest that liberalisation reforms, extraction of natural resources, reversal of universal policies and privatisation of public systems have been more intense and prolonged in the southern regions, with a more recent experience of social deficits and austerity in high-income countries. While aggregate life expectancy has improved in many countries in past decades, the same cannot be said for quality of life or measures for healthy societies for many communities. In Nehru's India, for example, the public-private split of the health system and for-profit privatisation of healthcare further commodified private curative services, weakened public sector preventive care and meant that marginal attention was paid to health promotion, with a greater negative impact on exclusion and socio-economic insecurity in the lowest income groups and castes.

The global political economy would itself appear to generate momentum for a focus on structural determinants of health, in its cycles of 'boom and bust', its war, violence and insecurity and mass population movements, environmental and climate crises and declining public services. Yet crisis itself is not a guarantee of a demand for recognition of causes or for transformation. After the framing of comprehensive PHC at Alma Ata, rather than intensifying momentum for it, subsequent energy, financial, climate and conflict crises were used to prioritise existing economic interests and promote selective, biomedical, targeted interventions as being more feasible. There has, however, also been a growth in movements and processes north and south questioning the current global political economy and its markers of progress. In addition, opportunities have increased for communication across people and countries internationally to more rapidly profile harms and to raise and share ideas, capacities and experiences to inform alternatives.

Earlier than in high-income countries, the consequences of neoliberal reforms stimulated indigenous, anti-neoliberal and political movements in all three regions, raising expectations of better lives from policy change from newly elected governments. Social medicine and BV in Latin America challenged the expropriation and extraction of land and other natural resources and the social deficits in health they caused, as have social rights movements in India and health equity movements in ESA countries. While much of this activity has located within regions, there is a widening recognition of the shared impact of global and commercial determinants. *Section 2* describes various institutional alliances that have formed across countries, civil society and technical institutions on this, as well as the political and economic obstacles to implementing alternatives, in some cases leading to right-wing populism, protest, or scapegoating of already marginalised social groups (Ichoku et al., 2013; EQUINET, 2012; Vearey et al., 2019).

Profiling and engaging with structural, commercial and global determinants in a neoliberal global economy needs to integrate a strategic analysis of the interests, institutions, politics and power relations involved, from local to national and global levels.

As evident from the processes described, beyond the use of more coercive approaches, the engagement on ideas has called on a mix of political, social, technical and institutional levers, including through alliances across constituencies, countries and different actors. This has enabled a continuity and progression of ideas and influence, including during periods of reversal.

3.4 Moving from ideas to policy influence and uptake

We did not aim to explore the factors that lead to the implementation of ideas and policies in practice or the factors that enable or impede this. This calls for follow-up inquiry.

The trajectories and experiences described in this paper at global and regional levels do, however, point to a 'battle for ideas' that has infused debates on how to advance healthy societies up to today, from crude impositions and suppression of opposing forces during colonial periods, to a more diplomatic engagement through commissions, declarations, conferences and reports at global and regional levels, and through movements, electoral platforms and alliances and media and at country level. ***The experiences show the potent presence of contestation in advancing paradigms for healthy societies. They highlight the need to more openly recognise the underlying basis for contestation of ideas, to provide spaces for and engage with their proponents, appreciating that paths to healthy societies include strategies that not only contribute but also challenge, disrupt or transform.***

Different ideas exist not only within and between countries and constituencies. Different global institutions have also aligned more closely to different paradigms, assigning their global resources and agency power to promoting and operationalising their approach. Some have more clearly positioned with a biomedical paradigm, such as the World Bank and WTO, and others more clearly with social determinants ideas, such as the ILO and UNEP. With intensifying globalisation and integration into the global economy, diverse global policy actors, some private, have become more influential, in processes that are not always transparent or inclusive. The WHO has provided space for both paradigms. This reflects its internal paradigmatic divisions and debates, as well as the power and influence in its governance and resourcing of different countries, regions and foundations, particularly Gates and Rockefeller, of civil society and in an indirect but still powerful manner of corporations (Chorev, 2012). These influences on WHO have been the subjects of separate discussions, beyond the scope of this paper.

The regional experiences indicate that the nature and stability of local and central government are critical to provide the time to develop, implement and improve chosen paradigms. Generally, leftist-oriented political regimes or multi-party coalitions that opened space for ideas have been more enabling of a diversity of ideas (Escobar, 2020). In India, the 2004 United Progressive Alliance government responsiveness to civil society organisations, noted earlier, opened new inputs to social policy design (Gudavarthy and Vijay, 2020). Beyond these conditions for the introduction of ideas, many paradigms call for changes that take time and need stable government and institutions. They may face challenges from countervailing international influences, and opposition from influential middle and upper classes, private health actors, some medical personnel and academia, and from large corporations and financial institutions. Volatile political and economic environments, rapid turnover of governments and public sector personnel and unpredictable funding flows can undermine such longer term changes and the stability and capabilities needed to address challenges. In the southern regions covered, only Cuba has had a sufficiently sustained government to progress the socio-economic transformation and national universal public health system to address social determinants and health inequities, notwithstanding economic and military attack. In Europe, Finland's consistency in government policy in the area has made it an important champion for whole of society approaches in health. As noted before, the experiences from countries such as China would provide further important experience on this issue.

Collaborations between health and other sectors, across different actors and disciplines within countries, and alliances across countries appear to have played an important role in profiling ideas and in policy influence. Alliances forged between mayors and local governments in the various Healthy city networks, between civil society, state, political and technical actors in networks like ALAMES and EQUINET, between different sections of civil society in the PHM and critically between states in regional organisations like UNASUR, the

Southern African Development Community, the East African Community and the Africa group of diplomats, and now in south-south organisations like the BRICS and the China-Africa Forum have all played a role in building collaborations that have helped to raise and share priorities and approaches and engage on them globally. Networks have provided sustained mechanisms for intellectual debate, leadership and a continuity of ideas, even as changes of government and global volatility have opened or closed spaces for particular paradigms. ***There was less evidence of networks that build transdisciplinary thinking and practice, despite this being critical for healthy societies.***

All regions covered show the influence global institutions have had on ideas for healthy societies. But ideas have also flowed in other ways, and a 'model of circulation' may now better suit how paradigms on healthy societies are developing. The emigration of followers of Virchow from Europe to Latin America and their establishment of academic courses on SM influenced the policy uptake of SM by left governments in the region. Exiled activists and diaspora populations have played a role in sustaining ideas and policies that are introduced after new governments are elected. However, countries in the three southern regions covered and their regional organisations have also influenced global ideas and debates. Latin American indigenous movements and PAHO have integrated ICH in global declarations on indigenous peoples. Brazil and Chile influenced the ideas in the WHO CSDH. India's community health experience with other country and local experiences influenced the thinking behind comprehensive PHC. ESA treatment activist and Africa group of diplomats influenced the Doha declaration on the TRIPS agreement and public health. Information technologies and international travel have enabled a flow of ideas across diverse regions and actors. One analysis of international conferences revealed that international networks were not just 'conveyor belts' for policy ideas from the USA and Europe into Latin America. Rather, there was often contentious debate over the relevance and appropriateness of health and social policy models being proposed for local contexts and key input made to global processes from intellectuals from the region (Carter, 2019). Even where ideas have flowed from global level or north-south, such as social medicine's entry from Europe to Latin America, they have been reinterpreted locally, such as in the more politically radical and epistemologically integrated view of social medicine in Latin America compared to its expression in Europe (Carter, 2019). In contrast to core–periphery or imperial-colonial models, Birn (2006) thus suggests a model of 'circulation' to make sense of the flows between different regions and networks in how "health and scientific ideologies, policies, and practices undergo an intricate process of give and take among multiple actors who are linked in particular professional, political, and practical circles" (Birn, 2006:57).

3.5 Moving forward, moving in circles or reaching tipping points?

By the 2020's two profound global conditions with significant local and national impact provide a useful insight on the critical point we have reached in our histories for the way we think and act on healthy societies, and both disturbing and aspirational lenses on the approaches used.

The first, the COVID-19 pandemic has provided evidence of the insufficiency of reactive, nationally self-protective, biomedical-focused public health approaches to a global pandemic and the risks this poses for health and social inequality. This has generated demand for more comprehensive, equity-focused, participatory approaches and for access to and distributed production of essential health technologies as global public goods (Sambala et al., 2020; AMREF, 2015; Loewenson et al., 2020). This is not unique to COVID-19. The same arguments were made by figures such as Nelson Mandela to promote social cohesion and solidarity around HIV/AIDS at national, regional and global levels. In many respects this resonates with the ideas of reciprocity and collective wellbeing evoked in the traditional health systems described in this paper and in *ubuntu* and BV concepts.

In contrast, the response to COVID-19 has provided mounting evidence of the wide application north and south of an intensive biosecurity-focused, pathogenic approach and a nationalist protectionist response as the means to secure public health. There is evidence of an accumulating health debt from loss of income, food insecurity, solitude and dying alone, mental health problems and discontinuity of preventive, promotive and curative care for other health conditions (UNAIDS, 2020), "particularly when measures are prolonged, neglect lived realities, disproportionately target disadvantaged communities and do not provide adequate

social protection" (Loewenson et al., 2020:1). There have been significant solidarity- and rights-based and multi-sectoral responses in some local communities, civil society networks and groups and countries. However, building on trends in the 1900s that posed pathogens as threats to national security, populist and powerful executives have defined the virus as an 'enemy', using war rhetoric and fear to justify authoritarian, sometimes militarised, approaches to public health that violate social rights, drawing on outdated laws, such as noted earlier for the 1897 Epidemic Act in India (Loewenson et al., 2020; Gebreyes et al., 2014; Sambala et al., 2020).

A second profound challenge and potentially a tipping point for paradigms on healthy societies lies in climate change and extreme loss in biodiversity and the proactive reciprocal, collective co-operation it demands to address it. As the threat to survival from climate change becomes an increasingly immediate reality and its intergenerational risk is more widely understood, it is beginning to stimulate new ways of understanding interdependency; new forms of international co-operation reflecting collective interests and new demands to tackle the vested interests and power imbalances that undermine sustainable and equitable patterns of production and consumption (Whitmee et al., 2015). Ecosystem crises have already stimulated the ecohealth and planetary health paradigms, described earlier, and engagement in global platforms on protection of biodiversity and sustainable development (Roger et al., 2016).

The recent global articulation of planetary health and the integration of ecosystems as an area of collective global responsibility are raising new ideas on interdependence and reciprocity, some of which have existed in the southern regions for centuries. While recently emerging in global discourse, ecological-, psychosocial- and reciprocity-driven paradigms have existed in traditional health beliefs, in the role of biodiversity in promoting health and managing illness, and in BV and resource nationalism. The interdependency and reciprocity articulated in planetary health has also existed in the three regions in traditional health systems, *ubuntu*, BV and ICH, even as these ideas and beliefs have been actively undermined in their application by political and economic developments.

Will crisis be sufficient to make a Copernican shift in thinking and global relations even amongst powerful global actors who benefit from the factors that undermine health equity into the next century? The even more intense forms of the pathogenic paradigm in a biosecurity-focused response to the COVID-19 pandemic suggest that we are not yet at that point. Yet the social movements, including in youth, and the negotiations that have grown around climate change and extinction suggest that there is a widening aspiration for new thinking and global policy. Waiting for the climate crisis to reach a tipping point may be too late. What then will it take to respond to this growing mobilisation, to listen to and collectively adopt ideas on a psychosocial, physical, material and ecological balance and on intergenerational and collective responsibilities that have existed in southern regions for centuries and to use these to frame policies that present the necessary deeper challenge to structural determinants than are perhaps found in the diplomatic consensus of the SDGs?

4. Concluding reflections

The paradigm trajectories outlined in this paper suggest that ideas do matter in producing change and that there are diverse ideas on and pathways to a healthy society. Beyond the changes imposed by military coercion, ideational power has combined with material, political and institutional power to give some approaches greater dominance.

Pandemic and climate change as manifestations of global crises show a potential of significantly different futures in the thinking about and shaping of healthy societies. There is a sense that we are at a critical moment in reflecting on histories, learning from diverse sources and making choices between them. There are challenges to healthy societies in our way of life, production and consumption patterns, environmental degradation and in the extreme social inequality generated in the current global political economy. Yet pathogenic and biomedical paradigms and social determinants approaches have often avoided direct challenge to a neoliberal political economy. We need paradigms that will serve us better in tackling the crises we face, including those relating to extreme inequality, biosecurity and planetary challenges, and that maximise our opportunities for achieving the 'health for all' that was envisaged a half century ago. How can research practice contribute to this and generate knowledge that supports change?

4.1 Promoting values-based, reflexive and context-dependent knowledge

While a positivist science has made significant contributions to understanding public health risks and to disease control, particularly in biomedical sciences, it has been less successful in building the type of multidisciplinary, reflexive and context-dependent knowledge needed to understand what promotes health equity and wellbeing at population level. In posing as a values-neutral method for ascertaining knowledge, positivist scientific approaches can rather reflect dominant forces and ideologies. Yet, the way knowledge about population health and wellbeing is generated and applied is deeply linked to differences in local cultures and identities that need to be recognised not only for the validity of the knowledge generated, but as a right.

We suggest a research practice, knowledge and science on healthy societies that is explicit on the values applied and that recognises that ideas differ across different cultures and contexts. This implies inter/trans-disciplinary embedded research, as well as participatory, citizen science approaches that enable authentic and systematic forms of self-determined, collective analysis.

Approaches to healthy societies such as comprehensive PHC, BV, SM, the Gandhian paradigm, 'people's health in people's hands', *ubuntu*, resource nationalism, and planetary health have, for example, explicitly articulated the values and collective rights that inform their understanding of both the drivers of deficits and improvements in wellbeing. Action on inequality calls for more than an understanding of its determinants at different levels. It calls for an understanding of and engagement with the drivers of societal values of perceived rights and of what is acceptable or unfair from local to global levels. Benatar et al. (2009) observe that an expanded discourse on ethics and human rights is critical to drive change towards improved global health; and we would add that such a discourse needs to be reflexive, contextual and dynamic.

Integrating subjective knowledge does not imply an unquestioning absorption of 'facts' asserted by the loudest voices, but a systematic, organised process to draw, analyse, collectively validate evidence from lived experience and to use it to problematise, frame collective action and to learn from action. As a collective research practice, providing space for and reflecting on knowledge drawn from different contexts and constituencies also calls for systematic processes to explore the learning across them, not just from what is common, but also from what is different and why. This type of knowledge generation becomes even more important as the gap between ideas and practice is less and less a matter of material knowledge and technologies and more of the socio-political drivers that determine how they are used, particularly, as noted earlier, given the critical implications of the choices we make today for the long-term future of healthy societies.

4.2 Enabling diverse forms of knowledge on healthy societies

Biomedical and disease control approaches and a fragmentation into individual determinant-outcome relationships have generated a larger body of published knowledge on health (and medicine) than qualitative, social, practice-driven knowledge, especially that drawing from more reflexive and participatory methods research (Wilson, 2000). However, singular connections made between disease and biological determinants make a weak contribution to understanding the multidimensional complexity and potential ethical choices around policy on healthy societies in an interdependent world. A Newtonian Reductionist, determinist worldview, while simple, also ignores the human agency, values, and creativity that apply in health and social systems.

Recognising the circular flow of mutually useful learning and knowledge on the shared problems in population health is a challenge to the homogenising effect of information and media in globalisation. It implies different, perhaps slower, listening processes in building global thinking on healthy societies and greater horizontal exchange across regions.

We suggest providing spaces for 'bottom-up' connections across different regions to inquire, discuss and understand how ideas, knowledge and practice on pathways to healthy societies compare across regions and what this implies for both local action and global framings.
A holistic analysis of pathways for healthy societies calls for an assessment matrix that goes beyond individual determinants and interventions to a deeper understanding of the drivers in and social determination of pathways for healthy societies, as raised in *Section 3*. Case studies may enable depth, cross-disciplinary input and reflexive approaches to explore, collectively analyse and co-construct international knowledge. Such case studies may be on local issues, such as

how equitable area-based approaches are developed and framed to address the multiple dimensions of urban wellbeing, or they may relate to how global determinants are being addressed in global challenges such as pandemics and planetary health.

Such processes could bring together different disciplines, actors and constituencies to better understand the interconnections, influences, power and relationships and the forms of alliances and collaborative action that build influence and support for ideas, within and across countries.

Some suggest that this is best done when research, learning and knowledge are embedded in the day-to-day context and practice of those affected, linked to intervention models that are self-organising, dynamic, and able to address different dimensions of reality (De Angulo and Losada, 2014). The earlier section pointed to the value of collaborations between health and other sectors and disciplines and networks within and across countries in advancing ideas and policies for healthy societies. While there are growing networks, there is still a deficit at national and global levels in collaborations that build transdisciplinary thinking and practice and that generate the collectively validated knowledge from the lived experience of those directly affected.

4.3 Without agency and self-determination, there is no healthy society

The continuing social deficits and inequality identified in the paper that affect healthy societies, the continuing use of measures to address emergencies in ways that fatigue and harm public trust and the generation of stigma and protest as a feature of electoral politics suggest that a key driver of healthy societies will be when people and countries see an unhealthy status quo as no longer acceptable and have the ideas and the confidence to produce change, including for intergenerational equity (Schram and Goldman, 2020; Dube et al., 2014). Ideas have power when understood and embraced by the wider public and make sense to people (Escobar, 2020).

One analysis of the barriers to implementing comprehensive PHC in ESA identified that it was not a lack of policies that weakened application, but a lack of lack of shared understanding and ownership of the PHC concepts amongst policy-makers, health workers, sectors and the public (WHO AFRO, 2008). Some approaches described in this paper have alienated and rendered people passive, while others have promoted collective ideas, power and action. *Without agency and self-determination, however, can we really talk about healthy societies?*

The paper points to a diversity of actors, often in situations of unequal power relations, for whom such agency is relevant, whether from countries engaging in global platforms, or social groups engaging in national platform or public actors engaging with local or global private sectors. Building forms of knowledge that support such engagements call for an understanding of the spaces and actors involved. It also implies forms of knowledge generation and evidence that link to the processes and actors producing change towards healthy societies, whether through social organisation, system reforms, capacity building, policy negotiation, legal challenge, and so on.

Research can generate strategic evidence that feeds into such agency and claims, particularly when implemented with/within the social movements and institutions engaging on their health conditions and in processes that link theory and practice and that build in strategic review and learning from action. Research can support explanations and discourses that enable new ideas, and build a confidence to articulate them, including when they challenge dominant paradigms.

Paradigm shifts take place when their possible achievement attracts an enduring group of adherents away from the status quo or when previous ideas raise too many problems to resolve. We live in a Gramscian moment of old and new ideas, where health threats are responded to by reviving old coercive public health approaches and wellbeing practice remains marginalised, even while new frameworks for global co-operation and collective responsibilities are advocated. The experiences in this paper show that whose ideas dominate matter in who claims and exerts agency. Globalisation has not only generated political economy challenges to healthy societies, it has expanded the flow of information and ideas and social connectedness with a potential for both control or for a plurality of ideas and imagination (Franco et al., 2014). The future trajectories for healthy societies are thus not just trajectories of different ideas, but of how agency is organised and claimed for whose ideas matter most.

5. References

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Appendix 1: Timeline of major contextual, paradigm and policy events

Date	Paradigm / policy event
Pre-1900s	• BC Hippocrates disease-agent causality and Aristotle material and non-material dimensions of wellbeing. • Slave trade, colonial expansion and settlement • 1500s: Fall of the Azteca and Inca empires in Latin America by Spanish conquistadores • Traditional medicine and *ubuntu* in the ESA region • Scientific advancement of germ theories in Renaissance • 1700s: Earliest promotion of SM and BV by Eugenio Espejo in Ecuador • USA independence and growth of influence in Latin America • Industrial revolution, communicable disease and pathogenic/ sanitary public health development in Europe and USA (1842 UK Chadwick Report; 1850 US Shattuck Report). • Virchow and Engels in Europe on the social origins of illness and social medicine
1900-1978	• Cold War and nuclear escalation; WW1 and WW2 and 1930s economic depression • Enactment of public health laws; laws suppressing traditional health systems; eugenics and pathogenic public health controls in colonies and of faith-based medical services • Promotion of Marxist political economy analysis and 1917 socialist government in USSR Permanent institutions for international health – • Pan American Sanitary Bureau evolved to PAHO • in 1902 • 1920: League of Nations Health Organization • 1948: WHO constitution - health as 'physical, mental and social wellbeing and not merely the absence of disease'; United Nations Universal Declaration of Human Rights • Scientific development of germ theory and sanitary interventions with Rockefeller Foundation • 1950s: WHO Global Battle Against Disease; malaria eradication campaign in India reversed due to failure by WHA in 1969 • 1960s: Vertical disease control, technological malaria and population control in India 1930s onwards: • Socialised medicine in Russia and increased science in high-income countries on chronic conditions related to food, harmful products • National anti-colonial liberation struggles and independence in Africa • 1940s: Bhore Committee Report for Indian health services, Indian independence and Nehruvian state-led capitalist development, with a 1960s fical crisis • 1959: Cuban revolution and introduction of socialism followed by left • Juan Garcia leads on SM from PAHO, creation of ALAMES and key technical institutions supporting SM (UAM Xochimilco, CEBES, ABRASCO); Paulo Freire pedagogy of the oppressed • Social medicine movement in Latin America, Allende as Health Minister and creation of national health service in Chile and Justo in Argentina. Followed by USA supported military coups and dictatorships in Latin America and exile of SM leaders • 1960s: Non-Aligned Movement, UN Conference on Trade and Development (UNCTAD) promoting fairer terms of trade and more generous development financing • 1970s: Indian economic stagnation, targeted poverty alleviation, forced sterilisation and emergency laws contested by civil society, political and Ghandian socialist opposition; experiments with local democracy and community health • 1973: China re-entry in the UN • 1974: UN declaration on the New International Economic Order • Mahler as WHO DG, promoting community health experiences from Africa, Asia, Latin America and China's barefoot doctors
1978	1978: Alma Ata Declaration on primary healthcare and goal of "Health for All in the Year 2000"
1979-1990	• Oil crisis, global recession, rising external debt in ESA countries; repeated climate related famines and food crises • Introduction of Bretton Woods structural adjustment/ neoliberal policies and focus on fiscal

Date	Paradigm / policy event	
	austerity and external trade-driven GDP growth	
	• Deepening neoliberal reforms in India, centralisation of political power, rise of BJP and Hindu nationalism; growth of private corporate hospital and pharmaceutical sector in medical care	
	• Selective PHC GOBI promoted by Rockefeller Foundation, World Bank, Ford Foundation, USAID, UNICEF as pragmatic, low-cost, limited interventions	
	• GFATM, Gates Foundation focus on high mortality HIV, malaria and TB	
	• Post-independent countries integrating comprehensive PHC in policy, expanding curative health services and with development aid implementing selective PHC	
	• End of the Cold War	
	• 1979: African Charter on Human and Peoples' Rights (ACHPR), adopted by the OAU: *"Every individual shall have the right to enjoy the best attainable state of physical and mental health"*	
	• 1980: OAU Lagos Plan of Action for the Economic Development of Africa, 1980-2000 emphasising intra-regional trade and co-operation and collective self-reliance	
	• 1980s: Spread of HIV and high levels of AIDS mortality in ESA countries	
	• 1987: African health ministers adoption of the Bamako Initiative to accelerate PHC practice	
	• 1988: Rights-based constitution and creation of the national health service (SUS) in Brazil	
	• UN World Commission on Environment and Development led by Norway and 1992: Earth Summit	
	• 1986: Ottawa Charter for Health Promotion promoting IAH/MAH on social determinants	
1990s	• USA CDC director William Foege points to "global infectious disease threats; sets a strategy for the 21st century	
	• USA Institute of Medicine's report, America's Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests, with a role for the Department of Defence Global Emerging Infections Surveillance and Response System	
	• Commission on Macroeconomics and Health established, identifying (in 2001) disease	
	• priorities requiring focused intervention	
	• WHO leadership role health diffused as mission dispersed to World Bank and other UN agencies	
	• 1993: World Bank World Development Report: Investing in Health promotes selective cost effective interventions using DALY analysis in ESA and India	
	• UNICEF promotion of "adjustment with a human face" in ESA countries	
	• Bamako initiative funding of public healthcare from cost recovery from medicine charges	
	• Chile's national adoption of the Washington consensus neoliberal model	
	• India: Decline in public expenditure on health; efficiency reforms with World Bank soft loans and targeted safety nets for poverty alleviation	
	• 1992: ESA country negotiations to protect national resources in the Convention on Biological Diversity (CBD), the Convention on International Trade in Endangered Species (CITES), the International Protocol on Trade (IPT), the Trade-Related Aspects of Intellectual Rights (TRIPS), the OAU model and the UN Declaration of the Rights of Indigenous People.	
	• 1998, Yach and Bettcher on "The Globalization of Public Health" pointing to the interdependence from globalisation and implications for marketing of harmful products and spread of infectious disease.	
	• WHO publication of Social Determinants of Health: The Solid Facts putting social systems in the centre of the analysis.	
	• Promotion of BV, SM and ICH by indigenous and social movements and newly elected left governments in selected Latin American countries; Creation of ALBA left political grouping	
2000	UN Millennium Development Goals with three health-related goals on child mortality, maternal mortality, access to reproductive healthcare and HIV, TB and malaria to be met by 2015.	
2000-2009	• 2000: People's Health Movement People's Health Charter' affirming comprehensive PHC	
	• 2001: New Partnership for Africa's Development (NEPAD) calls for fairer returns from globalisation and development support	
	• 2000s: India Coalition government with Hindu Nationalist Party (BJP) followed by a United Progressive Alliance Coalition alliance both continuing liberalisation but in the coalition period with greater attention to rights, social determinants and space for civil society	
	• 2001 Doha Declaration on TRIPS and public health led from African states, Brazil, India, treatment access social movements challenging to intellectual property constraints in public health	

Date	Paradigm / policy event	
	• 2003 WHO Framework Convention on Tobacco control and 2005 WHO International Health Regulations as binding health rules and standards for cooperation across borders for collective security specific areas of public health • 2006 EU Health in All Policies (HiAP) approach promoted by Finnish presidency • 2006: Harmonisation for Health in Africa led by WHO AFRO to co-ordinate partner support • 2008 Report of the WHO Commission on Social Determinants of Health promoted by UK, Chile, Brazil • 2008 Ecuador Constitution integrates BV/ICH • 2009: Bolivia constitution integrates BV/ICH • 2009: Sarkozy Commission on Measurement of Economic Performance and social Progress (involving Joseph Stiglitz) raising limits of GDP as an indicator of economic and social progress, focus on quality of life, sustainable development and multidimensional wellbeing • Growing attention to climate crisis and loss of biodeiversity • Increasing monopolies in transnationals in ICT, pharmaceutical, food, health commodities • 2006: Launch of the Brazil, Russia, India, China and South Africa (BRICS) forum challenging USA/western hegemony, seeking wider voting rights in Bretton Woods institutions • 2008: International financial, energy, food crisis, especially in USA, Europe	
2010-2015	• 2010: Adelaide Statement on HiAP and UNDP Human Development Report integrating Amartya Sens capability and freedoms • 2010: Conference of the Parties (COP) involving UN. UNEP, WHO adopt 20 global Aichi Biodiversity Targets including ecosystem for health, livelihoods and wellbeing • 2010: USA Affordable Care Act (Obamacare) • 2011 World Conference on Social Determinants of Health in Brazil • 2011: Launch of the 'One health' agenda on animal and human health in Ethiopia • 2011: Japan promotes human security as the core of its health diplomacy • 2012 COP Secretariat of the Convention and WHO Strategic Plan for Biodiversity 2011-2020 • 2012: Publication of the European Policy Framework for Health and Wellbeing and the Bhutan Gross National Happiness Index • 2013: African Union adoption of Agenda 2063 focusing on inclusive, sustainable development • 2013 8th Global Health Promotion Conference on Health, Helsinki Statement on HiAP5 and the HiAP Framework for Country Action noting the need to engage society, private sector; few concrete examples of successful HiAP policy impact; Scotland and Wales recommendation to refer to wellbeing so that HiAP is not seen as a parochial concern of the Health sector. • 2014: WHO promotion of Whole of Government approach • 2014: Global Health Security Alliance launched • 2015: Report of the Lancet (UK) Commission on Planetary Health • 2014: BJP elected promoting Hindu nationalism, liberalisation, commodification in health with marginalisation and control of minorities, civil society, civil liberties • 2014: West and Central African Ebola epidemic; concern over rising multidrug resistant TB • 2015: World Bank promotion of performance based financing and USAID promotion of essential health service packages	
2015	UN Sustainable development Goals (SDGs) in General Assembly Resolution A/RES/70/1, "Transforming our world: the 2030 Agenda for Sustainable Development' with 17 goals and 169 targets around the concept that sustainable development encompasses the environmental, social and economic needs of present and future generations.	
2016-2019	• 2016: 9th Global Conference on Health leaders in China and Shanghai declaration calling for whole of society and an integrated response, noting powerful commercial forces counteracting health and that economic growth alone does not guarantee improvement in population health. Calling for political and global collective action. • 2017: Pan American Sanitary Conference, PAHO adoption of policy on ethnicity and health • 2017: Lancet Commission on Health in Africa advocating people-centred health systems and health as catalyst for the achievement of the SDGs • 2018: Astana Declaration on PHC, but with UHC as the rallying point • Climate and biodiversity crisis stimulating youth climate strikes and extinction rebellions • 2016: UN Commitment on Antimicrobial resistance and promotion of a 'One health' co-ordinated approach to causes of AMR in humans and animals • MERS, SARS, Ebola pandemics	

Date	Paradigm / policy event	
2020	COVID-19 Pandemic • Costa Rica call for patent pool for distributed production of essential health products (EHP) • WHA 2020 resolution on COVID-19 • WHO ACT Accelerator, COVAX to ensure access to diagnostics, medicines and vaccines • Leadership call for global public goods • Professional call for 'Reclaiming public health'	

Afifi and Breslow, 1994; Agyepong et al., 2017; Baru,1998; 2018; Baru et al., 2010; Boron, 2015; Brown et al., 2006; Buse and Hawkes, 2015; CEPAL, 2015b; Chatora and Tumusime , 2004; Chorev, 2012; CLASCO, 2020; De Angulo and Losada, 2014; Dube et al., 2014; EQUINET, 2012; Fernandez, 2010; Fidler, 2009; Gakuya et al., 2020; Gill, 2009; Giovani et al., 2011; Harmer and Buse ,2014; Healthier Societies for Healthy Populations Group, 2020; HealthyPeople.gov, 2020; Howard and Gunther, 2012; Ichoku et al., 2013; Iyengar, 2017; Kickbusch, 2008; Kothari, 1984; Loewenson et al., 2014; 2020; Mersmann et al., 2014; Mkandawire, 2005; Mokaila 2001; Montano, 2018; Nunes, 2015; PAHO and WHO, 2017a,b; 2019; Qadeer et al., 2001; 2016; Rao and Sexton, 2010; Rasanathan et al., 2017; Reich et al., 2011; Ridgway et al., 2019; Rifkin, 2020; Roger et al., 2016; Shah, 1990; Shukla and Phadke, 1999; Srinivasan, and Narayanan, 2007; Streefland, 2008; Vearey et al., 2019; Waitkzin et al., 2011; Whitmee et al., 2015; World Bank, 1994; WHO, 2019; WHO AFRO, 2008, 2014; WHO Euro, 1986;