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THEMATIC SECTION

# Infections Post-inequalities: Realizing the End of Tuberculosis Through Equitable Economic Orders

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## Abstract

The twenty-first century has welcomed significant progress in the battle against deadly infectious diseases through investment programmes (e.g., the Global Fund) and new treatments (e.g., bedaquiline), yet yawning gaps remain. Through the lens of tuberculosis (TB) – a preventable and curable disease exacerbated by inequality – this article revisits Paul Farmer's insights from *Infections and Inequalities* on the relationship between disease, inequities, and colonialism in the political and economic order. Assessing the chronic inadequacies in the international financial architecture and failures of global health decolonization to address macroeconomic structures that undermine governments' ability to fulfill human rights obligations, this article explores two remedies that center economic equity: (1) fair taxation rights; and (2) debt cancellation and reform. The article proposes taking direct aim at colonial financial structures driving TB burden and ill health to decolonize global health and realize robust, sustainable, country-financed health systems — built from community decision-making and power — and a world free of TB and diseases of poverty.

**Keywords** Debt · Taxation · Health systems · Right to science · Right to health

Since the ratifications of the Universal Declaration of Human Rights in 1948 and the International Covenant on Economic, Social, and Cultural Rights of 1966, states have legal obligations to take steps to support the realization of the rights enumerated within (Dang and Frick 2023). These rights include the right of all citizens to enjoy the 'highest attainable standard of health' (hereafter: right to health) and the 'benefits of scientific progress and its applications' (hereafter: right to science) without discrimination (Dang and Frick 2023). Despite these legal frameworks, countries have struggled to meet their obligations due to high care costs and economic constraints, a dynamic illustrated through the ongoing global burden of tuberculosis (TB) (Kessy and Charle 2009; Sobhani 2019).

In the nearly 30 years since Paul Farmer released *Infections and Inequalities* (1999), global TB incidence has decreased 1.5% on average annually (Global Programme on Tuberculosis and Lung Health 2025b). This successful reduction in incidence can in part be attributed to scientific advancements that made it easier to find and treat TB, making TB fully preventable and curable (McKenna et al. 2023). However, these advancements were not met with matched country or global investments to ensure their implementation in national TB programmes and integration into health systems – representing an ongoing failure to realize broad access to TB advancements for those who need them most (Global Programme on Tuberculosis and Lung Health 2025b).

TB has long been considered a disease of poverty and inequality, found in crowded domiciles and amongst the malnourished, and for which treatment often constitutes catastrophic household costs (Global Programme on Tuberculosis and Lung Health 2025b). The burden of TB falls along an unequal gradient within countries, as the poor suffer most from TB, and between countries, as poorer countries have higher TB rates (Janssens and Rieder 2008; Koura and Harries 2024). When countries lack resources to invest in social protections to eliminate poverty, eradicate hunger and provide adequate shelter for all, they lack resources to both treat TB and address its underlying risk factors. High TB burden countries have demonstrated a clear interest in implementing new tools, but their ability to invest through

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domestic budgets alone is hampered by stifling debt cycles and tax systems that allow wealth and resource drain from the Global South (1/4/6×24 Campaign 2024; McConnell 2025; Hickel 2018). This is particularly true of low-income countries (LICs) and lower middle income countries (LMICs) that have long experienced challenges in expanding domestic resources to invest in health (Kessy and Charle 2009). The international financial architecture (IFA) – the policies, practices, and institutions enforcing the global financial and monetary systems – is inadequate to ensure all countries can accrue resources to ensure the right to health. As such, the IFA has proven incongruent with realizing Sustainable Development Goal 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

The failure to realize the end of TB is not the sole responsibility of the global health field; but rather, a failure shared with an IFA that prioritizes the interests of wealthy countries while failing to ensure global access to TB testing and treatment, despite commitments to do so (The General Assembly 2023). In the wake of rapid divestment from global collaboration against infectious diseases in 2025, the global health community must reckon with the role of the unjust, colonial IFA in precluding the end of TB and advocate for solutions to overcome economic inequalities that undergird TB spread (OECD 2026). While the field of global health is largely aligned on the need to decolonize, disagreement about what 'decolonization' means and how to achieve it remains (Chaudhuri et al. 2021). This article argues that meaningful decolonization of global health – that is, the systemic dismantling and overhaul of structures that preserve colonial power – is wholly dependent on decolonizing the international financial architecture such that countries can achieve the sovereignty necessary to direct their own health investments in partnership with citizens and affected communities. The failure to realize the end of TB is a meaningful proxy for assessing the success of the global health field in decolonizing itself to realize healthy societies.

This article explores two examples of structural changes that advance IFA decolonization, support decolonization of global health, realize the rights to health and science, and achieve SDG 3: Health. First, the creation of a United Nations Tax Convention to transform unfair global tax rules and enable significant revenue collection; and second, debt reform to reduce onerous payment outflows that constrain country budgets. Both efforts reflect the hopes of generations of activists, are championed by Global South coalitions, and contain significant potential to create a new, more equitable IFA.

## The Economics of Inequality: *Infections and Inequalities* Redux

Persistent health inequities, like the global burden of TB, are not haphazard in distribution and effect. In a world which contains more than enough resources and tools to end preventable illness, lack of progress on TB primarily reflects political priorities and power imbalances rather than technical or financial constraints (Farmer 1999). Through this lens, Paul Farmer called for the field of global health to undertake deep investigation into 'the precise mechanisms by which such forces as racism, gender inequality, poverty, war, migration, colonial heritage, coups d'etat and even structural-adjustment programs become embodied as increased risk' (Farmer 1999: 148). Farmer's essential insight, via *Infections and Inequalities*, holds that understanding ill health globally requires an understanding of historical and contemporary systems of unequal economic and political power: namely, colonialism and its ever-evolving mutations, including the IFA.

The modern field of global health originated from the nineteenth century colonial concept of 'tropical medicine' – a name that represents its origins in European colonies in the tropics of Africa, Asia, and the Americas. The purpose of tropical medicine was to protect settlers, soldiers, and administrators from diseases endemic to the regions they were colonizing (Farmer et al. 2013). The lack of supportive public infrastructure for indigenous populations was a deliberate feature of colonial systems, alongside neglect for preventative care and refusal to develop national primary healthcare. These decisions reflect both the prioritization of resource extraction for wealth and the deliberate stunting of community health to weaken local opposition (Farmer et al. 2013). Direct extraction of labour, minerals, and wealth – estimated in the trillions of dollars – contributed immensely to unequal development between the Global North and Global South, keeping the Global South artificially poor while the Global North rapidly industrialized (Hickel 2018). This manufactured poverty stunted the ability of nations to create and maintain robust public health systems.

As independence movements overthrew colonial rule in the mid-twentieth century, newly formed governments began developing social services, building health and education systems, bolstering infrastructure and pursuing economic sovereignty (Mukherjee and Farmer 2021). Global South cooperation represented a direct threat to Global North capital accumulation, and colonial states intervened to construct and enforce a global economic structure to maintain the imperialist order (Hickel et al. 2026). From the 1940s to 1960s, the Global North set up and repurposed international bodies, such as the International Monetary Fund (IMF), World Bank (WB), and the Organization for

Economic Cooperation and Development (OECD) to regulate global tax and financing rules in their favour. One particularly successful neocolonial intervention was the imposition of Structural Adjustment Programmes (SAPs) by the IMF. These programmes forced austerity, privatization and liberalization in indebted countries – resulting in an estimated loss of US$480 billion annually in potential GDP throughout the 1980s and 1990s (Hickel et al. 2026). SAPs cheapened the cost of labour and commodities, weakened local competition, and allowed northern firms to recreate captive markets. This enabled the appropriation of resources through unequal exchange and increased reliance on foreign capital – a net drain from the Global South of US$152 trillion including lost growth (Hickel et al. 2021). Observed through the lens of TB, SAP's crippled health infrastructure: participating in IMF programmes was associated with increased rates of TB incidence (13.9%), prevalence (13.2%) and mortality (16.6%) (Stuckler et al. 2008).

Following the end of formal colonialism and the establishment of the neocolonial world economic order, the field of global health evolved to focus on 'development' (Farmer et al. 2013). However, predominant global health structures served to maintain and enforce neocolonial extractive practices. For example, stringent patent restrictions through Trade-Related Aspects of Intellectual Property Rights (TRIPS) treaties enabled northern pharmaceutical firms to set medicine prices, control access to lower-cost generics and restrict medicine trade across jurisdictions (Sell 2007). This system resulted in rationed access to revolutionary medical advancements, such as limited access to bedaquiline for treatment of drug-resistant TB, as prices were set out of reach for many high TB burden communities (Tu 2023).

A quarter-century after Farmer's exhortation in *Infections and Inequalities*, the global health field is still reckoning with its colonial origins and neocolonial positioning. Literature on decolonizing global health is still sparse and suffers from over-representation of northern perspectives (Amri et al. 2025). While there is now broad agreement that global health scholarship reflects colonial power imbalances, there is disagreement on what 'decolonizing' global health means and what a decolonial agenda would look like in practice (Chaudhuri et al. 2021; Stewart et al. 2025).

While some literature focuses on financial control and donor power as central blockers of decolonizing global health, IFA decolonization is not yet viewed as an essential tenet of achieving global health equity, nor as an essential activity among global health practitioners and organizations (Kumar et al. 2024; Osborne 2025). Many implementation strategies with the aim of increasing financing flows for global health focus on increasing foreign direct investment, de-risking private finance, and innovating financing mechanisms (Vyas 2025). These strategies reinforce, rather than dismantle, structures that preserve Global North power by prioritizing northern-based private corporations over country-led or publicly owned health systems. Moreover, these proposals focus mainly on increasing access to finance via augmented private investment – a strategy which has contributed a fractional amount to developing countries – while reducing focus on eliminating exploitative neocolonial outflows which could return trillions to Global South countries for public health investments (Bretton Woods Project 2025). In an era of increasing financialization of health, expanded privatized insurance schemes and high out-of-pocket costs are often relied upon to cover health costs in lieu of government spending (World Health Organization 2019). These proposals in tandem with financialization of health serve to entrench systems that foist the cost of healthcare onto individuals in the name of ensuring returns on investment.

Today, neocolonial economic rules enforce net appropriation from the Global South to the Global North: extensive debt payments, trade imbalances and tax evasion and avoidance produce an estimated net outflow of US$2 trillion annually (Hickel et al. 2021). Stemming these outflows must be an essential part of any critical global health analysis: while imbalanced international financial systems persist, governments will be unable to fulfill their obligations to furnish the rights to health and science for their people, and global health will retain its colonial structures.

## Infection and Inequalities in 2026: The Story of TB

Since the publication of Infections and Inequalities in 1999, advancements in TB prevention, diagnostics and treatment have saved more than 79 million lives (Global Programme on Tuberculosis & Lung Health 2025a). However, this progress is threatened by current international divestments, risking up to 10.67 million additional cases of TB globally through 2030 (Mandal et al. 2025).

TB burden will continue to fall heavily on countries that have suffered the most from the economic system enforced by the Global North: LIC and LMICs, and the hard to reach, marginalized and vulnerable communities within them (Mandal et al. 2025). The economic gap between the Global North and Global South continues to grow (Hickel and Sullivan 2026). Meanwhile, between 2024 and 2029, 57% of the world's poorest countries, representing 2.4 billion people, will need to cut public spending by a combined US$229 billion – worsening TB outcomes as TB prevalence, incidence, and mortality are inversely associated with social spending levels below 11% of GDP (Siroka et al. 2016; Oxfam Int.

2024). Aspects of the IFA – such as IMF conditionality, high debt burdens, and tax revenue repatriation – have been historical primary drivers of cuts to social spending and are tied to increased or sustained rates of TB prevalence within poorer nations (Maynard et al. 2012; Stubbs et al. 2017). The foundational causes of poor health and TB incidence that Farmer highlighted in *Infections and Inequalities*, inequity and poverty, remain deeply entrenched within both the global health field and the IFA as Global North control over financial systems, wealth, and resource accumulation is prioritized over country level sovereignty and health (Moyo 2024). As such, it is increasingly evident that the goal of ending TB will remain out of reach if the inequality between nations and between citizens perpetuated by the IFA is unaddressed.

## Decolonizing the IFA to end TB

As the world confronts the failure of development models to overcome economic inequities and produce healthy societies, humanity must envision what can be built to address these ills. Ending TB is not an impossible dream, but the necessary financing remains encumbered within the neocolonial IFA. Two ongoing actions which hold promise to decolonize the IFA, and in turn support decolonizing global health, are as follows:

1. Reworking the global tax system to enable and empower Global South countries to retain revenue generated in their jurisdictions through the creation of a United Nations Tax Convention; and,
2. Debt cancellation and structural reforms to protect country budgets from the outflow of resources to Global North lenders.

These efforts reflect many years of immense work from affected and oppressed communities whose enduring hope of achieving a rebalance of power in the IFA has produced the conditions for these initiatives to take root through constant power struggle. The continued inclusion of these communities is tantamount to the success of these initiatives, as increased fiscal space does not necessarily translate to direct improvements in public health. It is essential that communities and civil society continue to hold governments accountable to their rights mandates, such that increased budgets are spent transparently and accountably towards programmes that support the rights to health and science.

### Redrawing Tax Systems

Taxation is one of the most sustainable and consistent sources of revenue (Baer and De Mooij 2026). Yet, for the past half century, there has been a concerted effort to move away from robust taxation of those who generate the most profit and carry the most wealth – corporations and high net worth individuals. Since 1980, the corporate tax rate has declined from 48% to 23.1%, with countries lowering statutory rates despite record corporate profits (Oxfam Int. 2024). Companies further leverage tax incentives, profit shifting and tax havens to produce actual tax rates closer to zero – robbing many countries of resources that could otherwise be invested into TB, health, or social programmes (Oxfam Int. 2024).

These pro-corporate policies were embraced in the belief that lowering taxes and deregulating industry would usher in an era of economic growth, job creation and well-being. Instead, these policies resulted in an erosion of domestic revenues, social spending and progress against poverty (Hickel 2018; Oxfam 2024, 2026). Tax policies which aim to incentivize corporate investment through low tax rates or loopholes shield an estimated US$3.55 trillion from taxation annually (Oxfam 2026). For some countries, these incentives exceed the annual budget of the entire health system.

This system of tax loopholes was intentionally designed to re-entrench imperialist and colonial systems, allowing the indirect rule of Global South countries by Global North corporations (Klein 2007; Frankfurter et al. 2019). While colonial empires have receded, corporate empires have established indirect control over local governance – enabling corporations to evade tax obligations while extracting public resources. For example, in the decade prior to the 2014 Ebola outbreak in Sierra Leone, the country lost nearly US$560 million annually through tax evasion and the intentional underdevelopment of government institutions tasked with policing the tax obligations of corporations operating within the country (Frankfurter et al. 2019). The loss of government revenue and associated underinvestment in public services directly fed into health system failures that exacerbated the Ebola outbreak (Frankfurter et al. 2019).

Countries that embraced progressive and stringent tax policies that allowed them to generate revenue and invest in governance, social spending, and improving health offer a different vision (Hickel 2018). Through such policies, countries like Costa Rica and South Korea – which were not subject to SAPs that undercut tax and tariff policies – achieved higher life expectancy, quality of life, and lower TB incidence as compared to their regional neighbours and income groups (World Bank Open Data 2024; Hickel et al. 2026). Costa Rica and South Korea exemplify the potential

of a decolonized tax system, a system which should be globally available.

Civil society and Global South governments, led by the Africa Group at the United Nations, have kept hope of a fair, democratic international tax system alive through decades of campaigning. In 2024, the United Nations General Assembly affirmed this effort by voting to begin the development of the United Nations Framework Convention on International Tax Cooperation (UNTC), which is under negotiation for proposed adoption in 2027.

The UNTC negotiations offer an opportunity to decolonize global taxation and create a more equitable system that accounts for the increasingly globalized and digitalized economy. In particular, the negotiations are opening conversation around four key provisions which would provide greater agency and power to Global South governments:

1. Automatic exchange of information on account holdings of corporations and wealthy individuals across jurisdictions to reveal assets sheltered in offshore accounts;
2. Country-by-country reporting which would provide transparency into corporate profit shifting;
3. Unitary taxation with formulary apportionment that would disburse multinationals' profits equitably and fairly across all jurisdictions in which they are active and collect profit according to an established formula that accounts for real economic activity and market share; and,
4. Global minimum corporate tax rate to define a floor for corporate taxes and undercut the global race to the bottom.

Integrating these measures into a global tax framework could result in 20 developing countries receiving US$2.8 billion in tax revenue from Meta, Alphabet and Microsoft alone – a figure which represents 729,000 nurses or 771,000 midwives for each country (ActionAid International 2020). A broader 2% global tax on the ultra-wealthy could generate US$10–15 billion more for healthcare – over half the annual US$22 billion dollars needed to realize the end of TB (The General Assembly 2023; Zucman 2024; World Bank Open Data 2025). These tax cooperation initiatives, if adopted, carry the promise of recovering tax revenue well in excess of the annual US$371 billion required to meet SDG 3: Health for 67 LIC and LMICs (World Health Organization 2017; Tax Justice Network 2025).

For TB programmes, increased revenue associated with any of the UNTC measures could increase funding available to fill critical gaps and support countries in procuring the best treatments, especially for high TB burden countries that rely on domestic budgets to finance TB programmes (ActionAid International 2020; Global Programme on Tuberculosis & Lung Health 2025b). While this would be true even if the percent of GDP flowing to TB programmes remained static, states ultimately must choose to prioritize health systems. Expanded fiscal space via tax reforms is a necessary precondition for this prioritization, but civil society and communities must continually push governments to direct spending appropriately and in line with their rights mandates. Expanded fiscal sovereignty comes with the responsibility of increased oversight and accountability for government spending, but this is a challenge that civil society has long confronted.

## Breaking Cycles of Debt

'Debt is a skillfully managed reconquest of Africa, intended to subjugate its growth and development through foreign rules', observed Burkina Faso's President Thomas Sankara in 1987 (Sankara 1987). Sankara's sentiment rings true today, as the global debt crisis drains US$1.5 trillion – primarily in interest payments to Global North creditors – from indebted countries each year (World Bank 2025). Global lending policies tie loans to forced market deregulation, liberalization and austerity, reinforcing an endless cycle of borrowing (Levinson et al. 2025). Collection of these debts is enforced not through explicit violence, but through financial intimidation tactics that threaten capital flight, credit rating downgrades, loss of market access, or increased borrowing costs (Levenson et al. 2025). These policies replicate colonial patterns of extraction and ensure that Global South nations remain dependent on debt to meet their obligations to human rights.

In 2023, debt service accounted for 30% of government spending on average across developing countries, compared to an average of 5–7% spent on health in LIC and LMICs (Martin et al. 2023). The enormous pressure placed on government revenues and budgets due to debt commitments limits investment in critical tools to address TB burdens and broader health system strengthening. For example, Sierra Leone's national budget reduced health spending from 11.5% to 7% in 2024, noting: 'large debt service payments… have narrowed the policy choices and presented difficult policy tradeoffs…reducing the resources available for spending on Government priority programmes' (Sierra Leone Ministry of Finance 2024: 2, 11).

Aside from reducing budgetary space for public services, countries with heavy debt burdens are forced to adopt austerity measures to prioritize debt repayment, causing chronic under-resourcing of the health sector. Wage bill caps are one of the IMF's most commonly enforced austerity policies, recommended in over 90% of countries with IMF programmes in 2020 (Archer 2021). These constraints directly reduce a government's ability to recruit, hire, and

retain health workers, crippling health systems' ability to respond effectively to infectious diseases like TB, which require extensive patient support to maintain lengthy treatment regimens (McKenna et al. 2023). A 2025 survey across six heavily-indebted countries revealed 87% of health workers reported scarcity of medical supplies and 84% reported severe shortages in staff due to budgetary constraints associated with high debt burdens – conditions which directly impact the quality of TB care and successful outcomes (ActionAid 2025).

Even modest debt relief would carry major implications for health systems. If external debt servicing burdens were reduced to 10% of GDP, high debt burden countries could make significant health gains through reinvestment. For example, Angola could reduce deaths of children under five by almost 11%, while Egypt could eliminate maternal deaths during childbirth (ACET 2025). In addition, reducing interest payments could shift significant fiscal space towards health. The UN Trade and Development Commission reports that 46 developing countries spend more on interest payments than on health, with 23 of these countries being high-TB burden countries (UNCTAD 2025; McConnell 2025).

In tandem with Global South governments, civil society has long argued that developing country debts are largely illegitimate and must be cancelled, as the need for financing itself is driven by unequal economic and geopolitical constraints arising from colonialism (CADTM 2007). Debt cancellation and reform are essential to decolonizing the IFA through eliminating the outsized influence creditors exert on government investments in social services. The twin benefits of freeing up fiscal space for investment in health systems, paired with disempowerment of Global North lenders to shape the domestic expenditure policies of borrower nations, could reap substantial reward for TB programmes reliant on domestic investment when paired with continual oversight to ensure governments are directing funds appropriately.

Civil society, supported by Global South governments, has called for a multilateral legal framework that would comprehensively address unsustainable and illegitimate debt, including through extensive debt cancellation, under the auspices of the UN (Eurodad 2024). Such a framework could include principles for responsible borrowing and lending, a sovereign debt workout mechanism, rights-based debt sustainability metrics, and a pathway for debt cancellation to redress existing debt burdens (Eurodad 2024). This mechanism would not only address unsustainable debt burdens and end cycles of debt but would allow for a novel approach to debt governance that eliminates the prioritization of investor returns above countries' obligations to protect the health of their citizens. This could transform the debt systems within the IFA, ensuring that cancelled debt does not simply return to plague country budgets.

## To Build a Healthy World

It is challenging to derive hope from large, difficult, structural efforts to affect change within an imperialist order, particularly when 1.4 million people are dying from TB each year, with projected increases in the years ahead. But as UNTC negotiations advance and the Global South continues to agitate for long-term solutions to debt crises, hope must be found in these initiatives that no longer tinker around the edges of issues but instead aim straight at the core of retrenched neocolonial systems and build truly novel, internationalist solutions to address them. The advancement of the UNTC – against strong Global North pushback – suggests that countries and communities are no longer content to assume that our current world, and the inequities that define it, is the only option.

The current system reflects choices of those in power, in the absence of community input, and a lack of political will to realize a post-colonial world. Decolonial practice is grounded in believing a different relationship with each other is possible. Communities and civil society have been imagining this future for decades: a world that provides adequate and appropriate medical care for all people according to their needs and is free of preventable and curable diseases like TB, for one. Opportunities to build this world are at hand, as new means of global tax cooperation and debt reform represent tangible, concrete, and ongoing mechanisms of decolonizing the IFA by bringing power to governments across the Global South and away from multinational corporations. Successful adoption and implementation of the UNTC and debt reform carry the promise of expanded domestic revenues along with improved sovereignty for countries to decide how their own resources are utilized. Combined with continued oversight, accountability and community engagement, this will enable sustained investment towards realizing human rights obligations, including the rights to health and science.

If the global health field can look beyond triage and towards what truly hinders the ability of countries to provide for their own people, the process of decolonization can begin in earnest – through a systemic dismantling of structures that allow infections and inequalities to flourish. This can only proceed through committing energy, attention, and willpower to the deconstruction of colonial systems, including the IFA. Through the practice of radical hope for what is possible, and exercising the will to achieve it, the end of TB can be achieved.

## Declarations

**Artificial intelligence** Software was not used in the preparation or research of this manuscript or in the research.

**Positionality Statement** The authors of this article are queer white American women who largely benefit from the economic structures defined within the report. Coming from working class and middle-class backgrounds in the United States, the authors draw on personal experiences and personal struggles with unemployment, debt, and access to life saving healthcare within the United States' context to inform their perspective on the importance of government investment in social protections and healthcare to realize the health and well-being of all citizens, regardless of country of birth. Both authors work closely with community representatives in high tuberculosis (TB) burden countries and low income and lower-middle income countries and have engaged in extensive discussion with these partners on the proposed solutions and approaches to addressing global economic inequality to realize a world free of preventable diseases like TB. The perspective of partners has greatly shaped the approach to and perspectives within the submission. Both authors organize locally and focus on how economic inequality echoes differently in countries with disparate global positions despite a shared root; and focus on solidarity as a forward-looking tool to overcome systems of oppression and inequity.

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