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Commentary

Your call could not be completed as dialled: why truth does not speak to power in global health

Comment on "Knowledge, moral claims and the exercise of power in global health"

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Abstract

This article contends that legitimacy in the exercise of power comes from the consent of those subject to it. In global health, this implies that the participation of poor country citizens is required for the legitimacy of major actors and institutions. But a review of institutions and processes suggests that this participation is limited or absent. Particularly because of the complex political economy of non-communicable diseases, this participation is essential to the future advancement of global health and the legitimacy of its institutions. More analysis of power and legitimacy provides one entry point for fostering progress.

Keywords: Global Health Policy, Political Economy, Social Contract, Participation and Voice

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If poor or otherwise marginalized people are the ultimate beneficiaries of efforts in global health, then it would stand to reason that related actors and institutions would be responsive to their demands. At the very least, one would hope that the major powers in global health would have formal legitimacy to act on behalf of these groups. This is not the case in general and is an acute problem in many low- and middle-income countries because of weaknesses in national governance systems and inabilities to contest the influence of international actors. Many analysts have tried to advance global health by commenting critically on decisions, policies, and institutions, but the underlying issues of legitimacy and the exercise of power have escaped the attention of all but a very few. Power and legitimacy are central foci of political economy analysis and Shiffman's call (1) to analyze these phenomena is well-founded for the reason that he identifies—namely to question whether power in its epistemic and normative forms is justly held. In this article, I emphasize the importance of these analyses by showing how the exercise of power is now disconnected from the voices of those who bear its consequences. Further, I argue that the analysis of power is central to maximizing the humanitarian impact sought by those engaged in global health activities. This position is related to a general argument for more political economy analysis in global health made by myself and colleagues (2).

A core question of legitimacy in the use of power is whether it is used in the right way to do the right things—a statement that immediately raises questions about how "right" would be adjudicated. These questions have broad answers in many aspects of modern life. Hobbes, Locke, Rousseau and other Enlightenment thinkers conceptualized the "social contract" to articulate the citizen-state relationship that now underpins modern nations (3–5). In short, the social contract refers to the assignment of some powers to the state, meaning that these powers are relinquished by individuals, and in exchange the state protects the remaining rights of individuals. As I have observed elsewhere, government health systems comprise a prominent part of the modern social contract (6,7). In health, as in other areas, citizens influence state policies, as by voting in democratic countries, and thereby have some participation in the decisions about what constitutes the right use of power and the right objectives. This participation, or at least consent, conveys legitimacy. This legitimacy can be threatened by corruption, co-option by interest groups, oppression of a minority by the majority, or other problems.

But this social contract mechanism does not legitimize power in global health because most activities fall outside the realm of single nations. Recipient citizens and the providers of services are often at considerable remove and are not well-linked by any mechanism of representation or accountability. The actions of bilateral agencies may have some connection to the demands of their own citizens, but their responsiveness to the wishes of those to whom they ostensibly provide services is far weaker.

If the primary means for establishing legitimacy within a nation is inapplicable, then the next sphere of interest is mechanisms between nations. Most of the international agencies date to the post-World War II period and were not designed around an ideal of globalized democracy in general, nor with respect to legitimacy in health in particular. The United Nations (UN) was designed to promote stability by avoiding conflict between the major powers and isolating it in more limited settings. Although the UN acknowledges

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the idea of democracy in its General Assembly (one country, one vote), it reserves many important powers for its Security Council whose permanent members were allies in World War II[1]. The International Monetary Fund was designed to reduce economic conflict by establishing rules on currency manipulation and providing means to settle balance of payment matters. Its governance is based on contributed capital, which favors wealthier nations; the World Bank has the same structure. The UN agency most directly concerned with global health is the World Health Organization (WHO), but its ostensibly democratic World Health Assembly has been circumvented by rich countries using earmarked contributions and other measures to influence activities and priorities outside of the voting process.

The result of these dynamics is the intended beneficiary citizens and their governments are not adequately represented in global health decision-making, and thus are not fully enfranchised in the still-incomplete international version of the social contract. This concept of the social contract emphasizes the formal political power of governments and states, but this is certainly not the only kind of power important to global health.

The legitimacy of actors and institutions in global health is further threatened by the absence of agreement about the process for making decisions. Even if the ostensible beneficiaries are poorly represented in decision-making, there could be some legitimacy to be found in transparency of process, which in turn might promote fairness. But decision-making in global health is not transparent, and as Shiffman observes, it is not clear how influential actors achieved their status nor obvious that it is deserved. With particular reference to normative and epistemic power, there are not even the rules of a discipline to suggest some standard by which conclusions could be reached and decisions could be made. This is because global health is not a discipline and instead is a practice area, meaning that it is defined by an objective rather than by methods. Although there would be considerable diversity in specific definitions of global health, in my opinion most people would agree that its general goal is to promote health and health-related capacities, or maybe to advance humanity, to borrow UNICEF's articulation.

Despite the harmony that might be inferred from this widely recognized goal, underneath lies a chaos of methods in largely unproductive competition. Physicians, lawyers, engineers, social scientists, natural scientists, and practically every other group can contribute to global health. Within each of these areas there are processes for guiding the production of knowledge, largely based on a form of peer-review. But global health lies between all of these areas and does not (yet?) have ways to reliably adjudicate disputes between different groups using different methods, for instance between economists and physicians. How one view gains ascendance over another is now a political process that unfolds without scrutiny commensurate with its importance. A perhaps worse alternative would be hegemony of a single method. Asking beneficiary citizens what they want could identify a better standard against which alternatives should be weighed, but their voices are not prominent in the deliberations of actors and institutions in the mainstream of global health.

Leaving aside uncertain legitimacy in process, I consider outcomes next. To the extent that people agree on an issue, democratic processes and the exercise of voice become less important to outcomes—just because if people agree anyway then the decision does not change with increased participation. In the first decades of what we now call global health, decisions about where to intervene and what to do rested almost solely on expert opinion (8,9). When targeting infectious diseases this proposition is not necessarily unreasonable because very few people—if any—want to contract them and in the early years there were far fewer viable interventions from which to choose. But the rising burden of Non-Communicable Diseases (NCDs) fundamentally changes this proposition because their political economy is profoundly different. Exposures linked to NCDs reflect industrial interests and therefore represent a contest of economic and health interests in many areas, including food, firearms, alcohol, tobacco, and pharmaceuticals. Particularly in tobacco, it has been demonstrated that rich countries and corporate interests have attempted to further subvert the decision-making processes of international organizations for their own purposes and at the expense of health of poor country citizens (10–14).

A central claim of this article is that legitimacy in the exercise of power is conferred by the consent of those subjected to it. This conviction is based on the philosophy of the social contract and in the ethical framework of process fairness (15). In global health, this means primarily the citizens of poor countries, and especially the marginalized among them. However, current arrangements do not foster their participation. The analysis of power and legitimacy is one helpful way of questioning whether decisions made in global health are consistent with the claimed objective of advancing the lives of poor country citizens. Identifying the interest groups and the sources of their power can suggest ways to incorporate more diverse views, and is also a sound approach for guarding against co-option of the social contract itself. This holds the promise of increasing the alignment of offered interventions and the preferences of recipients—greater legitimacy that comes from greater participation.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

JBB is the single author of the manuscript.

Endnotes

1. China's seat on the Security Council initially belonged to the Republic of China but has since been reassigned to the People's Republic of China.

References

1. Shiffman J. Knowledge, Moral Claims and the Exercise of Power in Global Health. *Int J Health Policy Management* 2014; 3: 297–9. doi: 10.15171/ijhpm.2014.120
2. Report from Bellagio: Advancing Political Economy of Global Health to Understand and Influence the Drivers of Universal Health Coverage. *Health Systems & Reform* 2015; 1: 20–1. doi: 10.4161/23288604.2014.991221

3. Hobbes T. *Leviathan*. London: Andrew Crooke; 1651.
4. Locke J. *Two Treatises of Government*. London: Awnsham Churchill; 1690.
5. Rousseau JJ. *Du Contract Social*. Amsterdam: Marc Michel Rey; 1762.
6. Bump J. The Long Road to Universal Health Coverage: Early decisions in Germany, the United Kingdom, and the United States. *Health Systems & Reform* 2015; 1: 28-38. doi: 10.4161/23288604.2014.991211
7. Bump JB. The Long Road to Universal Health Coverage: A century of lessons for development strategy. Seattle, WA: PATH; 2010. Available from: http://www.rockefellerfoundation.org/uploads/files/23e4426f-cc44-4d98-ae81-ffa71c38e073-jesse.pdf
8. Farley J. *To Cast Out Disease: A history of the International Health Division of the Rockefeller Foundation (1913–1951)*. New York: Oxford; 2004.
9. Farley J. *Brock Chisholm, the World Health Organization, and the Cold War*. Vancouver: UBC Press; 2008.
10. Mamudu HM, Hammond R, Glantz S. Tobacco industry attempts to counter the World Bank report curbing the epidemic and obstruct the WHO framework convention on tobacco control. *Soc Sci Med* 2008; 67: 1690-9.
11. Mamudu HM, Hammond R, Glantz SA. Project Cerberus: Tobacco Industry Strategy to Create an Alternative to the Framework Convention on Tobacco Control. *Am J Public Health* 2008; 98: 1630-42. doi: 10.2105/ajph.2007.129478
12. World Health Organization (WHO). *Tobacco industry strategies to undermine tobacco control activities at the World Health Organization*. Geneva: WHO; 2000.
13. Assunta M, Chapman S. Health treaty dilution: a case study of Japan's influence on the language of the WHO Framework Convention on Tobacco Control. *J Epidemiol Community Health* 2006; 60: 751-6. doi: 10.1136/jech.2005.043794
14. Chaloupka FJ, Laixuthai A. U.S. Trade Policy and Cigarette Smoking in Asia. NBER Working Paper No. 5543; 1996.
15. Daniels N. Accountability for reasonableness: Establishing a fair process for priority setting is easier than agreeing on principles. *Br Med J* 2000; 321: 1300-1.