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Commentary

Knowledge and networks – key sources of power in global health

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

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Abstract

Shiffman rightly raises questions about who exercises power in global health, suggesting power is a complex concept, and the way it is exercised is often opaque. Power that is not based on financial strength but on knowledge or experience, is difficult to estimate, and yet it may provide the legitimacy to make moral claims on what is, or ought to be, on global health agendas. Twenty years ago power was exercised in a much less complex health environment. The World Health Organization (WHO) was able to exert its authority as world health leader. The landscape today is very different. Financial resources for global health are being competed for by diverse organisations, and power is diffused and somewhat hidden in such a climate, where each organization has to establish and make its own moral claims loudly and publicly. We observe two ways which allow actors to capture moral authority in global health. One, through power based on scientific knowledge and two, through procedures in the policy process, most commonly associated with the notion of broad consultation and participation. We discuss these drawing on one particular framework provided by Bourdieu, who analyses the source of actor power by focusing on different sorts of *capital*. Different approaches or theories to understanding power will go some way to answering the challenge Shiffman throws to health policy analysts. We need to explore much more fully where power lies in global health, and how it is exercised in order to understand underlying health agendas and claims to legitimacy made by global health actors today.

Keywords: Power, Global Health, Bourdieu, Participation, Evidence-Based Policy-Making

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Shiffman (1) rightly raises questions about who exercises power in global health, suggesting power is a complex concept, and the way it is exercised is often opaque. Financial power, such as that of large donor country governments, for example, or major lending institutions such as the World Bank or International Monetary Fund (IMF) is not difficult to understand. But what about those who use other aspects of power to try to influence global health agendas? Power that is not based on financial strength but on knowledge, science or experience, is sometimes more difficult to estimate, and yet it may provide the legitimacy to make moral claims on what is, or ought to be, on global health agendas.

Twenty years ago power was exercised in a much less complex health environment. The World Health Organization (WHO) was able to exert its authority as world health leader in two ways. One, through its ability to draw on and coordinate, the views of experts and professionals throughout the world (epistemic communities of scientists); and two, through its being a membership organization which included most countries in the world, including rich and poor, with equal voting rights. Member states recognized WHO's legitimacy to draw attention to issues that needed attention, and to make decisions about ways to tackle problems and implement global policies. WHO's moral authority was thus derived first from its ability to draw on and debate, clinical and scientific evidence and expertise and second, from its political mandate stemming from the WHO Constitution – a document recognised in international law – and signed by its Member States.

However, the landscape today is very different. Financial resources for global health are being competed for by diverse organisations: public-private partnerships, research bodies and universities, non-government organizations, as well as international organizations such as WHO. Where once three-quarters of WHO's finances were generated from membership contributions, and only a quarter were earmarked funds from external donors (2), today the situation is reversed (3). Today WHO has less financial power, in a world where funds are much more diffused, and where many organizations compete to access health resources and to influence the global health agenda. But also, WHO's moral authority has been undermined (partly because of the changed economic landscape), and its expertise is often challenged by other organizations (4,5). Shiffman points to the example of the International Health Metrics Institute (IHME) and the extent to which its expertise – measuring the global burden of disease – has impacted on discourse and priorities in the field of global health, leading to contention over global figures on malaria. Similarly, WHO has been challenged in the case

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of the recent Ebola outbreak. It was the non-governmental organisation Medecins Sans Frontieres (MSF) whose high profile interventions, including at the UN Security Council, which was seen as having mobilised the international response. MSF's credibility and authority stemmed from its early involvement in this and earlier outbreaks and WHO was perceived to have been slow and distant in its recognition of the implications of Ebola for the region. A further example cited by Shiffman, is that of the medical journal, *The Lancet*, whose editor has, through linking with epistemic networks around the world, ensured that the journal itself has emerged as a powerful actor in global health. Its power is partly derived from being the most highly cited journal in the field. This power, plus the ability to attract resources has enabled *The Lancet* to become a key convening forum for debate and for setting global health priorities.

Shiffman's gaze on the role of these epistemic communities is timely: we need to know more about why some organizations or individual leaders are accorded legitimacy yet others are neglected or spurned. We observe below two ways which allow actors to capture moral authority in global health. We discuss these in turn and explore very briefly just one political science concept of power, proposed by Bourdieu (6,7) which health policy analysts may find useful. Like Shiffman, we hope that other concepts of power will be explored in relation to issues in global health policy to improve our understanding of how power is exercised.

First, over the past twenty years 'evidence-based' policy-making in global health has gained huge attention and currency (8,9). Recognition of health policy processes as political and non-linear (10), has led to greater efforts to translate the principles of evidence-based medicine into health policy decision-making including at the global level. The organizations which provide evidence and present it to implementing authorities have gained power in this climate. The authority of the IHME and *The Lancet* are testimony of this trend, deriving power and legitimacy from their claim to scientific knowledge and evidence. However, creating the evidence that allows organisations to claim moral authority and legitimacy in global health requires significant economic resources. The IHME and its Global Burden of Disease research has relied very heavily on funding from the Gates Foundation, which has emerged as a major funder in global health – not only of interventions – but also of research over the past two decades (11). While evidence is often perceived as 'neutral' or 'scientific' as long as it comes from authoritative sources, there has been limited attention on how financial resources used to gather evidence may have influenced its creation and presentation. Here the questions posed by Shiffman are particularly pertinent and need to be explored much more thoroughly.

Second, we need to explore more about the procedures that lead to claims of moral authority. For example, many governments, global institutions and organizations argue that they are meeting democratic deficits by having long consultative processes in deciding policies. One example is the process to establish the new Sustainable Development Goals (SDGs) post 2015. Proponents of these long processes suggest that opportunities for participation have led to more being involved in the processes of policy-making. But little research has been undertaken to demonstrate how participative are such processes, whose voices are being included, whose excluded – or how far small groups of elites may actually control these. We know little about the extent to which individuals and groups may be captured in the name of participation and greater democracy. More questions are being raised as to the huge costs of consultation and participation processes in time and travel alone, and their relationship with greater efficiency or better decisions or policies. Consultations risk becoming synonymous with a mandate, without greater interrogation of the effect and meaning of such processes.

One framework for analysing actor power in this context is provided by the work of Pierre Bourdieu whose theory of different capitals deepens our understanding of power beyond immediate economic assets. Bourdieu suggests that power originates from a multiplicity of sources. He recognises *cultural capital* derived from education, academic titles, epistemic knowledge and recognised experience as one source of power. This helps to explain the claim to moral authority by the examples suggested by Shiffman – the IHME and *The Lancet* – as well as the position of WHO. Yet much of their power is enabled or reliant on the *economic capital* of funders such as the Gates Foundation, who in turn rely on academic institutions to transform their *economic capital* into *cultural capital* in the form of scientific evidence. *Economic capital* thus may influence the type of *cultural capital* by determining the type of research undertaken, the sort of evidence that is well-regarded, how the evidence is presented and advocated. Relationships between research institutions and funders may thus influence what evidence-based research is translated into policy solutions. *Social capital,* in Bourdieu's framework denominates the links and connections between networks of organisations and individuals, and how these links facilitate access to different types of capital. By exploring more thoroughly actors' social capital, we will understand better how legitimacy is established between actors and organisations, derived from procedural claims of consultation and participation. Connection to a wide range of organisations or a large number of individuals within a policy process increases social capital, and raises moral claims. The last of Bourdieu's capitals – *symbolic capital* – is perhaps the most elusive and context specific of the four types of power, but the claim that WHO was 'the world's conscience' (12) is characteristic of this sort of power. WHO's guidelines and policy directives are based on cultural, social but also symbolic power – they have no legal status in Member States, who, nevertheless, will often use them to create national legislation or policy in turn.

Bourdieu's capitals provide just one instrument to help health analysts understand who has power and why, and how it is exercised in global health. Other approaches and frameworks also encourage insights into these complex questions. We support Shiffman's call for more transparency and greater interrogation of knowledge, moral claims and the exercise of power in global health. We need to explore much more fully where power lies in global health, and how it is exercised in order to understand underlying health agendas and claims to

legitimacy made by global health actors today.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

Both authors discussed the main points of response and structure, and JH wrote the first draft to which GW contributed.

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