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Global Health as a Field of Power Relations: A Response to Recent Commentaries

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Abstract

Actors working in global health often portray it as an enterprise grounded in principled concerns, advanced by individuals and organizations who draw on scientific evidence to pursue health equity. This portrait is incomplete. It is also a field of power relations—a social arena in which actors claim and draw on expertise and moral authority to gain influence and pursue career, organizational and national interests. A clear understanding of how power operates in this field is necessary to ensure that it is used productively to serve the aims of health equity and improved population health. Responding to commentaries on an editorial published in this journal, I offer 3 ideas toward this end: (1) be skeptical of the global health rationality project—the effort to rescue the field from the alleged indignities of politics through the application of scientific methods; (2) analyze global health as a field of power relations, a concept developed by sociologist Pierre Bourdieu; and (3) elevate the place of input legitimacy—inclusive deliberation, fair process and transparency—to address legitimacy and knowledge deficits in this field.

Keywords: Global Health, Politics of Health, Field Theory, Legitimacy

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Introduction

In an editorial published in this journal[1], I argued that actors in global health exert influence by conveying expertise and asserting moral authority, 2 forms of power (epistemic and normative) less commonly recognized than other forms such as control over financial resources. I contended that we should not assume these forms of power are legitimate, but rather consider the circumstances under which they are justly derived. The editorial prompted 9 thoughtful commentaries, 8 in this journal[2-9] and 1 in *the Lancet* by that journal's editor.[10] The ideas in these commentaries are too rich and numerous to address thoroughly in one short response. I will instead attempt to draw and build on the commentators' insights to make three points concerning the exercise of power in global health.

The Global Health Rationality Project Is Illusory

The first point is that it is not possible to factor out power from the global health field as a means of ensuring the objectivity of decision-making. This effort is akin to what Deborah Stone (cited by Fischer), referring to the field of policy analysis, has termed *the rationality project*—"the common mission of rescuing public policy from the irrationalities and indignities of politics" through the use of "rational, analytical and scientific methods."[11,12] While scientific evidence is essential, the expectation that the use of scientific methods might remove power from the field—what might be termed a global health rationality project—is illusory. There are several reasons. First, as Kelley Lee observes, "global health is shot through with power relationships,"[7] a point also emphasized by Garrett Wallace Brown[2] who notes that, "power is something that cannot be erased from the equation altogether and the exercise of power itself is not always necessarily a bad thing." Power struggles are inextricably part of nearly all of the field's basic concerns, including reforming global health governance, addressing health's social determinants, and fighting industries whose products cause illness and death. Second, scientific methods alone cannot resolve fundamental questions in global health, such as what health equity means and how health resources should be allocated. These are normative questions; deriving answers inevitably involves social and political deliberation.

Global Health Is a Field of Power Relations

The second point is that global health is usefully understood as a *field*, a concept developed by sociologist Pierre Bourdieu. A field, such as the arts, law and medicine, is a social arena structured by specific rules and a central stake, and populated by actors who share similar dispositions but hold unequal positions. Actors deploy various forms of capital to advance their preferences and interests, and to get ahead in the field.[13,14] Many observers and participants portray global health as an arena of principled action populated by actors driven by normative concerns.[15,16] It is certainly that in part: individuals and organizations, among other aims, seek to reduce disease prevalence, address health inequities and promote global solidarity. But it is not just that. Actors also seek, among other goals: to gain global recognition as experts and humanitarians; to secure organizational leadership; to obtain job security; to acquire resources and prestige for their institutions; to

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advance national interests; and to profit financially. Often, we ascribe these motivations to our rivals and public-spirited aspirations to ourselves. But the reality is more complex, and viewing global health as a field directs us to pay attention to the power dynamics and nonnormative interests that also shape activity in this social arena.

Core to Bourdieu's theory of fields are four forms of capital,[17] which Johanna Hanefeld and Gill Walt[6] usefully describe and suggest are essential to understanding global health power dynamics. Cultural capital—noneconomic assets including education credentials and style of speech—and social capital—networks of connections—are crucial. And as Ruth Levine[8] also notes, these forms of capital are intertwined with another form—financial, or command over economic resources. The fourth form of capital—symbolic—is the least well-defined, but Peillon[18] suggests it can be understood roughly as legitimacy—the form capital takes when it is perceived as justly held. Many public struggles in global health concern who is right about what works for improving population health, and whose ethical principles are most valid for grounding decision-making and practice. Global health actors draw on the four forms of capital in order to position themselves favorably in these struggles, as a means both of advancing ideas they hold to be valid, and securing power for themselves.

Other commentators offer additional ideas valuable for understanding global health as a field. Eivind Engebretsen and Kristin Heggen[4] draw on Foucauldian concepts to suggest we need to be careful about how we use language, since it is a source of power that structures and limits the way we view the world, often unconsciously. For instance, noting the term commonly employed to describe the field, *global* health, they point to the fact that, "To name an idea as global is to attribute universal legitimacy to the idea…an imperialistic act because it excludes diversity and local differences." And Simon Rushton[9] calls for global health actors to engage in self-reflection—attention to their own positionality. He means this to apply not only to those widely understood to wield power in the field (such as the heads of the Gates Foundation, World Health Organization [WHO] and World Bank) but also scholars and nongovernmental organization (NGO) activists from high- and low-income countries in a position to criticize the field, including we who make these comments. In his commentary, *Lancet* editor Richard Horton[10] concurs and demonstrates attention to positionality, writing, "How those invested with the power to make decisions are selected and rewarded should all be a much greater subject of scrutiny. Including the (modest) contribution of medical journals."

To Address a Global Health Legitimacy and Knowledge Deficit, Elevate Inclusive Deliberation

The third point is that good intentions and effectiveness are insufficient grounds for considering an actor or decision legitimate. Inputs—inclusive deliberation, fair process and transparency—are equally crucial.[19] Democratic theorists distinguish between input and output legitimacy,[20] and most consider the right to exert power to depend on both.[21] This point merits emphasis since discussion in global health governance reform emphasizes performance more so than participation and transparency. Insufficient attention to input legitimacy is likely due in part to an erroneous belief held by many global health actors that expertise and moral authority in this field are concentrated among educated elites, and that their intended beneficiaries have little knowledge or capacity to analyze their own realities.[22]

All the commentators express concern about the quality of input legitimacy in global health. Jesse Bump[3] makes the point forcefully, arguing that, "legitimacy in the exercise of power comes from the consent of those subject to it," and expressing concern that, "a review of institutions and processes [in global health] suggests that this participation is limited or absent." Karen Grépin[5] argues that, "the real challenges in global health are due to the types of power imbalances that can sustain a world in which life expectancies at birth in some countries is less than half what it is in others." Brown[2] argues that, "legitimacy requires…acceptable political processes." Rushton[9] notes the, "fundamental importance of democratizing decision-making." Levine[8] asks, "Is it healthy for global health to be so strongly influenced by organizations, including funders, that are outside of any intergovernmental framework and not subject to public accountability?" Hanefeld and Walt[6] question whether consultative processes in global health are truly participatory. And Lee[7] insists that, "power must be continually revealed, managed and adjusted."

Conclusion

The 9 commentators eloquently and from different angles reveal the pervasiveness of power and a deficit of legitimacy in the global health field. Drawing on their analyses, I argue that we might better understand the exercise of power in global health and discover ways to address the legitimacy deficit by questioning any overarching global health rationality project, considering global health as a field of power relations, and elevating the place of input legitimacy. We need a productive discussion on the exercise of power in global health, including its more subtle and less commonly acknowledged epistemic and normative forms. The discussion should not wish power out of existence but rather examine how it works in practice, with a view to specifying more clearly what constitutes its legitimate use, how to ensure those who wield it are held accountable, and how best to leverage it to achieve common aims surrounding equity and improved population health.

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Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

JS is the single author of the manuscript.

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