http://ijhpm.com
Int J Health Policy Manag 2014, 3(3), 149–150

doi 10.15171/ijhpm.2014.75

IJHPM
International Journal of Health Policy and Management

Commentary

Democracy – the real 'ghost' in the machine of global health policy

Comment on "A ghost in the machine? politics in global health policy"

Andrew Harmer*

Abstract

Politics is not the ghost in the machine of global health policy. Conceptually, it makes little sense to argue otherwise, while history is replete with examples of individuals and movements engaging politically in global health policy. Were one looking for ghosts, a more likely candidate would be democracy, which is currently under attack by a new global health technocracy. Civil society movements offer an opportunity to breathe life into a vital, but dying, political component of global health policy.

Keywords: Democracy, Partnerships, Civil Society

Citation: Harmer A. Democracy – the real 'ghost' in the machine of global health policy; Comment on "A ghost in the machine? politics in global health policy". *Int J Health Policy Manag* 2014; 3: 149–150. doi: 10.15171/ijhpm.2014.75

Article History:
Received: 6 August 2014
Accepted: 22 August 2014
ePublished: 24 August 2014

***Correspondence to:**
Andrew Harmer
Email: andrew.harmer@ed.ac.uk

Is politics the 'ghost in the machine' of policy, ask Bruen and Brugha in a recent Editorial for this journal (1). The answer must surely be no. If politics were the 'ghost' and policy the 'machine', how could they "causally interact" as the authors say they do? Gilbert Ryle asked much the same question in his critique of Cartesian dualism, accusing Descartes of that most heinous of philosophical crimes—the category mistake (2). For Ryle, there was no dualism: body and mind were essentially the same category of analysis. The same is true for politics and policy—they are from the same categorical 'stock' rather than distinct entities. In this respect, the authors are reiterating a contention that has echoed down through the decades, that politics and policy are synonymous (3). To research health policy is to research politics, and that will require an understanding of influence and power: who influences policy, how is that influence exercised, and under what conditions? (4)

This will come as no surprise to public health activists, who have long understood the intimate relationship between politics and policy. As if to make the point, Bruen and Brugha begin their analysis with an ongoing international health governance issue that has excited much political activism, namely reform—or rather clarification—of relations between the World Health Organization (WHO) and non-state actors. WHO Director General Margaret Chan's assurance that Public Interest and Business Interest NGOs (PINGOs and BINGOs) will be regarded as distinct entities has mollified some civil society global health movements, if not all (5,6). But Milton Friedman reminds us why this is unlikely to remain anything but a temporary cease fire: "*asking a corporation to be socially responsible makes no more sense than asking a building to be*" (7). Those who are cognizant of the limits of transnational corporations to socially interact are likely to resist efforts by the WHO to participate in consensus-building dialogue with corporate 'partners' (8).

The South Africa access to essential medicines *cause célèbre* is another well-documented example of politics in health policy. The campaign received international attention in 2001 when the South African Treatment Action Campaign (TAC) successfully sued the South African government for violating its constitutional guarantee of access to healthcare services, specifically by failing to provide Nevirapine-based Prevention of Mother to Child Transmission of HIV (PMTCT) (9,10). In a separate case, TAC was also instrumental in resisting efforts by the United States' pharmaceutical industry to pressure the South African government not to amend its Medicines Act to allow for the issuing of compulsory licences and permit parallel imports of pharmaceuticals. While TAC and Doctors without Borders ran a concerted campaign of resistance against the US Pharmaceutical Manufacturers Association (PhRMA), behind the scenes William Clinton and Albert Gore were lending their support in order to secure 2 million US dollars worth of campaign funding (11). Ultimately, the reason why South African women were able to access cheap Anti-Retroviral drugs (ARVs) was because two United States Democratic Party candidates decided it would enhance their chances of electoral victory if they withdrew their support for PhRMA's legal action against the South African government. Given the evident symbiosis between politics and health policy, one cannot help but wonder whether Bruen and Brugha's principal enquiry has something of the 'straw man' about it: does anyone actually treat "politics… as distinct from policy"? The authors cite past Global Fund Executive Director Richard Feachem—"no cautious political operator"—as someone quick to describe the Fund as "apolitical" (1). Of course, Feachem is being disingenuous. As Bruen and Brugha recount, the birth of the Global Fund involved an intense period of political 'horse-trading' amongst governments and international political institutions.

Missing from the authors' account, however, is a sense of the options available to global policy-makers at the time, and thus an appreciation of which ideas were ultimately rejected. One particularly significant fault line fell between supporters of selective global health provision (i.e. supporters of a Global

Global Public Health Unit, University of Edinburgh, Scotland, UK

Fund for a selected number of infectious diseases) and supporters of a more comprehensive approach. The WHO had initially proposed a broad initiative focused on diseases of poverty, but that was quickly narrowed to a set of specific diseases. A fund with the broadest mandate—a global fund for health—was favoured by the United Kingdom, Italy, and Sweden but failed to gain wider support. But good ideas die hard, and, in recognition of both the underlying social determinants of global ill-health and the profound epidemiological transition from communicable to non-communicable diseases, there have been concerted efforts in recent years to breathe new life into the idea of a Global Fund for Health broadly defined (12).

The evident glee displayed by Feachem describing the freedom of the Global Fund to make "principled and technical decisions" unencumbered by that most-annoying of political creations—the *demos*—is a 21st Century reminder of a highly technocratic, but limited, view of democracy that has its roots in the competitive elitism of Weber and Schumpeter (13). Both Weber and Schumpeter shared "a conception of political life in which there was little scope for democratic participation and individual or collective development, and where whatever scope existed was subject to the threat of constant erosion by powerful social forces" (13). Adopting Weber and Schumpeter's descriptive methodology, we might equally describe the current system of global health governance as one where democratic participation is under threat by unaccountable but increasingly powerful social forces.

The WHO—perhaps the *only* global health institution that still retains the vestige of democracy—is presented as the bloated corpse of a new global health architecture. It is perceived as a tar pit for innovation and entrepreneurial spirit where, as Bruen and Brugha observe, 'good ideas go to die'. The organisation is being outmanoeuvred at every turn by a fleet of nimble, "apolitical", global health partnerships, such as the Global Fund and the GAVI Alliance. Meanwhile, the most powerful social (yet politically unaccountable) force in global health—Philanthropic Foundations—provide seed funding for these partnerships, and are major financers of the WHO. At least thirty eight foundations provided 18% of WHO's voluntary funding in 2011–12, with just one foundation, the Bill and Melinda Gates Foundation donating most of that—approximately 446 million US dollars (14,15). That is more than any other donor except the United States and twenty four times more money than the BRICS (Brazil, Russia, India, China, and South Africa) economies combined. Voluntary contributions to the WHO are "specified", meaning that they can only be spent on the specific health issues or priorities of the contributor, limiting the scope for WHO to respond effectively to global health emergencies.

Bruen and Brugha are right: the political *is* an enduring feature of global health policy, and thus of policy analysis. But should researchers limit their activities to analysis and generating evidence, as the authors suggest, or is there scope for a broader, and more active, engagement in politics? For example, Anthony Costello has recently called on health workers to "*shout from the rooftops*" the message that climate change is a health problem (16). A desperate measure perhaps, but one that suggests mainstream channels of communication are becoming ineffective. Civil society movements such as the Peoples Health Movement are actively working to provide a new politics of global health that is more active, more direct, than the 'apolitical' 21st Century global health architecture currently being constructed. Democracy, not politics, is the real 'ghost' in the machine, but through civil society movements, it may be possible to counter concerted efforts by elite technocrats to de-democratise global health policy.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

AH is the single author of the manuscript.

References

1. Bruen C, Brugha R. A Ghost in the Machine? Politics in Global Health Policy. *Int J Health Policy Manag* 2014; 3: 1–4. doi: 10.15171/ijhpm.2014.59
2. Ryle G. *The Concept of Mind*. 1st edition. Chicago: Hutchinson; 1949.
3. Walt G. *Health Policy: An Introduction to Process and Power*. Johannesburg: Zed Books: 1996.
4. Buse K, Walt G, Mays N. *Making Health Policy*. 2nd edition. Maidenhead: Open University Press; 2012.
5. MMI 2014 Statement by Medicus Mundi International to the 67th session of the World Health Assembly on agenda item 11.3, Non State Actors [internet]. Available from: http://www.medicusmundi.org/en/topics/pnfp-sector-and-global-health-initiatives/who-reform/mmi.pdf
6. IBFAN 2014 Statement by the International Baby Food Action Network to the 67th session of the World Health Assembly on agenda item 11.3, Non State Actors [internet]. http://www.medicusmundi.org/en/topics/pnfp-sector-and-global-health-initiatives/who-reform/ibfan.pdf
7. Birn AE. Making it Politic(al): closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. *Social Medicine* 2009; 4: 166–82.
8. Richter J. WHO Reform and Public Interest Safeguards: An Historical Perspective. *Social Medicine* 2012; 6: 141–50.
9. Berger JM, Kapczynski A. *The Story of the TAC Case: The Potential and Limits of Socio-Economic Rights Litigation in South Africa (SSRN Scholarly Paper No. ID 1323522)*. Rochester, NY: Social Science Research Network, ; 2009.
10. Gray DM. Fire in the Blood, Directed by Dylan Mohan Gray. Dartmouth Films and Films Transit; 2014.
11. Ostergard RL. The Political Economy of the South Africa–United States Patent Dispute. *J World Intellect Prop* 2005; 2: 875–88. doi: 10.1111/j.1747-1796.1999.tb00097.x
12. Cometto G, Ooms G, Starrs A, Zeitz P. Towards a global fund for the health MDGs? *Lancet* 2009; 374: 1146. doi: 10.1016/S0140-6736(09)61740-2
13. Held D. *Models of Democracy*. 2nd Edition. Cambridge: Polity Press, Blackwell Publishers; 1996.
14. Feig C. Setting the Record Straight on WHO Funding [internet]. *Foreign Affairs*, 2011 November 18. Available from: http://www.foreignaffairs.com/articles/136687/christy-feig-and-sonia-shah/setting-the-record-straight-on-who-funding
15. Harmer A. Who's funding WHO? [internet]. 2012. Available from: http://www.globalhealthpolicy.net/?p=826
16. Costello A, Montgomery H, Watts N. Climate change: the challenge for healthcare professionals. *BMJ* 2013; 347: f6060. doi:10.1136/bmj.f6060