
Transnational Governance and Democratic Legitimacy

The Case of Global Health

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1. Introduction

The democratic legitimacy of transnational arrangements for global health is contested. The traditional United Nations' body for health, the World Health Organization (WHO), is subject to severe criticism regarding its focus, effectiveness, and independence from country specific, and private sector interests. It is confronted by budget cuts and a fundamental reorganization. Other major actors, such as the Global Alliance for Vaccines and Immunization (GAVI), Global Fund and the Bill and Melinda Gates Foundation (hereafter The Gates), make significant contributions to international health projects,¹ but they can be criticized for not being representative and accountable. The global health landscape in general has become an intransparent patchwork of organizations and interests, where objectives of public health, development, economy, security, and foreign policy dominate to various degrees, and sometimes clash. This paper discusses the principal arrangements for transnational governance in the area of global health, and analyses their democratic legitimacy using five different prisms: (1) representation; (2) accountability; (3) transparency; (4) effectiveness; and (5) deliberation.

Transnational governance is a catch-all concept that includes multiple forms of institutional innovation, and often informal ways to address transnational problems and challenges.² The concept illustrates the increased recognition that thinking and action on global issues extends beyond the traditional UN-based multilateral system of one nation, one vote. It is a recognition of states no longer being able to tackle international problems effectively (on their own). They require solutions in which relevant stakeholders, such as the private sector and non-governmental organizations (NGOs), are not only involved in deliberations, but also take up commitments and responsibilities. They are involved in both policy implementation and policy shaping. The question is how this relates to the democratic legitimacy of international efforts.

In the field of global health, the WHO is under siege on account of its spending having decreased, and its credibility is disputed by suggestions about the pharmaceutical industry having infiltrated the organization. Public-private partnerships, such as the Global Fund and GAVI, undermine its authority, and the

¹ See for an overview: Nirmala Ravishankar, Paul Gubbins, Rebecca J. Cooley, Katherine Leach-Kennon, Catherine M. Michaud, Dean T. Jamison, and Christopher J.L. Murray, "Financing of Global Health: Tracking Development Assistance For Health From 1990 to 2007", *The Lancet*, vol. 373, no. 9681 (June 2009). See also Declan Butler, "Revamp For WHO", *Nature*, vol. 473 (May 2011).

² Peter van Ham, "Transnational Governance and Democratic Legitimacy – A Conceptual Overview", The Hague Institute for Global Justice and the Netherlands Institute of International Relations "Clingendael", 2014.

World Bank, the G20, and the Organization for Economic Co-operation and Development (OECD), increasingly encroach upon its remit. Donors increasingly prefer to channel their funds through the new transnational governance structures, since they can more easily control them.³ They are also preferred by those advocating a more “neo-liberal” approach, based on lending facilities and innovative financing,⁴ as opposed to a more “interventionist” approach, focused on international norm-setting, public health regulation, and scaling up development assistance for health.⁵ Another difference is their focus on combating specific diseases, or groups of diseases, rather than improving the quantity and quality of health systems generally. The rise of multiple new actors in the global health system poses questions about the roles various organizations should play, the rules by which they should play, and who should set those rules.⁶

At the same time, the treaty-making function of WHO has been reinvigorated with the revision of the International Health Regulations (IHR) for infectious diseases, the Framework Convention on Tobacco Control (FCTC), and the Pandemic Influenza Preparedness (PIP) framework. These multilateral processes and debates, on for instance the relationship between intellectual property rights and research into diseases disproportionately affecting the poor,⁷ have proved cumbersome, and evoked a debate on how to incorporate legitimate interests of non-state actors in these processes. It is likely that, in the near future, pressure will mount for new international standards to address factors contributing to non-communicable diseases linked to inter alia the “obesity pandemic”. This could mean the launching of a new era of measures to promote increased regulation and taxation of unhealthy consumption (levels) of processed food and alcohol. Newer issues, such as the interlinkages between animal, human, and ecological health, demand increased international standard-setting as well, something which transnational governance arrangements that are not able to offer “hard law” solutions cannot offer. The question is whether the WHO still is considered the strong, reliable, and credible organization that has the constitutional mandate to negotiate such solutions for global health problems.

³ Devi Sridhar, “Who Sets the Global Health Research Agenda? The Challenge of Multi-Bi Financing”, *PLoS Medicine*, vol. 9, no. 9 (2010).

⁴ Mark Dybul, Peter Piot, and Julio Frenk, “Reshaping Global Health”, *Policy Review*, vol. 173, (July 2012), p. 3.

⁵ Lawrence O. Gostin, Eric A. Friedman, Gorik Ooms, Thomas Gebauer, Narendra Gupta, Devi Sridhar, Wang Chenguang, John-Arne Røttingen and David Sanders, “The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities For Health”, *PLoS Medicine*, vol. 8, no. 5 (May 2010).

⁶ Nicole A. Szelzák, Barry R. Bloom, Dean T. Jamisonm, Gerald T. Keusch, Catherine M. Michael, Suerie Moon and William C. Clark, “The Global Health System: Actors, Norms, and Expectations in Transition”, *PLoS Medicine*, vol. 7, no. 1 (January 2010).

⁷ John-Arne Røttingen and Claudia Chamas, “A New Deal For Global Health R&D? The Recommendations of the Consultative Expert Working Group on Research and Development”, *PLoS Medicine*, vol. 9, no. 5 (May 2012).

This paper seeks to identify which governance mechanisms can deal most effectively with global health challenges, and their level of legitimacy. It will specifically look at the ongoing debate on the WHO reform, and what this tells us about the legitimacy of this traditional UN body in contrast to new forms of transnational governance. With regard to transnational governance arrangements in the field of global health, a selection of key players is made: the World Health Organization,⁸ Global Fund, the GAVI Alliance, and the Gates Foundation. While the first is part of the UN family, the latter three are not, but they are nevertheless considerable funders of international health programs. They are public-private partnerships (Global Fund & GAVI), or completely private (The Gates). This allows us to make a comparison of their legitimacy, and to look at their interlinkages and contextual determinants in relation to this concept. We have chosen to examine these four institutions, as they have been at the center of the changing global health landscape over the last decade, with the understanding that this selection does not provide a full picture of the complex global health landscape. In terms of expenditure, the World Health Organization spent (or envisaged to spend) 2,000 million US dollars in 2012, whereas the Global Fund spent 3,475, the GAVI Alliance 934, and The Gates 1,485 million. Other big international funders were the World Bank, UNICEF, Doctors Without Borders, Oxfam International, and the Wellcome Trust.⁹

2. WHO: Organization Under Siege

For a number of years, the WHO has been subject to severe debate on reforming the organization and the way it currently functions, which is closely linked to financial constraints imposed by a freeze of the assessed contributions of WHO member states since the mid-1980s. An important aspect in the most recent debates on the WHO is that its legitimacy would be undermined by: 1) inadequate finances and a lack of transparency and accountability towards the member states; 2) unjustified private sector interest influence; 3) ineffectiveness due to its intergovernmental character and regional structure; 4) a lack of clear organizational priorities; 5) inadequate civil society involvement; and 6) other international actors becoming increasingly active in the field of global health.¹⁰ The organization would no longer be able to act as the directing and coordinating authority on international health work for global health, as described in article 2 of its constitution.¹¹

2.1 Inadequate Finances and a Lack of Transparency and Accountability

⁸ Including its partnerships, sub-entities and treaties negotiated within its remit, such as the Stop Tuberculosis Partnership (Stop TB), UNITAID, Global Outbreak & Response Network (GOARN), FCTC and IHR.

⁹ Julio Frenk and Suerie Moon, "Governance Challenges in Global Health", *The New England Journal of Medicine*, vol. 368, no. 10 (March 2013).

¹⁰ Charles Clift, "The Role of the World Health Organization in the International System", *Chatham House Centre on Global Health Security* (February 2013); GAO, "World Health Organization: Reform Agenda Developed, But U.S. Actions to Monitor Progress Could be Enhanced", *United States Government Accountability Office Report* (July 2012).

¹¹ Constitution of the World Health Organization, July 22, 1948.

Several sources indicate the financial troubles the WHO finds itself confronted with. In its WHO-strategy, Sweden argues that the WHO's legitimacy is undermined by accountability issues regarding the allocation of resources.¹² Budget control was found to be weak, and operations only partly governed by decisions of the WHO's official governing bodies – the World Health Assembly (WHA) and Executive Board (EB). Financers of voluntary contributions would form a parallel governance mechanism. This is in stark contrast with the 1970s, when the UN had a more prominent stance on poverty eradication and social justice, which for the WHO culminated in the landmark Alma Ata declaration on Primary Health care. The WHO was then largely financed by contributions provided by its members, assessed according to their population numbers and GDP, the so-called assessed contributions.

The trend towards more multilateral public policies regulating the role of the different and diverging interests on the health agenda was undermined in two ways. In response to the perceived politicization of the UN organizations, in 1984, the Geneva Group (comprising the eleven major donors of the UN agencies, including the US and several European states) set out to restrict the growth of international agency budgets, such as that of the WHO, to zero in real terms. A major factor in this was US opposition to the WHO's essential drugs policy, and the code for the marketing of breast milk substitutes in 1982.¹³

Secondly, the World Bank (WB), with its macroeconomic and neo-liberal culture, and the establishment of a Population, Health, and Nutrition department in 1979, completely changed the landscape of global health in the 1980s. In one decade, the WB, whose governance structures are mainly dominated by wealthy OECD countries, was lending a multiple of the WHO's annual budget to the health sector in lower income countries. The WB's intrusion into the health domain has been the most sophisticated and structural response to the WHO's position, particularly with respect to its endeavor to promote "Health for All".¹⁴

This has led to a current situation in which the WHO relies on the voluntary contributions of Member States, and the sponsors of the WHO largely determine the organization's priorities through funding tied to specific projects or programs. Voluntary contributions now make up most of the organization's budget, and most of these funds are earmarked. Nearly half of it is said to come from non-state donors. Upon closer inspection, only a very limited amount is paid directly by the industry (-supported foundations), while most of it is coming from private philanthropic

¹² Swedish Ministry of Health and Social Affairs, *Sweden's Strategy For WHO 2011-2015* (February 2011).

¹³ David Legge, "Future of WHO Hangs in the Balance", *British Medical Journal*, vol. 345 (October 2012).

¹⁴ Remco van de Pas and Louise van Schaik, "Democratizing the World Health Organization", *Public Health*, vol. 128, No. 2 (February 2014), pp. 195-201.

foundations – such as The Gates, Rockefeller, and Bloomberg –, and other international organizations, such as UNICEF and UNDP.¹⁵

Member States of the WHO approve multi-annual and bi-annual budgets, but these budgets are not the final guidance on the allocation of funds. One reason is that a large part of the money still needs to be raised during the budget time, another one is the WHO not being accustomed to provide transparency on how it has eventually spent its budget.¹⁶ A proper evaluation of programs hardly ever takes place, resulting in a lack of insight on whether resources are spent effectively and efficiently. For member states, which use taxpayers' money to fund the organization, this is hardly satisfactory, and therefore they demand a greater degree of transparency and accountability in an ongoing effort to reform the WHO.¹⁷

Some measures were decided upon to improve the accountability and evaluation functions of the WHO, such as a strengthening of the Program, Budget and Administration Committee (PBAC). Another important reform has been the establishment (in 2013) of new financing mechanisms, a so called finance dialogue, in which the World Health Assembly approves the entire bi-annual budget (the combination of assessed and voluntary contributions). Afterwards, in a WHO facilitated pledging conference, countries come together with non-state donors to agree in a transparent way on funding the complete program.¹⁸

These measures may improve the situation, yet fail to solve the inherent legitimacy problem of the WHO that consists of it being governed and considered as a traditional intergovernmental body, whereas it spends much of its time serving non-state actors and a small selection of states which pay for its activities. Its state-based membership may complain about this, but as long as they are unable to step up their own financial contributions and are unwilling to see a halving of the organization's activities by disallowing it to accept external funding, they cannot do much about it. Moreover, even if they strengthen their grip on the WHO, still many international health activities, i.e. those of other organizations, are left unattained, considering the WHO is currently not directing and steering them.

2.2 Unjustified Private Sector Influence

The WHO relies on its intergovernmental nature to justify its credibility as a public health interest defender for a number of its tasks, including norm-setting, surveillance, and providing independent technical advice. It is the most universal, and thus

¹⁵ World Health Organization, *Voluntary Contributions By Fund and By Contributor For the Year Ended 31 December 2012, Annex 66th World Health Assembly*. A66/29 Add. 1 (April 2013).

¹⁶ Charles Clift, "What's the World Health Organization For?, Final Report from the Centre on Global Health Security Working Group on Health Governance", *Chatham House Report* (2014).

¹⁷ Department for International Development, "Assessment of the WHO Multilateral Aid Review Ensuring Maximum Value For Money For UK Aid Through Multilateral Organizations", *Multilateral Aid Review Assessment Summaries* (March 2011), p. 206; "Institutional report World Health Organization (WHO)", *Multilateral Organisation Performance Assessment Network (MOPAN)* (2013).

¹⁸ World Health Organization, *Financing of the WHO*, 66th World Health Assembly, A66/48, (May 2013).

representative, organization for health, if equality of states is taken as a way to measure representativeness, and its legitimacy is to a large extent based on its worldwide membership of states. However, its intergovernmental character contrasts with calls for an increased involvement of private sector actors to strengthen its effectiveness. A debate on public-private cooperation dates back to the time when Gro Harlem Brundtland was the Director General of the WHO. In 1997, the newly elected UN Secretary-General Kofi Annan advocated strengthening ties with the business community as a particular focus of his UN reform proposal. He launched the Global Compact initiative as the flagship of this trend at the 1999 World Economic Forum in Davos. Although the WHO never formally joined the Global Compact, it developed closer ties with the private sector via the creation of a number of partnerships, such as the Roll Back Malaria initiative and collaboration with pharmaceuticals under the Special Program for Research and Training in Tropical Diseases (TDR). Dr. Brundtland justified the restructuring of the global health arena at the 2002 World Health Assembly with the claim that there was no way to solve “complex health problems” except through these new partnerships. She asserted that “whether we like it or not, we are dependent on our partners ... to achieve health for all.”¹⁹

Ever since, concerns about the allegedly unjustified involvement of private sector actors in the WHO’s activities have been expressed. For instance, according to a critical report of the Council of Europe’s Parliamentary Assembly, the WHO’s impartiality during the H1N1 (“Mexican flu”) pandemic of 2009-2010 can be put into question.²⁰ The report considers that the WHO has overrated the seriousness of the pandemic, and relates this to pharmaceutical industry interests, which may have influenced its decision-making. The WHO was found to be non-transparent pertaining to possible conflict of interests of participants of important committees advising the WHO on the severity of the pandemic (and its definition), and the use of medicines and vaccines to combat it. For similar reasons, Indonesia, in 2007, refused to share samples of the H5N1 virus with the WHO before obtaining the guarantee that once they were shared with pharmaceutical producers, these would also make the resulting medicine available at a reasonable cost.²¹

Recently, a new debate has emerged in respect of the WHO being susceptible to interests of producers of alcoholic drinks, and unhealthy processed foods and beverages. After the establishment of the Framework Convention on Tobacco Control (FCTC), contacts with tobacco producers are strictly forbidden for WHO staff, but they are still on speaking terms with the alcohol industry and producers of unhealthy processed food and beverages. In February 2013, a group of worried scientists and experts issued a *Statement of Concern* on the increasing involvement of the alcohol

¹⁹ Judith Richter, “WHO Reform and Public Interest Safeguards: An Historical Perspective”, *Social Medicine*, vol. 6, no. 3 (March 2012).

²⁰ Council of Europe, *The Handling of the H1N1 Pandemic: More Transparency Needed*, Report of the Parliamentary Assembly of the Council of Europe (June 2010).

²¹ Adam Kamradt-Scott and Kelly Lee, “Global Health Security Interrupted: The World Health Organization, Indonesia and H5N1”, *Political Studies* (forthcoming).

industry in public health activities.²² The statement was addressed to the WHO as a reaction to a declaration of industry on the *WHO's Global Strategy to Reduce the Harmful Use of Alcohol*. According to the group, industry efforts compromise the work of the WHO. They call for stronger conflict of interest policies to avoid partnerships with producers of beer, wine, and spirits, their “social aspects” organizations, and other groups funded by the commercial alcohol industry.

An influential article in *the Lancet* moreover illustrated how companies, such as PepsiCo, Kraft, and SAB Miller seek to avoid regulation by funding research – directly or through associated organizations (i.e. the “social aspects” organizations) –, advanced media strategies, and lobbying governments and the WHO.²³ According to these researchers, their strategies are similar to the ones used by the tobacco industry before they were banned. The sugar industry, for instance, would have threatened the WHO to lobby for the US to completely withdraw its funding, because of the *WHO strategy on diet, physical activity, and health* highlighting a strong link between sugar and obesity. They argue that it would now be time to put an end to the illusion of industry self-regulation, and consider stronger measures.

The legitimacy of the WHO as a public health organization has thus been oppugned owing to the allegations regarding industry interests influencing the policies of the organization. Even according to a report by the US Government Accountability Office,²⁴ the WHO's policies on conflict of interest and information disclosure are insufficient to deal with the growing complexities of global health. This is despite the US and others, such as Japan, Canada, Switzerland, Norway, and EU countries, being relatively open to higher degrees of cooperation between the WHO and private sector.²⁵ To address the concerns over unjustified private sector influence, the WHO presented a document on the relationship with private commercial entities to the Executive Board in May 2013 as part of the ongoing reform of the organization.²⁶ The ensuing debate evolved over whether or not to distinguish between the different non-state actors collaborating with the WHO, which would imply different policies for nonprofit NGOs and commercial organizations. Most Western countries prefer not to distinguish, whereas the majority of countries from other regions do so prefer. The

²² Global Alcohol Policy Alliance, *Statement of Concern: The International Public Health Community Responds to the Global Alcohol Producers' Attempt to Implement the WHO Global Strategy on the Harmful Use of Alcohol* (October 2012).

²³ Rob Moodie, David Stuckler, Carlos Monteiro, Nick Sheron, Bruce Neal, Thaksaphon Thamarangsi, Paul Lincoln and Sally Casswell, “Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries”, *The Lancet* (February 2013). Internet: <http://people.ds.cam.ac.uk/ds450/details/LancetProfits.pdf>.

²⁴ GAO (2012); *Ibid*.

²⁵ Louise G. van Schaik and Samantha Battams, “The EU's Role in Creating a More Effective WHO”, in Edith Drieskens and Louise G. van Schaik (eds.), *The EU and Effective Multilateralism: Internal and External Reform Practices* (London and New York: Routledge, (forthcoming).

²⁶ World Health Organization, *WHO Governance Reform*, 133rd Executive Board Meeting (May 2013).

debate will be continued at a next board meeting, while in the meantime the secretariat will consult with member states, NGOs, and the private sector.²⁷

2.3 WHO's Effectiveness Undermined By Its Intergovernmental Character and Regional Structure

The WHO is the only inclusive organization for global health with universal membership.²⁸ Its effectiveness is inherently hampered by the fact that all 194 Members have blocking power. For the vast majority of activities, and for accomplishing joint objectives set in treaties and resolutions agreed upon at the World Health Assembly, the organization, just like other international organizations, has to rely on their proper and adequate implementation. Only in case of a reasoned suspicion of a country not acting adequately in response to a (possible) outbreak of a dangerous and infectious disease, some weak mechanism has been agreed upon to send in international observers to monitor and report on the situation (in the context of the International Health Regulations). Both the International Health Regulations and the FCTC, the two legally binding WHO agreements, do not include dispute settlement mechanisms. Instead, they promote and urge active cooperation between states and the WHO, without possibilities for external enforcement of public health measures.²⁹

Furthermore, WHO predecessors have been the Regional Sanitary Offices, and this regional structure has been maintained when the WHO was founded in 1946. The six regional offices of the WHO (PAHO, EURO, EMRO, AFRO, SEARO and WPRO) have their own governance structures (regional committees). Coordination and coherence between the WHO headquarters and the regional offices have been a matter of concern, with fundraising and allocation not always connected to global strategic objectives. According to DeCoster, a case can be made for strong regional and country offices, if only to be able to provide context-specific support. Needs in the AFRO region are obviously very different from needs in the EURO or SEARO region, and priorities of work will differ.³⁰ Nevertheless, the WHO's weaknesses are most obvious in the AFRO regional office, and in the country support it provides (or fails to provide) in some sub-Saharan African countries. This lackluster performance is a main reason why the WHO lost support in the African region. The regional structure therefore can be considered a crucial impediment to the WHO's effectiveness. This view is confirmed in several other sources on the functioning of the WHO.³¹

²⁷ International Breast Feeding Action Network, *WHO Secretariat Fails to Act On WHA Decision On Relations With Non-State Actors*, A digest of discussions at the 133rd Executive Board on WHO's engagement with non-state actors (NSA). Internet: http://info.babymilkaction.org/sites/info.babymilkaction.org/files/Digest%20May%20EB%202013_FA ILSTOACTFINAL.pdf.

²⁸ Frenk and Moon (2013).

²⁹ *The International Health Regulations*, May 25, 2005, Part VIII, General provision, Art. 42- 46.

³⁰ Kristof DeCoster, "Is WHO Ready For a Rising Africa?", *International Health Policies* (January 2013).

³¹ See for an overview: Clift (2013).

2.4 Debate on WHO Priorities

Developing countries complain that the WHO is driven excessively by the interest of Western donors. These donor countries, on the contrary, criticize the WHO for having engaged into development aid activities to the detriment of its norm-setting role, which is considered of most direct relevance to them since it concerns norms and standards for health hazards in their countries. They prefer other UN agencies, the World Bank, bilateral development agencies, and NGOs, to focus on development aid for health, and point to most of the resources of the WHO going to the regional and country offices located in developing countries. At the same time, many of them also use the WHO to implement part of their own development funding for health. Partially as a result of the development efforts, notably concerning the health-related Millennium Development Goals (MDGs), the WHO's mechanisms for stopping bioterrorism and dangerous infectious diseases from becoming pandemics, i.e., the Global Outbreak Alert and Response Network (GOARN) and provisions of the International Health Regulations (IHRs), are said to not receive the investments needed. The problem is most severe in developing countries lacking strong institutions and capacities to detect new outbreaks.³²

On top of this, the WHO is facing extensive budget cuts, and has to adapt to austerity. "The WHO of tomorrow will not be the same hegemonic health powerhouse of the past. It will likely be more decentralized, placing a greater share of the responsibility for health on individual nations. Countries will be compelled to carry the onus for provision of health, including epidemic control, on their own shoulders, increasingly based on domestic revenues."³³

2.5 The Tricky Issue of Civil Society Involvement to Boost Legitimacy

Civil society in turn complains about the intergovernmental and closed character of WHO. This would be a constraint for their involvement, while they carry out a considerable part of the global health work on the ground, and as a result possess considerable expertise and know-how on issues discussed at the WHO. In comparison to other multilateral organizations, NGOs are allowed hardly any speaking time during official meetings of WHO. Member states counter-argue that most civil society groups are funded by the big foundations, specifically the Gates Foundation, and already have a great say through the WHO activities they fund. They consider themselves the legitimate representatives of their citizens. China, for instance, does not see the added value of civil society involvement, also given its own limited experience with them contributing to public policy-making. A proposal for further involvement of civil society was blocked in 2004 at the 57th WHA by a number of member states, including China.³⁴

³² House of Lords, *Diseases Know No Frontiers: How Effective Are Intergovernmental Organisations in Controlling Their Spread?*, Select Committee on Intergovernmental Organisations (2008).

³³ Maxine Builder and Laurie Garret, "Adapting to Austerity: WHO Remodels For 2014", *Devex Editor* (May 2012).

³⁴ World Health Organization, *Policy For Relations With Nongovernmental Organizations*, 57th World Health Assembly, A57/32 (May 2004).

In democratic states, it could be wondered whether international health concerns receive sufficient attention in public debates and election campaigns. National health ministers and parliaments appear most concerned with national, as opposed to international, health, let alone the activities of the WHO. International health matters only feature prominently when a pandemic occurs, and during other times the link of representative democracy is weak. The degree of accountability towards ordinary citizens is indirect at best. In order to include civil society still, countries like Brazil and Thailand have created national health assemblies where a broader range of actors are invited for policy shaping on both domestic and international health issues. Switzerland and the EU have also created fora in which international health policies, including the WHO's, are discussed with civil society.³⁵

2.6 Restoring WHO as Directing and Coordinating Authority

Despite all its shortcomings, the WHO is still perceived a relatively legitimate body by many observers, on account of being allegedly more neutral than any national health or development agency, company, or NGO. Even though its effectiveness may be jeopardized by inefficient (financial) processes and a lack of resources for all the global health challenges confronting humanity, it is probably still the most authoritative and expert-based organization to advocate and promote public health matters. In this respect, it being widely criticized for not being able to coordinate and steer other efforts in the area of global health, is worrisome.³⁶ None of the organizations active in the field want to be coordinated, and double work and competition abound. A systems' integrator or network coordinator is absent, and would be useful *inter alia* to identify gaps and new threats, and watch over heavy administrative burdens for recipient countries. It could be a counterweight to a self-sustaining aid community that disconnects from the real health needs, and concentrates only on specific diseases and methods of treatment.

Some mechanisms for coordination were established, such as the International Health Partnership (IHP+), which focuses on operationalizing aid effectiveness in the health sector and is made up of the WHO, World Bank, donor countries, NGOs, and The Gates. Another one is the Health 8 (H8), which is an informal group of eight health-related organizations comprising the WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, the World Bank, and The Gates. It was created in mid-2007 to stimulate a global sense of urgency for reaching the health-related Millennium Development Goals. These efforts are noteworthy, but do not overcome the coordination challenge completely, nor did they reestablish the centrality of the WHO as coordinating and directing organization for international health. The position of the WHO as the prime legitimate international organization for international health matters has eroded over the last two decades. According to Mahbubani, the diminution of the WHO's role

³⁵ World Health Organization (2013).

³⁶ Suerie Moon, Nicole A. Szlezák, Catherine M. Michaud, Dean T. Jamison, Gerald T. Keusch, William C. Clark and Barry R. Bloom, "The Global Health System: Lessons For a Stronger Institutional Framework", *PLoS Medicine*, vol. 7, no. 1 (January 2010).

undermines long-term Western interests.³⁷ The West should have spent the past few decades strengthening the WHO, notably by providing it with more resources. Instead, it starved the WHO thereof. At a time when more complex health matters, such as an epidemic, spread around our global village in a day or two, the weakening of the WHO by western countries can be considered a strategic error.

The WHO is thus subject to severe pressures that undermine both its authority and legitimacy. In addition to financial constraints, it is confronted with fundamental questions regarding its accountability, the way it involves the private sector and civil society, and its position within the overall global health landscape. In the remainder of this paper, we will examine in what way other players operate, and how they can be judged from a legitimacy perspective.

3. Global Fund and GAVI: Big Public Money Belts For Global Health

In 2012, the Global Fund to Fight AIDS, Tuberculosis, and Malaria was the main multilateral funder in global health, channeling approximately three billion US dollar annually – 2/3 of all international financing for tuberculosis and malaria, and 1/5 of all international financing for AIDS. The aim of the Fund is to attract and disburse additional resources to prevent and treat these diseases. The GAVI alliance aims to save children's lives, and protect people's health by increasing access to immunization in poor countries. Both the Global Fund and the GAVI alliance receive considerable levels of support from the Gates, and GAVI has even been initiated by this foundation.³⁸ They are largely funded by a limited number of Western donors. The lion's share of GAVI's budget, for instance, comes from just three donors: the UK, the Gates, and Norway.³⁹

Global public private partnerships in health (GPPH) emerged in the mid-1990s, at a time when the UN and its member states became more interested in partnerships. The socio-political shifts in several Western countries, known as “the third way”, led the UN to see the benefits of industry as “re-legitimizing the UN”. Harnessing the private sector for human development, was, and is seen, as a way to enable UN agencies to fulfill their mandates by means of funding and advice from the private sector.⁴⁰

The legitimacy of GPPHs remains highly contentious. According to Buse and Harmer, the “inclusion of private actors, both for-profit and not-for-profit, enhances

³⁷ Kishore Mahbubani, *The Great Convergence: Asia, the West, and the Logic of One World* (New York: Public Affairs, 2013), pp. 89-116.

³⁸ See for an excellent account of the establishment of the GAVI from an international relations perspective, Ingstrad K. Sandberg, Steinar Andresen and Gunnar Bjune, “A New Approach to Global Health Institutions? A Case Study of the New Vaccine Introduction and the Formation of the GAVI Alliance”, *Social Science & Medicine*, vol. 71, no. 7 (2010).

³⁹ Ann D. Usher, “GAVI Funding Meeting Exceeds Expectations”, *The Lancet*, vol. 377, no. 1984 (June 2011).

⁴⁰ Kent Buse and Gill Walt, “Global Public-Private Partnerships Part 1: A New Development in Health?”, *Bulletin of the World Health Organization*, vol. 78, no. 4 (January 2011).

the problems of democratic legitimacy in international institutions rather than help to alleviate them, considering private actors contribute to the ‘de-governmentalization’ and the ‘commercialization’ of world politics”.⁴¹

According to Devi Sridhar, there are several ways in which these organizations differ from a traditional intergovernmental organization, which in general make them more attractive to donors.⁴² Firstly, the Global Fund and GAVI are governed by boards consisting of the WHO and other international organizations, civil society representatives, the private sector, and the Gates Foundation. Secondly, unlike the broad mandate of the WHO (“the attainment by all people of the highest possible level of health”), they have narrowly defined mandates that are problem-focused. Thirdly, they are entirely funded by voluntary contributions, allowing for maximum influence of donors on what they pay for. Fourthly, they do not have offices and personnel in recipient countries, which makes them rather flexible and able to operate in relative isolation from (failing) national policies. Finally, they derive their legitimacy from their effectiveness in improving specifically defined health outputs and outcomes in contrast to traditional multilateral agencies, which rely on claims of being representative and the result of state-based deliberations.

The Global Fund and GAVI thus rely on a different type of legitimacy based on effectiveness. They are quite transparent in providing detailed information about their activities to (potential) donors, even though this does not mean that they have been free from corruption and fraud. Given their donor-driven set-up, they can be expected not to be responsive to the development objectives of recipient countries, and thereby to miss opportunities to support and stimulate nationally-funded health initiatives. However, concerning GAVI, an independent assessment conducted by a network of donor countries found that its support of country ownership and its alignment and harmonization of arrangements and procedures with partners were highly valued by survey respondents.⁴³ They considered that GAVI support was aligned with national priorities, and that procedures, such as funding application and reporting requirement, took into account local conditions and capacities.

The Global Fund is considered to be sensitive to national health systems’ priorities and constraints, and to take serious national ownership of the activities it funds as well.⁴⁴ Apparently, both The Global Fund and GAVI consider that being responsive to national health preferences and approaches increases their legitimacy and effectiveness. A large scale assessment of interactions between GPPH and country health systems indicates mixed results. The Global fund and GAVI are praised for leveraging financing, ambition, and speed in attaining the health related MDGs, but at

⁴¹ Kent Buse and Andrew Harmer, “Power to the Partners? The Politics of Public-Private Health Partnerships”, *Development*, vol. 47, no. 2 (January 2004).

⁴² Devi Sridhar, “Who Sets the Global Health Research Agenda? The Challenge of Multi-Bi Financing”, *PLoS Medicine*, vol. 9, no. 9 (2012).

⁴³ Multilateral Organisation Performance Assessment Network (MOPAN), *Organisational Effectiveness Assessment: GAVI 2012* (2012).

⁴⁴ Moon *et al.* (2010).

the same time are encouraged to extend their mandate to health systems strengthening and align to a larger degree their planning to national health policies. Despite the investments by the Global Fund and GAVI, domestic revenues for health have not really increased in many low and middle income countries, and global health financing is levelling off in the wake of the economic crises.⁴⁵

Another point of criticism is their focus on achieving short-term gains, instead of structurally improving the long-term viability of health systems. For instance, a fundamental problem in Sub-Saharan Africa is a shortage of doctors, nurses, and community health workers. This problem is not addressed by setting-up externally funded disease treatment programs and bringing in vaccines. Perhaps even more fundamentally, the Global Fund and GAVI alliance operate as parasites on the knowledge infrastructure and capacity of the WHO. Whilst pretending to be independent, they rely heavily on WHO expertise about, for instance, tuberculosis, and use WHO (and World Bank) country offices for many of their activities. GAVI and the Global fund have so far paid too little attention to a country's macro-economic framework and its health care system. Health systems strengthening, such as training and retention of the health workforce in rural areas, has been included in new funding rounds of GAVI and the Global Fund. These provide a basis for improved direct health care provision, but do not take into consideration the country's legal and policy framework. The reason why the health workforce has not increased considerably in most low and middle income countries is that the wages of (governmental) health staff are often correlated to macro-economic and fiscal factors.⁴⁶ This aspect remains unaffected by the investments by GAVI and the Global Fund.

The contribution of the industry's know-how is said to have been essential to the success of the Global Fund and GAVI alliance.⁴⁷ Nevertheless, some specific concerns have been raised that illustrate the drawbacks of their public-private construction. The organizations focus on increasing the use of drugs and vaccines, whereas they have less attention for prevention and (antimicrobial) resistance to certain drugs.⁴⁸ This appears in line with the sales objectives of pharmaceutical industry, but not necessarily with the overall public health interest. The Global Fund has also been accused of supporting a rather expensive and inefficient new treatment

⁴⁵ World Health Organization Maximizing Positive Synergies Collaborative Group, "An Assessment of Interactions Between Global Health Initiatives and Country Health Systems", *The Lancet*, vol. 373, no. 2137 (June 2009).

⁴⁶ Markus Rossier, Seble Frehywot, Amie Heap and Alan Greenberg, "Policy Analysis of the Impact of Global Health Initiatives on Health Systems: Policies and Lessons Learned From Donor Programmes", *Interactions Between Global Health Initiatives and Health Systems: Evidence From Countries* (June 2009). Internet: http://www.who.int/healthsystems/publications/MPS_academic_case_studies_Book_01.pdf.

⁴⁷ Michael McCarthy, "What's Going on at the World Health Organization?", vol. 360, no. 9340 (October 2002).

⁴⁸ Select Committee on Intergovernmental Organisations, *Diseases Know No Frontiers: How Effective are Intergovernmental Organisations in Controlling Their Spread?* (July 2008).

system for malaria.⁴⁹ It was furthermore accused of conflicts of interests in relation to alcohol producers. In South-Africa, it funds the so-called Tavern Intervention Program (TIP) that aims to minimize alcohol related harm, and the spreading of aids. The program is implemented by liquor producer SABMiller, and is criticized for providing unwarranted justification for their image as socially-responsible producers, while the company actually is said to be at the root of the problem by ensuring that its sales and profits are maintained.⁵⁰

Moreover, in 2011, the Global Fund had been suffering from internal management squabbles and allegations of theft in a few recipient countries.⁵¹ The problems led to an overhaul of how the organization allocates money, and the appointment of a new director. As a result, and on account of the overall economic crisis, it is estimated that financial resources from its biggest contributors – which include the European Commission, EU member states, the United States, and Japan – will decline slightly from 2012 to 2013. Contributions from private foundations and companies are also diminishing. Bill Gates finds this unfortunate, as he still considers the Global Fund “one of the kindest things people have ever done for each other”, and therefore a “terrific investment”.⁵² Civil society organizations appear less happy about the recent changes made at the Global Fund. They complain about the organization being less engaged with organizations in the field, among others due to the removal of a dedicated civil society team at the secretariat of the organization in Geneva.⁵³

GAVI is partially funded through so-called innovative finance mechanisms. It has helped to develop the International Finance Facility for Immunization (IFFIm) and Advance Market Commitments (AMCs). With the former, donor countries make legally-binding aid commitments for 10-20 years, against which IFFIm borrows on capital markets. AMCs are mechanisms to attract private sector investment for new vaccine products for poor countries by guaranteeing purchase volumes at agreed prices over a period of time. After the financial crisis started in 2008, these mechanisms have become less effective and appetite to explore new options for innovative finance has lowered.⁵⁴ Until recently, European governments could

⁴⁹ Oxfam (ed.), “Salt, Sugar, and Malaria Pills”, *Oxfam Briefing Paper* (October 2012).

⁵⁰ Richard Matzopoulos, Charles D.H. Parry, Joanne Corrigan, Jonny Myers, Sue Goldstein and Leslie London, “Global Fund Collusion With Liquor Giant is a Clear Conflict of Interest”, *Bulletin of the World Health Organization*, vol. 90, no. 1 (January 2012).

⁵¹ “‘Difficult times’ in global fight against AIDS, TB and malaria”, *Euractiv.com* (April 2013). Internet: <http://www.euractiv.com/development-policy/global-fund-seeks-billions-eu-do-news-518954>; and Richard G. A. Feachem, “The Global Fund: Getting the Reforms Right”, *The Lancet*, vol. 378, no. 9805 (November 2011).

⁵² Bill Gates, “Why the Global Fund Is a Terrific Investment”, *Huffington Post* (April 8, 2013). Internet: http://www.huffingtonpost.com/bill-gates/the-global-fund_b_3034610.html.

⁵³ Alvaro Bermejo, “Global Fund at Risk of Alienating Civil Society, Responses”, *The Lancet*, vol. 380, no. 9854 (November 2012).

⁵⁴ For an overview of innovative mechanisms in use and possible additional options, see Taskforce on Innovative International Financing for Health Systems (ed.), *More Money For Health and More Health For the Money: Final Report* (June 2009).

account for the guarantees “off budget” – or off the balance sheet – until the bill came due. That flexibility was eliminated with new accounting requirements for the European Union following the financial crisis.⁵⁵ Additionally, the mechanisms, especially the AMC, are criticized for “subsidizing” pharmaceutical industry by paying too high a price for vaccines.⁵⁶

Currently, the Global Fund and GAVI provide assistance to developing countries in the form of activities and funding. According to Mark Dybul, Peter Piot, and Julio Frenk, the Global Fund perhaps could be even more effective if it would hand out loans for national initiatives to strengthen global health efforts in a country.⁵⁷ They call for a new Bretton Woods-style agreement to guide a new international health strategy and rationalize its structure. Funding and providing technical advice should become two separate activities to avoid conflict of interests, and the WHO’s role would be to provide global standards, surveillance, and accountability, rather than to deliver technical support and program implementation. Roger England takes a rather different perspective. He is critical about the loans currently provided to health systems by the World Bank, and doubts the ability of all three organizations to contribute to health systems strengthening.⁵⁸ In 2009, the World Bank, the Global Fund, and GAVI proposed a health systems funding platform that should have enabled external health funding to be integrated coherently into national health systems. However, both GAVI and the Global Fund had to abandon further steps in this direction as declining funds forced them to return to their original, narrower mandates: the provision of disease specific treatment and vaccines.⁵⁹

While the accountability of the WHO to ordinary citizens was considered weak, this is even more so the case for the Global Fund and GAVI Alliance. Despite their effectiveness in promoting global health, few citizens of donor countries contributing to their funding know of their existence. Citizens of recipient countries have little say either. Even though they have received some board member seats to contribute on the basis of their experience, in practice they are simply expected to be grateful for the treatment and vaccines provided. Hence, the legitimacy of the funds rests above all on their (short-to-medium term) effectiveness, and them not being contested by the general public of donor and recipient countries.

⁵⁵ Dybul *et al.* (2012).

⁵⁶ Ann D. Usher, “GAVI Funding Meeting Exceeds Expectations”, *The Lancet*, vol. 377, no. 2165 (June 2011).

⁵⁷ Dybul *et al.* (2012).

⁵⁸ Roger England, “The GAVI, Global Fund, and World Bank Joint Funding Platform”, *The Lancet*, vol. 374, no. 9701 (November 2009).

⁵⁹ Peter S. Hill, Peter Vermeiren, Katabora Miti, Gorik Ooms and Wim van Damme, “The Health Systems Funding Platform: Is This Where We Thought We Were Going?”, *Globalization and Health*, vol. 7, no. 16 (October 2010).

4. The Gates: Big Money, High Effectiveness, But Little Accountability

In 2007, the spending of The Gates on global health was almost equal to the annual budget of WHO.⁶⁰ The mission of The Gates Global Health Program is to encourage the development of life-saving medical advances, and to help ensure they reach the people who are disproportionately affected. It focuses on two main areas: 1) access to existing vaccines, drugs, and other tools to fight diseases common in developing countries; and 2) research to develop health solutions that are effective, affordable, and practical. The Gates continues a century old tradition of philanthropic institutions, such as the Rockefeller Foundation, being involved in international health policy and shaping its agenda.⁶¹

Several concerns have been raised as regards the role, effect, and lack of accountability of The Gates. Research illustrates that all significant contributors to global health have an association with The Gates through some sort of funding arrangement.⁶² Coupled with the large amount of money involved, these relations give the Foundation a great degree of influence over the structure and policy agenda of global health. Through its funding of NGOs and think tanks, the Foundation has also established some leverage over the voice of civil society.

An example of an advocacy NGO alliance fully funded by the Gates is Action for Global Health (AFGH). It is a network of development and health organizations that aims to ensure the progress of the Health MDGs through additional funding of health, strengthening health systems, and ensuring fair access to healthcare.⁶³ The group propagates a continuation, and even increase, of current levels of official development assistance (ODA) for global health. It is also influential in the debate on the health-related objectives to be set after 2015 when the MDGs come to an end, and are likely to be replaced by new sustainable development objectives (i.e. the so-called MDG post-2015 debate). In this essentially “intergovernmental” debate, The Gates is believed to have its own positions, such as opposing the idea of an objective for universal health coverage. It calls for stepping up investments in the current health related MDGs.⁶⁴ The establishment of universal health coverage is strongly promoted by the WHO, for whom the topic is a new strategic priority defined as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost”.⁶⁵ A new MDG would set targets for better access to health services and financial protection to prevent ill-health from leading to poverty. This idea is

⁶⁰ David McCoy, Gayatri Kembhavi, Jinesh Patel and Akish Luintel, “The Bill and Melinda Gates Foundation’s Grant-Making Programme For Global Health”, *The Lancet*, vol. 373, no. 9675 (May 2009).

⁶¹ Ane-Emanuelle Birn and Elizabeth Fee, “The Rockefeller Foundation and the International Health Agenda”, *The Lancet*, vol. 381, no. 9878 (May 2013).

⁶² *Ibid.*

⁶³ See Action for Global Health website, internet: www.actionforglobalhealth.eu/index.php?id=197.

⁶⁴ The High Level Dialogue on Health in the Post-2015 Development, *Meeting Report* (March 2013).

⁶⁵ World Health Organization, *Universal health coverage*, Report by the EB Secretariat (January 2013).

supported by a group of prominent public health experts,⁶⁶ but considered too “interventionist” and broad by others. They argue that the goal should be healthy people and populations, not systems.⁶⁷ This latter view apparently is shared by The Gates.

The question is whether The Gates uses its funding to NGOs to propagate such specific objectives, which may counter the preferences of states deciding upon the post-2015 goals. So far, AFGH has been a strong voice for universal health coverage, with a reference to the international Human Right to Health and health equity, to be included in the post 2015 development framework.⁶⁸ AFGH focuses its advocacy on development policies for health, and has so far not addressed policy coherence and broader determinants of health, such as international free trade agreements and macro-economic policies. It has been argued that without attention to these contextual determinants, the attainment of universal health coverage will not be possible.⁶⁹

A more general legitimacy concern is that civil society groups often accuse states of being influenced by specific (economic) interests, whereas they should operate for the common good or the most vulnerable. They claim the moral high ground, but questions can be posed as regards their own representativeness and accountability. Those who fund NGOs increasingly ask for more transparency and accountability. However, particularly in case of large charitable donors, the incentives to share information on what NGOs do with their money are lacking.

Formal lines of accountability to ordinary citizens and governments of donor and recipient countries are non-existent in the case of The Gates Foundation, despite the organization receiving a considerable tax exemption and some public subsidies. Some comments are made regarding funding being disproportionately allocated towards US-based organizations, new technologies and vaccines development (rather than towards overcoming the barriers to the use of existing technologies), and health care delivery regarding specific diseases, including malaria and HIV/AIDS (rather than strengthening health systems).⁷⁰

Moreover, questions are asked about potential conflict of interests. For instance, The Gates has a considerable holding in Coca-Cola, and also participates in grants that encourage communities in developing countries to become business affiliates of Coca-Cola. Observations by researchers Stuckler, Basu, and McKee indicate that some of the same people who participate on the boards of major multinational pharmaceutical and food corporations are also linked to the managerial boards of the Gates. The researchers advise the Gates three practical strategies for mitigating

⁶⁶ Gostin *et al.* (2011).

⁶⁷ Dybul *et al.* (2012).

⁶⁸ Action For Global Health (April 2013)

⁶⁹ Eduardo Missoni, “Understanding the Impact of Global Trade Liberalization on Health Systems Pursuing Universal Health Coverage”, *Value Health*, vol. 16, no. 1 (February 2013).

⁷⁰ McCoy *et al.* (2009).

conflicts of interests: *divestment*, as there should be separation between investment management and the foundation's board; *full transparency* of a potential conflict of interest, such as the corporate affiliations of board members of the Gates; and lastly the *alignment of aid* with community needs.⁷¹

Nevertheless, in general, the activities of The Gates are not widely contested and criticized. They are rather well respected, and its legitimacy therefore rests above all on its effectiveness in addressing global health problems.

5. Conclusions: Legitimacy To The Detriment of Health?

The overall picture that emerges when discussing the legitimacy of transnational arrangements of global health is that there are many issues of concern. While the WHO is criticized for lacking effectiveness, transparency, accountability, and for losing ground within the overall landscape of global health activities, the Global Fund, GAVI, and The Gates are not considered representative for the global community. Moreover, they have restrained from investing in public health systems' expertise and in-country capacity. Nevertheless, they are considered effective, and their activities are not widely contested. Perhaps this should not come as a surprise. After all, who would oppose generous providers of (funding for) global health?

Within the debate on global health, what is considered legitimate appears closely intertwined with how one views the roles and responsibilities of transnational arrangements for global governance. What can be left to the market and private philanthropists, and to what extent is private sector involvement a hurdle or a necessary asset for delivering global health solutions? How can health security considerations be strengthened?

On the one hand, interventionists call for a strong WHO, an increase of ODA for reaching the health-related MDGs, a reinforced infrastructure for addressing health threats (pandemics, bioterrorism, anti-microbiological resistance, etc.), and vastly expanded regulation and public health measures to combat unhealthy living (e.g. policies to lower the intake of alcohol, salt, sugar, and fat) and environmental degradation (drinking water, air pollution). They advocate a focus on health systems strengthening, prevention of diseases, and health equity as a basis for a stable and healthy society. In this view, legitimacy rests primarily on representative democracy steering choices and action, accompanied by clear mechanisms for accountability being in place to check and balance.

On the other hand, neo-liberals promote a focus on combating specific diseases, involvement of the private sector to effectively provide health solutions and stimulate innovation, personal responsibility guiding healthy lifestyle choices, and adequate risk management (instead of trying to avoid all possible risks). Here, legitimacy of global health activities rests above all on effectiveness, and the idea that the market will help

⁷¹ David Stuckler, Sanjay Basu and Martin McKee, "Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed?", *PLoS Med*, vol. 8, no. 4 (April 2011).

in finding the most cost-efficient solutions for global health problems facing today's world.

An extra layer of complexity in this debate on the legitimacy of transnational arrangements for global health is the (gradual) emergence of a different set of views and values that could be summarized as “post-Western”. In the current era, how the legitimacy of global health arrangements, and the WHO specifically, is seen, is likely to depend to an increasingly high degree on the viewpoints and involvement of the major emerging economies (the BRICS). They would be able to form “a countervailing force” to Western-dominated prescriptions for global health, but seem to view its legitimacy in rather different ways.

It can be observed that the BRICS' global health agenda is shaped at specific ministerial health meetings, preceding WHA meetings. India and Brazil make robust interventions at the WHA, while China is investing in (international) epidemic disease surveillance and is currently represented in the WHO's Executive Board. Together with most Western countries, the BRICS see the need for stronger global governance for health in relation to the containment of (emerging) infectious diseases.

Yet, it is “still early days” for the BRICS in global health, and so far they have focused on bilateral and trilateral cooperation in global health matters, with a small role for the WHO and diplomacy more focused on the G20 (except from Brazil). Concerning legitimacy, the largest problem is that they follow rather different diplomatic and development cooperation approaches, and political paradigms to deal with issues such as human rights, health equity, universal health coverage, and the Non-Communicable Diseases burden that is becoming a major concern in high, middle, and low income countries.⁷² The lack of involvement of the BRICS in the GAVI and Global Fund is also noteworthy, and worth further investigation.

Nevertheless, for two reasons, the BRICS' influence in global health is likely to increase over the coming years. Firstly because these countries will make more use of the ‘soft power’ in international fora, such as the WHA, including the strengthening of their diplomatic representation. Secondly, the scale of UN assessed contributions was recently revised with important increases of the BRIC's share, giving these countries a larger financial interest to steer the organizations' spending priorities.⁷³ The potential transformative discourse employed by the BRICS bloc hence gives weight to the claim that a paradigm shift in global health *is* underway.⁷⁴

⁷² Andrew Harmer, Yina Xiao, Eduardo Missoni and Fabrizio Tediosi, “BRICS Without Straw'? A Systemic Literature Review of Newly Emerging Economies' Influence”, *Globalization and Health*, vol. 9, no. 15 (April 2013); and Katherine E. Bliss *et al.*, “The Changing Landscape of Global Health Diplomacy”, *Centre for Strategic & International Studies* (April 2013).

⁷³ Lara Gautier, Andrew Harmer, Fabrizio Tediosi and Eduardo Missoni, “Reforming the World Health Organization: what influence do the BRICS wield?”, *Contemporary Politics*, Vol. 20, No. 2 (2014).

⁷⁴ Andrew Harmer and Kent Buse, “The BRICS – a paradigm shift in global health?”, *Contemporary Politics*. Vol. 20, No. 2 (2014).

In short, the debate on what constitutes legitimacy of global health institutions has just commenced, and challenges are still abound with regard to how legitimacy is to be defined and judged, both from different Western-dominated ideological perspectives and “post-Western” (i.e. BRICS) outlooks. In this respect, the contribution of public-private partnership and philanthropists are basic issues, and certainly deserve more attention. The same is the case for the dinosaur in the landscape of global health: do we accept an ever-growing weakening of the WHO, or do we acknowledge the need for a large-scale rescue and true overhaul of the organization? Can unjustified private sector interests (most notably the food and pharmaceutical industries) still be contained?

In our view, the legitimacy of the global health system as a whole is probably most adequately served if some steps are taken to strengthen the WHO, and with a careful review of the conflicts of interest issues in all institutions analyzed in this paper. The current weakness of the WHO is a serious point of concern, particularly relating to its ability to identify new health threats, prevent and stabilize new outbreaks of highly infectious diseases, and set standards for health-damaging consumption goods and/or patterns. Health and economic objectives are not automatically commensurate. From a legitimacy, or global justice, perspective, therefore, a stronger force and coordinating authority for global health seems justifiable.