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Author Response to Letter to the Editor: Making Power Visible in Global Health Governance

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I thank Muntaner, Ng, and Chung (2012) for their letter to the editor in response to my *American Journal of Bioethics* article, *Shared Health Governance (SHG)* (Ruger 2011). Muntaner and colleagues' main worry is that major power differentials among nations are largely absent from the SHG article. While that article does not directly and explicitly speak to the importance of power relations in global health governance, other works do address these issues. For example, an analysis of the interests of powerful states through priority setting multilaterally in multilateral organizations (such as the World Health Organization) and bilaterally through international agreements is included in work that takes stock of the major issues, needs and challenges in global health governance (Ng and Ruger 2011). Other work characterizes the current global health architecture in terms of a rational actor framework whereby agents (actors) act on behalf of principals (foundations, national governments, and private institutions) or on their own and who may or may not share common goals of health equity, necessitating common commitments and shared health governance (Ruger 2012). Under a rational actor model, each actor has its own set of objectives and goals and actors make decisions and take actions based on a cost benefit analysis of various options. However, narrow self-interest maximization can lead to suboptimal results in global health policy. Shared health governance, by contrast, advances health agency for all, groups affected by national and global health initiatives must be able to participate in decisions that affect them; the SHG framework focuses on addressing the needs of the recipients of aid effectively and reining in national and powerful industry interests in international health relations and global health. In a governance study in Malawi, for instance, indicators were developed and tested to assess meaningful inclusion and participation of key global, national and subnational groups and institutions and to understand special efforts to ensure the participation of vulnerable groups most affected by policy decisions (the poor, youth, persons with disabilities, the elderly, women) (Wachira and Ruger 2011). SHG grounds global health in principles of justice, seeking to bind actors together for health cooperation. SHG critiques political bargaining models, which rely on power relations, rational actors' positions, and changes among such actors, rendering resultant bargains contingent on interest convergence and a balance of power (Ruger 2007). By contrast, under SHG, a consensus on health equity is a moral conception, affirmed on moral grounds. Authentic authority is contrasted with self-interest and national interest

inherent in power relations. SHG puts forth a set of principled ideas to shift from material and power interests to moral concerns. One must also recognize the importance of political institutions for health, and the role of democratic principles, such as universal suffrage, representation, civil liberties, multiparty competition, regular elections and one person, one vote. Democratic institutions have both inherent and instrumental value in addressing social disparities and health (Ruger 2005). After all, legitimate political authority requires evaluation of whether those who hold political power use it to satisfy themselves or deploy it for the benefit of citizens generally.

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