From Ebola to COVID-19: what explains institutionalized manias and the ultimate preference for non-optimal solutions in global health governance?

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Abstract

Purpose – The purpose of this paper is to investigate how “manias” in global health governance lead to health inequalities even before, during and in the aftermath of acute health crises such as the COVID-19 pandemic. “Manias” as used here refer to obsessive irrational behaviors, misguided policy/strategic choices and the exercise of power that benefit the major global health actors at the expense of stakeholders.

Design/methodology/approach – From post-colonial and historical perspectives, this study delineates how the major global health actors in influence outcomes in global health governance and international business when they interact at the national–global level using an illustration from an emerging economy.

Findings – Power asymmetry in global health governance is constructed around the centralization of economic influence, medico-techno-scientific innovation and the geopolitical hegemony of a conglomerate of super-rich/powerful actors. They cluster these powers and resources in the core region (industrialized economies) and use them to influence the periphery (developing economies) through international NGOs, hybrid organizations, MNCs and multilateral/bilateral agreements. The power of actors to maintain manias lies in not only how they influence the periphery but also the consequences of the periphery’s “passivity” and “voluntary” renunciation of sovereignty in medical innovations and global health policies/politics.

Social implications – As a quintessential feature of manias, power asymmetry makes it harder for weaker actors to actually change the institutional conditions that produce structural inequalities in global health.

Originality/value – This timely and multidisciplinary study calls for a novel architecture of global health governance. Thus, democratizing global health governance with sufficiently foresighted investments that prioritize equitable access by and the inclusiveness of vulnerable stakeholders will help dismantle institutionalized manias while decreasing health inequalities.

Keywords Post-colonialism, Pandemics, COVID-19, Manias, Pharmaceutical MNCs, Power asymmetry, Global health, International organizations

Paper type Research paper

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Introduction

This multidisciplinary paper examines how “manias” define the structural role of the major actors in global health governance. More prominently, the paper problematizes how the maniacal exploitation of power asymmetries in global health governance perpetuates global health inequality. This study was conducted before and after the 2014 Ebola epidemic (Conton, 2017; Wilkinson and Leach, 2015; Stiglitz, 2014) and before and during the current COVID-19 outbreak. Both outbreaks were preceded by the 2007–early 2009 financial crisis (Crotty, 2009). While they are contextually different health crises in terms of their magnitude and impact, most of the historical manias or preferences for non-optimal solutions leading to either an epidemiological crisis or global financial crisis remain enduringly similar and recurrent. Global health crises always impose costs on households and international business (IB) (Ahen, 2019). Both IB (international finance) and global health can adversely impinge on the general wellbeing of populations but with a wide gulf of avoidable inequalities between low and high-income nations (Sachs, 2006; Stanton, 2014). The role of manias and preferences for suboptimal solutions, however, has not been critically analyzed.

Confronting powerful private, public and global organizations does not constitute “anti-anything.” Rather, it is a pragmatic deliberation that favors society for which these organizations exist. Global health is not about cold abstractions but the lives of real people. A refusal to worship at the altar of unbridled capitalism is not socialism but intellectual honesty – a prerequisite for serious scholarship. As seen in this pandemic, drugs or health are not exactly prototype-patentable private goods but essential global public goods that are mostly produced with donations and government subsidies. Therefore, critique of the global health actors mainly serves to advance understanding and supply feedback for improving their operations to generate the equitable health benefits (Sachs, 2006; Stiglitz and Jayadev, 2010).

Labonté and Gagnon (2010) structure global health diplomacy into six policy domains: security, development, global public good, (international) trade, human rights and ethical reasoning. An important missing domain is the medico-techno-scientific infrastructure (Ahen, 2019). Pandemics are global health security questions (Price-Smith, 2008; King, 2002) whose solutions require all the above multidisciplinary areas and cross-sector actors (Ahen, 2019). Hence, they cannot be meaningfully studied in silos. IB and global health have existed as codependent and intertwined and have shaped what we now know as globalization (Huynen et al., 2005; Shim et al., 2011), modern geopolitics and international trade (Ahen, 2019; Cipolla, 2002). To further clarify the link between IB and global health, it is instructive to mention a commonly used word during this pandemic – “quarantine”, which is an epidemiological term with IB origins. When the 14th century merchant ships that arrived at the port of Venezia, Italy, were suspected of any contagious diseases, crew, passengers, and goods were all forced to remain in isolation and allowed to disembark only after forty days (“una quaratina di giorni” or “quaranta giorni”). Then as now, supply chains are disrupted and global interdependence is adversely affected (Cipolla, 2002; Ivanov, 2020; Yu et al., 2020). Pandemics bring declining production, layoffs, closure of structures and delayed cargo and passenger flows. In addition, social interactions are regulated by pharmaceutical and non-pharmaceutical interventions (Ahen, 2019; Ferguson et al., 2020). It follows that IB, infectious diseases, foreign policy, their colonial legacies, the definitions of cure and the governance of pharmaceutical supply chains are entwined (Ahen, 2015; Feldbaum, et al., 2010; King, 2002; Price-Smith, 2008). COVID-19 is as much about therapeutics (e.g. vaccines) as it is about geopolitical constraints, power dominance (King, 2002; Stuckler and McKee, 2008; Wainwright, 2008) and the link between the management of ecology and contagion on a global scale (Price-Smith, 2008).
Three themes run through this paper: manias, global health crises (i.e. pandemics) and the historical origin of power asymmetry and global health inequalities. The final part theorizes the ultimate preference for non-optimal solutions in global health governance, followed by conclusions. The conclusions are generalizable to “the internationalization of issues related to food, health and safety and the global harmonization of health security issues” (Runge and Michelmann, 1990) that are exacerbated by the current pandemic.

The paper focuses on the repetitively grotesque manias in the form of destructive but rational organizational behaviors or political maneuvers that are perpetuated and institutionalized by the major actors. The manias include under-preparedness (underfunding of health agencies and R&D for vaccines), corruption (Gagnon, 2013) and mishandling of subsequent outbreaks. This generates serious adverse effects on the equitable distribution of health benefits as global public good. Thus, the paper contributes to the understanding of manias as inhibitors of institutional change in global health governance. Preemptive interventions against pandemics are mostly inhibited by a complicated historical pattern (Ferguson et al., 2020; Snowden, 2019). This pattern is characterized by manias similar to what precedes a financial crisis (Kindleberger and Aliber, 2005; Crotty, 2009), in other words, ultimate preference for non-optimal solutions (Ahen, 2015).

The foregoing analyses are supported by selected empirical data from a longitudinal, intermittent field study in Ghana. Significant illustrative quotes are not randomly reported but used here to build a bigger picture. Of note, the phenomenon of global pharmaceutical counterfeiting (Liang, 2008; Mackey and Liang, 2011; Shepherd, 2010) is used as a lens to study power asymmetries. It helps to explain the structural role of pharmaceutical multinational companies (MNCs), intergovernmental organizations (IGOs) and host/home governments given their inextricably intertwined interventions during pandemics. Thus, the demand for counterfeit medicines is simply a symptom of the lack of access to “real” medicines. This in turn is a symptom of global health inequality. These inequalities stem from price issues (unavailability or exorbitant prices), a historical lack of investment in neglected diseases (Gagnon, 2013), retarded innovations by governments (Ahen and Salo-Ahen, 2018; Stiglitz, 2014) and the geopolitics of diseases and cure (Snowden, 2019; Shim et al., 2011; Pereira, 2002).

### Manias as a theoretical superstructure in international business and global health analysis

The use of manias in global health as an analytical frame is a complicated process that reveals a simple thing: at any given time, we are between outbreaks. We know, but we do not care (Table 1).

<table>
<thead>
<tr>
<th>Type of pandemic and year</th>
<th>Percentage of affected and number of morbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1918–1919: Spanish flu (started from Texas)</td>
<td>20%—40% of the global population affected; 50 million deaths of which 675,000 only in the US</td>
</tr>
<tr>
<td>1958–1959: Asian flu</td>
<td>2 million deaths</td>
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<tr>
<td>1968–1969: Hong Kong flu</td>
<td>1 million deaths</td>
</tr>
<tr>
<td>October 2000: Ebola (lasted 144 days)</td>
<td>242 deaths</td>
</tr>
<tr>
<td>2014: Ebola outbreak in Sierra Leone, Liberia and Guinea (lasted 6 months)</td>
<td>Causing &gt;11,000 deaths</td>
</tr>
<tr>
<td>2019–2021: COVID-19</td>
<td>&gt;1,000,000 deaths</td>
</tr>
<tr>
<td>Merciless pandemic in waiting</td>
<td>Disturbingly too many</td>
</tr>
</tbody>
</table>

*Source: Adapted from Gabanelli and Offeddu (2020)*
Historically, the manias that are typically practiced by MNCs, governments and health-related organizations between and during outbreaks shape global health outcomes (Ahen, 2015; Stiglitz, 2014). Manias as used here refer to ir/rational behaviors (Kindleberger and Aliber, 2005) leading to structural flaws (Crotty, 2009), or vice versa depending on the institutional context. Manias include ritual addiction to learned incompetence, negligence, deferred action, slow action, too-little, too-late interventions, privileging political expediency or profits over public welfare, thereby aggravating crises (originally in the financial crises) (Kindleberger and Aliber, 2005). These are practiced even in the face of real, tangible immediate and actively dangerous warning signs.

Manias involve recursive model-based rational behaviors with short-term gains for political and economic agents. However, they are inherently and particularly harmful to stakeholders and society in general. Manias are characteristically reckless, cynical, formalized foolishness and myopic obsessions albeit often institutionalized and viewed as unalterable standard practices. The increase in prices of 250 different drugs by the pharma industry during the pandemic is an example (Rees, 2020). Profiteering from desperation goes as far back as the late 90s, with the legal battle between the South African government and Big Pharma on the importation of patented drugs at cheap prices during the AIDS epidemic (Birmingham, 2001). Manias in global health are analogous to manias in IB (international finance) as subsequently explained.

Kindleberger and Aliber (2005, p. 21) maintain that “for historians each event is unique. In contrast, economists maintain that there are patterns in the data and particular events are likely to induce similar responses. History is particular, economics is general.” As global health governance (particularly pharmaceutical value/supply chains) is economic in nature (Ahen, 2019) and follows some historical patterns in its precursors and effects, it would be fair to argue that pandemics largely, exhibit both the uniqueness and generality of a typical financial crisis. Clearly, the similarities are less than precise owing to obvious empirical limitations. Financial crises are not caused by viruses but speculative manias or irrational speculative booms and bubbles foreshadowed by the bursting of values; thus, “the deviations in the price of assets, security or commodities” that are not easily explained in terms of fundamentals (Kindleberger and Aliber, 2005:29). However, the effects produced by global health crises and financial crises are similar in their systemic attributes, forcing governments to take the commanding role to save economies and households. Both financial and global health crises reverse socio-economic gains and create widespread panics, crashes and uncertainties as demonstrated in Table 2. During financial crisis governments (central banks) are lenders of last resort at the national level in advanced economies. However, by and large, in developing economies, the IMF, World Bank and big Pharma, international non-governmental organizations (INGOs) and proto institutions become the ultimate lenders (vaccines and finance) (Dearden, 2020). The primary concern of the paper is with the effects of manias. This meets the criteria of a theoretical model because:

- it is an imperfect representation of the real-world phenomenon; and
- it simultaneously provides answers while evoking in-built questions-models are experiments and theories are models (Mäki, 2005).

As Crotty (2009) explains in the structural causes of global financial crises, there is negligence in orchestrating an overhaul of a system that had huge cracks and built on weak theoretical foundations and “patently unrealistic assumptions”. There are both micro and macroeconomic factors that led to the 2007–early/2009 financial crisis. At the micro-level, managers were taking excessive risks to generate higher returns while households were
unaware and rating agencies were rating what “unknowingly” seemed like a low risk. Similarly, Pharma MNCs focus on short-term super-normal profits and diseases of the rich (Goldacre, 2012; Shah, 2010; Stanton, 2014) while global health governors focus on preventing diseases in the periphery from reaching the center, instead of fixing the overall underlying causes permanently (Washington, 2006; Gagnon, 2013). At the macro level, there were global financial imbalances along with an extended period of real low-interest rates fueling credit in industrialized nations and making banks take further risks. This credit boom fueled the housing market. These were followed by massive losses in the subprime market, bankruptcies of big banks such as Lehman Brothers, global consumer loss of confidence and a full-blown crisis followed. It is here that what looks like a local situation (an American Wall Street conundrum) became a global crisis (Valdez and Molyneux, 2010). These manias were known to be consequentially irresponsible but they went on far longer than they should have. Similarly, what looked like a Chinese local problem (first SARS; Kleinman and Watson, 2005; and now SARS-CoV-2) quickly became a global threat much quicker than we expected, but not without enough warnings. Here again, governments had to step in with new regulations, bailouts, subsidies and welfare packages to keep households and the economy afloat like in any financial crisis. Of course, lost jobs are not the same as

<table>
<thead>
<tr>
<th>Major features</th>
<th>Financial crisis</th>
<th>Global health crisis</th>
</tr>
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<tbody>
<tr>
<td>Actors</td>
<td>Big financial institutions, regulatory agencies, central banks</td>
<td>Pharmaceutical MNCs, international non-governmental organizations, governments/ universities</td>
</tr>
<tr>
<td>Antecedents</td>
<td>Overlooked unethical practices in the financial sector, structural flaws</td>
<td>Overlooked unethical practices and corporate irresponsibility on the part of governments and the pharmaceutical multinational companies (e.g. 90–10 rule)</td>
</tr>
<tr>
<td>Effect</td>
<td>Crises in low-income households; public finance emergency; economic recession that leads to uncertainties, public outrage against governance, market failures and outrageous executive compensations</td>
<td>Crises in global households; public health emergency; uncertainties; new travel restrictions (quarantine) and lifestyle changes; dampening community spirit; the poor get poorer; ultra-rich get super rich (e.g. Amazon)</td>
</tr>
<tr>
<td>Reach</td>
<td>Global (systemic)</td>
<td>Global (systemic)</td>
</tr>
<tr>
<td>Resources</td>
<td>Finance, revolutionary changes prompting new regulations</td>
<td>Finance and medico-techno-scientific resources</td>
</tr>
<tr>
<td>Radical changes</td>
<td>Decreased productivity and low consumer confidence owing to lower expectations</td>
<td>Lower expectations; decreased productivity owing to fear of spread of infections, lockdowns and quarantine</td>
</tr>
<tr>
<td>Normative changes</td>
<td>New policy guidelines that affect international business</td>
<td>New restrictive guidelines/global solidarity, quarantining and masking, all of which affect international business</td>
</tr>
<tr>
<td>Government response</td>
<td>Top-down policy response; bailouts, subsidies, stimulus packages for households and firms</td>
<td>Top-down policy response; bailouts, subsidies, stimulus packages for households and firms</td>
</tr>
<tr>
<td>Decision rule</td>
<td>Highly political and unclear alternatives and interventions, policies favoring investors and bankers and not the consumers</td>
<td>Highly political decisions about public health interventions to earn public trust</td>
</tr>
</tbody>
</table>

Table 2. Dangerous precipice: similarities in global health crises and international financial crises
Intersections between global health crises and global financial crises

There are many parallels and intersections between global health crises (e.g. pandemics) and global financial crises. This is because IB and diseases are intertwined (Ahen, 2019) and international finance is a prominent feature of IB. Fundamentally, both crises represent major disruptions to socio-economic life (produce poverty, disease and widen inequality or expose existing ones) (Ferguson et al., 2020; Snowden, 2019). Besides the marked diminution of the quality of life for low-income households, both crises characteristically create anxiety and panic both on the financial and labor markets by disrupting supply chains (Yu et al., 2020). During the 2020 COVID-19 pandemic 94% of the Fortune 1000 companies went through serious supply chain disruptions (Ivanov, 2020; Fortune, 2020). Both crises present similarities in terms of ignored premonitions and how they are governed before, during, and in the aftermath, leading to new crises. Before SARS, the 2014 Ebola, and the current COVID-19 outbreaks, we have witnessed several recurrent regional or national outbreaks such as cholera, HIV/AIDS, poliomyelitis, malaria (Price-Smith; 2008; Shah, 2010), Zika virus outbreak, or even the Ebola outbreak in 1976 (Wilkinson and Leach, 2015). Notwithstanding the high morbidity and mortality rates, lessons were hardly learned, and the manias were repeated owing to optimism bias. Table 2 shows the major similarities between international financial crises and global health crises/pandemics/epidemics.

From a classic economic perspective, the market is neutral to issues of social justice, equality and equity. These normative considerations are seen as rationally separable from issues of efficiency because they are assumed to impose limits on profits (Streeck, 1988). Corruption, mismanagement, wastes and lack of sufficiently foresighted regulatory innovations and safeguard regulations precede both financial crisis (Crotty, 2009) and global health crisis (Ahen, 2015, 2019) especially in the pharmaceutical industry (Gagnon, 2013). Manias are notorious for always making a pathological comeback pre and post-crisis – leading to panic and crashes as in the financial sector or outbreaks in the health sector. In the words of Chancellor Merkel during the 2015 annual assembly of the World Health Organization (WHO) in Geneva in the wake of the Ebola crisis: “The Ebola disaster in West Africa has made it painfully obvious how urgently we need to act on an international level in times of crisis […]”, admitting that the lesson learned is that “we should have reacted earlier” (DW, 2014). Nevertheless, five years later, little attention had been paid to these premonitions as exemplified in the case of Italy. “During the early onset of COVID-19, Italy looked at the example of China, not as a premonition of what’s on the horizon but as a ‘science fiction movie that had nothing to do with us.’ And when the infections exploded, Europe, ‘looked at us (Italy) the same way we looked at China,’ according to Ms. Sandra Zampa, Italian Deputy Minister of Health.” Other world leaders downplayed the outbreak, called it a common cold and refused to wear facemasks, with millions of people following suit. Having more power, the USA threatened to default on its contribution to WHO in the middle of the pandemic. Under political pressure and influence, the US Center for Disease Control (CDC) kept flip-flopping on the acceptable science-based protocols and depended more on “availability heuristics”. Science, politics and conspiracy theories were not easily separable despite their “differentially” unique features.

Consequently, COVID-19 has disproportionately affected millions in industrialized nations, effectively blowing away the myth of the “first world” and the “third world” (Friedman, 2020). The exposure of the new geographies of inequalities makes this paper relevant for both “high-income economies” and “low-income economies”. This is because the
illusion of exceptionalism (which emphasizes “us vs them”) of many “high-income economies” did not provide immunity in the global democratic republic of viruses. Thus, pathogens are definitely not the “distinct misfortune” of the poor.

Figure 1 shows the similarities in the anatomy of a typical global health crisis and financial crisis. This figure synthesizes the phases and facets of manias starting from the pre-outbreak, the actual outbreak phase, panic, shocks (caused by sudden outbreaks of war and disease or even crop failure), the systemic crisis (as the virus spreads globally accompanied by panicky interventions for local epidemics), stabilization and cooling down, adoption of ephemeral and permanent behaviors, and the final return to post-pandemic/crisis manias marked by euphoria and premature exuberance owing to decreasing infections or the availability of vaccines.

Inferred here is that complacency, abuse of power, and the attitude of exceptionalism was a major mania that worsened the crisis in many Western societies. Au contraire, like Vietnam and New Zealand, most African nations were humbly cautious owing to lessons from prior epidemics – leading to the lowest infections rate of all regions in the world as of December 2020 (WHO, 2020a). The next section deals with the historical antecedence of manias and how it has affected developing nations.

Pharmaceutical industry and institutionalized manias in Africa [1]

Historically, the market involvement of the pharmaceutical industry in Africa has been very low but crucial (Buabeng, 2010). The lateness of pharmaceutical FDI in Africa is explained by the perceived lack of market (Sachs, 2006; Stiglitz and Jayadev, 2010). Currently, however, Big Pharma, like all MNCs, plays a massive political role (Abraham, 2002) in emerging economies where weak institutions allow them to have a strong bargaining power (Scherer and Palazzo, 2007).
Pharmaceutical MNCs enjoy several freedoms under international treaties such as the World Trade Organization’s TRIPS (Trade-Related Aspects of Intellectual Property Rights) (t Hoen, 2002). Despite such privileges, a more plausible reason for the pharmaceutical MNCs’ engagement in strategic political management is the quest for legitimacy (Suchman, 1995), both internally with stockholders and externally with global governors/INGOs and host countries, by appearing socially responsible. This allows them “to enhance their survival prospects” (Meyer and Rowan, 1977): “We [Big Pharma] don’t see the healthcare needs of emerging economies of Africa only as the novel frontiers for organizing production and marketing but also an opportunity for showing corporate responsibility” (Manager-1/Big Pharma). “Fundamentally, pharmaceutical MNCs and WHO export medical commodities to developing economies. They define what a disease is and the appropriate cure from the Western orthodox medicine perspective. They also provide financial and technological support for the FDA and INTERPOL to combat global counterfeits in the quest to protect their intellectual property” (Manager-2/Big Pharma).

Notwithstanding the usefulness of vaccine donations and other philanthropic exercises by MNCs (Class, 2012), this form of intervention is questionable because it is unsustainable. One, these actions when institutionalized over time morph into actual manias. Two, these manias in turn create dependency on global health governors. Thus, such interventions weaken national agenda for pharmaceutical/public health sovereignty. Moreover, local pharmaceutical firms bear the negative consequences of this pattern of dependency owing to market distortion: In a visit to one pharma SME in Ghana the CEO argued that “even though we have the most advanced laboratories and manufacturing systems, we still don’t have the WHO prequalification that allows us to produce medicines and enter into competitive bidding. This undermines our efforts” (Manager/SME/Ghana). Further, dependency perpetuates corruption, maladministration and bureaucracy. These manias stifle progress in the healthcare sector (Okunonzi and Macrae, 1995). “To this day, African countries continue to depend on the Global Fund for the acquisition of drugs for tuberculosis, malaria, and AIDS” (Expert/Global Fund). As an additional example, “the private and the NGO sectors including the Christian Health Association of Ghana provide over 40% of healthcare in Ghana, especially in the rural areas” (WHO, 2009; McCabe et al., 2011). This allows governments to evade responsibility thereby undermining global health in the South.

Problematicizing pandemics and global pharmaceutical supply chains

According to the Coalition for Epidemic Preparedness Innovations (CEPI), the estimated annual global cost of moderately severe to severe pandemics is $570bn. The number of diseases WHO identified as public health risks owing to epidemic potential and lack of biomedical countermeasures are 11 and the minimum average cost for progressing one vaccine against priority epidemic infectious diseases is US$2.8bn (https://cepi.net/). Currently, according to the WHO’s landscape of COVID-19, drug candidate vaccines that have reached clinical stages are mostly being made across Europe, China, Russia, and the USA (WHO, 2020b). Out of 55 African countries with a population of 1.3 billion people, only two are in this race: Helix Biogen Consult, Ogbomoso and Trinity Immonefficient Laboratory (Ogbomoso, Oyo State, Nigeria) and National Research Center (Egypt). Additionally, the African Center of Excellence for Genomics of Infectious Diseases (ACEGID) in Nigeria is a WHO and Africa Center for Disease Control (CDC) Reference Laboratory for genomic research in Africa. The ACEGID COVID-19 vaccine has by October 2020 already gone through the required preclinical trial to test the vaccine’s efficacy and toxicity but unsurprisingly lacks the finance to proceed to the trials on humans. There are
worries that vaccines made outside Africa may normally not take into consideration the genetic make-up of the African population – making “made in Africa by African scientists” vaccine a moral imperative (Quarts Africa, 2020).

It follows that vaccines are the therapeutic Holy Grail for confronting outbreaks such as COVID-19 to halt the physiological, socio-economic and disruptive forces that are wreaking havoc on the global population (Ahen and Salo-Ahen, 2018; Ahen and Pierdicca, 2020). There is an extraordinary scramble for cures and an unprecedented demand by governments (Yu et al., 2020; Ahen and Pierdicca, 2020; WHO, 2020; Quarts Africa, 2020). However, the power asymmetry is maintained because of the incentives it provides to the status quo (King, 2002).

Two problems arise: One, low-income populations have historically had difficulties accessing such medicines (Ahen and Salo-Ahen, 2018) forcing them to settle for counterfeit/substandard medicines or knock offs (both traditional medicines and Western allopathic medicines) globally, according to the WHO and other major regional actors (see also Liang, 2008; Mackey and Liang, 2011; Shepherd, 2010). Two, for several decades now, the global South (the periphery) has depended on the global North (the center) for cures and global health governance solutions – this is a historical mania that power imbalance perpetuates. Besides the 90–10 rule that sees a constant 90% financing for pharmaceutical R&D favoring industrialized nations (Stiglitz and Jayadev, 2010; Ahen and Salo-Ahen, 2018), there is also the problem of price gouging, chronification of disease, pharmaceutical reps misleading doctors to harm patients (Goldacre, 2012), many cases of exploitation via the testing of new drugs on the world’s poorest patients (Shah, 2006; Washington, 2006).

Further, developing economies are ritualistically seen as centers of packaging, distribution and consumption of generics but not where value is added to pharmaceutical manufacturing and big R&D spending (Conton, 2017; Stiglitz and Jayadev, 2010; Ahen and Salo-Ahen, 2018). For Dr Margaret Chan, Director-General of WHO (ex Ufficio), “Ebola emerged nearly forty years ago. Why are clinicians still empty handed, with no ‘vaccine and no cure...Because Ebola has been, historically geographically confined to poor African nations. The R&D incentive is virtually non-existent. A profit-driven industry does not invest in products for markets that cannot pay” (Stanton, 2014). This leads us to the important engine of manias: power asymmetry as analyzed in the next section.

Pharmaceutical MNCs and power asymmetries in global health governance

There is no global health government but there are major actors who shape/enforce global health outcomes. The pharmaceutical industry as a political player (Abraham, 2002; Shah, 2010) along with global health organizations is uniquely placed to exert influence and shape global health outcomes (Ahen, 2019). The pharma industry gains power through an oligopolistic market with a huge concentration of medico-techno-scientific resources, lobbying, advertising and corporate political power (Abraham, 2002; Mantere et al., 2009). Power is embedded in the superior production capacity, economies of scale and scope, international network of production, bargaining power, entry barriers and the infusion of public subsidies. This sustains their natural pursuit of short-term super-normal profits. Big pharma leverages these powers at the World Trade Organization (WTO) (to induce regulatory/policy advantages through lobbying) (Goldacre, 2012; Okuonzi and Macrae, 1995). They are also WHO’s first choice for partnerships to produce vaccines on large scale during pandemics. SMEs in developing economies lack all these (Ahen and Salo-Ahen, 2018). On the contrary, developing nations continue to see spending cuts in science and technology. Such systems of institutionalized manias maintained over time disadvantage developing economies. Since 1990s the Agreement on Trade-Related Aspects of Intellectual Property Rights, or (TRIPS) negotiated at WTO extends Western-style patent protection
across the globe for 20 years; dictating price and usage rights. India and South Africa have requested a suspension of this practice to enhance cooperation and national level production during COVID-19 but were met with opposition from wealthy nations (Dearden, 2020). Similarly, the COVID-19 Vaccine Global Access Facility (COVAX), led by the WHO, has 180 (without US) signatories with 94 in the high income brackets. Wealthy nations signed bilateral agreements with Big Pharma to ensure their early share of promising doses and effect payments while the remaining 92 low-income nations will have to wait (Gosh, 2020). The main justification for not supporting low-income nations is that such an approach would disincentivize market-based innovations.

Theoretically and empirically, a scenario in which the healthcare systems of African countries were devoid of interventions from health-oriented organizations/firms would be hard to explain. There are host governments, INGOs, humanitarian organizations, MNCs/SMEs including public–private partnerships engaged in procuring-manufacturing-logistics and supply of pharmaceuticals (Ahen, 2015). Organizations such as UNAIDS, USAID and the US Pharmacopeial Convention support the governments of these economies to combat endemic diseases and threats to the pharmaceutical supply chains (counterfeits) (CPIAWG, 2011). The extant literature bears ample evidence that health crises in general and counterfeit problems in particular, are the “reflections of history, geography, domestic policies, and geopolitics” (Sachs, 2006) of which international organizations have always played a significant role (Arts, 2003). Jeffrey Sachs calls these kinds of collaborative initiatives or multi-stakeholder Institutions “ecosystems of engagement” (Green, 2013). Influential international organizations play a major role as agents in the architecture of either institutional change (Doh, 2003) or the perpetuation of certain “vested positions” (Oliver, 1992; Arts, 2003) in global healthcare and patient protection (Inoue and Drori, 2006). Their position as inhibitors of beneficial health policies or enablers in shaping social identities and political discourse on global public health remains ever-formidable (Doh and Teegen, 2002). An overview of the complex interdependence between these global health actors and the massive array of complicated normative obligations is presented in Figure 2.

While national organizations appear to know the local conditions and appropriate solutions, they may not be in the position to enact change owing to a complex set of historical and institutional reasons, treaties and multilateral agreements. Among these reasons, power asymmetry stands out although it has not been systematically formulated and explained, regarding how the prominent global actors legitimize over 150 years of activities in emerging economies (Feldbaum et al., 2010; Fidler and Gostin, 2006). For the sake of simplification, three categories of actors are identified in global health governance, civil society, industry and public sector. These groups, although not exclusive, face three theoretical dilemmas:

1. how do we protect consumers/patents (securitization);
2. how can we ensure access to medicines through equitable pharma supply chains (e.g. a potential COVID-19 vaccine) at affordable prices; and
3. how can we balance these demands with the firms’ quest for profits taking into consideration the three major categories of costs: R&D (innovation), production and marketing.

Historical-institutional and colonial vestiges of power asymmetries in global health governance

The institutional field for the study consisted of multiple actors whose relationships are characterized by competition, contestation and cooperation (Maguire and Hardy, 2006).
Within this field of global pharmaceutical supply chains, actors “seek to influence a shared outcome [such as regulation] and pay attention to one another in the process” (McNichol and Bensedrine, 2003) by creating the institutions which will serve as the traffic rules of future co-operation. These policy discourses and interactions have a direct and indirect impact on the institutionalization of patient protection as a core part of global health. The current state of healthcare systems in West, East, Central and Southern (WECS) Africa represent the product of centuries of decisions, policies and institutional dictates at national and global levels (Acemoglu, et al., 2001; Acemoglu and Robinson, 2012). These antecedents serve as a precursor for what the future would potentially look like. Figure 3 demonstrates the epochal changes and patterns in global health governance.

All health-oriented international organizations established before 1870 originated solely from religious backgrounds (Inoue and Drori, 2006). The year 1851 marks the origin of contemporary health diplomacy with the first international sanitary conference of cooperation on cholera, plague and yellow fever (Feldbaum et al., 2010). It is worth noting that during this period, a great part of the Western scientific community did not consider people of African extraction as humans, or at best they were sub-humans meant for medical experiments (Washington, 2006). The aftermath of Second World War saw the establishment of the WHO in 1948, within whose framework past agreements were amalgamated into a unique set of regulations referred to as the International Sanitary Convention. This was later re-invented as the International Health Regulations. Countries that adhered to and ratified these regulations, in essence, gave the WHO new powers to

**Notes:** EMA: European Medicines Agency; FDA: The US Food and Drug Administration; Gov’t: government; UNAIDS: United Nations Joint Programme on HIV/AIDS.
encroach on their national health agendas and state interests. In this way, countries “privileged global health governance over state sovereignty by allowing the use of surveillance reports by non-governmental organizations and electronic surveillance systems” (Fidler and Gostin, 2006). Contemporary practices of global health governance by INGOs, IGOs and MNCs or other actors such as Bill and Melinda Gates Foundation or the so-called proto-institutions (the Global Fund and the Global Alliance for Vaccine and Immunization) are structured in the colonial framework and hence their practices should be seen as a historical product (Wainwright, 2008). International organizations and adaptive hybrids in global health governance are not unified rational actors but complex settings and governance structures, with multiple external and internal stakeholders and, therefore, non-linear organizational structures. The conditions that permit complex, hybrid international organizations to survive through path dependence include the vast network of cartel-like global structure that is centralized in the core region and the organizations’ immunity and resistance to institutional changes that deviate from the original motive for which they were established. They are complex hybrids because, as Schemel (2013) argues, their formula for survival consists of a web of “local, national, regional and transnational” ingredients. That is, they are “made up of public agencies, private firms [e.g. Big Pharma], third sector associations and expert, activist, or lobbying interest groups” (ibid.).

Moreover, Shim et al. (2011), explain how legitimized, highly institutionalized systems of global health governance (e.g. WHO) require conformity of the lower order systems to their prescriptions (Meyer and Rowan, 1977; Shim et al., 2011). Second, their historical role and
lopsided control of medico–techno–scientific resources and political status suggest a certain level of uncontested credibility and bargaining power. Third, the total number of international treaties ratified by weaker nations and/or their membership in international organizations is one major way by which scholars measure the degree of conformity to these “higher-order global forces” (Inoue and Drori, 2006). By implication, the articulation of cure, based on Western allopathic medicine, is also dominated by MNCs and has led to apathy toward traditional medicine (Shim et al., 2011). Thus in a paternalistic fashion, Western allopathic medicines are regarded as standard while other medicines are seen as primitive (King, 2002)

At the micro-level, there can be many public health experts in e.g. national or professional institutions who truly appreciate the magnitude of the public health debacle but lack the power and resource to change things [3]. In the sections that follow, I shed light on the historical and structural roles of governments, pharmaceutical MNCs and international organizations.

Power asymmetry in global health – toward an empirical model

Weber (1978) refers to power as “the probability that one actor within a social relationship will be in a position to carry out his will despite resistance.” Fleming and Spicer (2014) identify four faces of power:

1. Coercion – the ability of actors with the power to directly use the power to achieve their goals;
2. Manipulation – here there is no direct use of duress but an implicit approach to shape agendas that suit the interests of the user of power;
3. Domination – deals with the arbitrary hierarchical structures that are made to appear as the natural order of things through the ideological shaping of perception; and
4. Subjectification to curb possible resistance: “This type of influence seeks to determine an actor’s very sense of self, including their emotions and identity” (p. 244).

The first two are said to be episodic (less visible and rarely used), while the second two are systemic (used often and on a larger scale). Fleming and Spicer further argue that there are four sites through which power is enacted; thus, power enacted “in”, “through”, “over” and against organizations/nation-states/stakeholders.

The cumulative asymmetric power relationship that is built on lopsided regulatory, political, decisional, discursive and agenda-setting power (Arts, 2003) increases global health inequity. Here both stronger and weaker actors express different expectations and domains of competence. The empirical model in Figure 4 attempts to capture the essential elements which explain the global power asymmetry in healthcare governance. Currently, developing nation’s weak governance and institutional structures are like a mirror image of the global power structures in the industrialized nations. Politics and ideologies define the nature of global health, aided by globalization and a complex network of formal bureaucratic structures (Baylis and Smith, 2005; Huynen et al., 2005). Global health as a foreign policy issue is the result of centuries of institutionalization, mainly in the West, through global governors with sovereign immunity statuses. Moreover, despite the high disease burden in emerging Africa, global health governance systems are centered outside the core areas of need. The axis of power is constructed around three major dimensions: business and non-business actors, instruments and functions. The most influential actors in global health governance are the global governors and Big Pharma. They possess the instruments that...
allow them to function through their decision-making power (Arts, 2003). These geopolitical commodities (e.g. economic influence, medico–techno–scientific innovation and the geopolitical status) are centralized in the core region and dispensed in the periphery as a conceptual schema that attempts to capture the above phenomenon.

The consolidation of power is reflected in the constant weakening of periphery through transaction-based structural adjustment programs (as donor conditionality). This is pro-free market and favors austerity that undermines public spending on science and technology infrastructure aimed at creating new medicines (Dearden, 2020).

How surrendered power and dependency widen gaps in health inequality

Whereas power has been conceptualized as the ability of one or more actors to influence others (Burt, 1977), the findings suggest that power is the ability to disempower others from action for as long as one’s interests are met. Hence, power lies not only in how the core influences the periphery, but also in the negative consequences resulting from the periphery’s complacency. Holding power consists essentially of being a player and a referee at the same time, both enjoying impunity and the capacity to put one’s interests first. Power
in global health governance is not expressed through despotic controlling mechanisms. Rather, it is exercised through a shrewd mechanism of benevolent donations from MNCs, charity by INGOs and economic aid packages from governments and multilateral organizations from the core region, with strings attached. These have the ability to transform governments and the governed into complacent, irresponsible “yes men” and cowed followers, resulting in over-dependence that never weans itself from pharmaceutical supplies from outside in combating the disease burden and its attendant problems. For evidence, in building capacity and utility, local researchers are hardly funded or put in charge of the planned research/innovation platforms. Rather, helicopter research is preferred where blood samples of Africans are taken away for research to publish in global North institutions and advance the careers of some scholars at the expense of local scientists (Conton, 2017). There are varieties of ways through which governments relinquish the power to change institutions to external actors. The interviewees do not say that the government lacks resources. They rather point to a lack of leadership and health-care investment priorities as a longstanding mania [4].

In addition to the donor-driven healthcare, more evidence to how power is surrendered can be found in three major areas:

1. Financially undernourished medico-techno-scientific R&D in universities and local pharmaceutical industries.

2. Constantly reducing capacity, poor working conditions and low incentives for health personnel resulting in ‘brain drain’ of qualified health professionals (Schubert, 2003).

3. Dependence on external knowledge systems dictated by health institutions and firms in the core region and statistical and surveillance data from global governors [5].

This surrendered power and lack of investments in research explains the incessant external projections on Africa’s health-care structure and development. “We [US Pharmacopeial Convention] have now built a US$1.5-million pharmaceutical training center in Ghana that will serve the whole of WECS Africa and we also provide portable technologies for the detection of counterfeit medicines” (Expert/US Pharmacopeial Convention). In the Global Engagement Report published in April 2012, the FDA announced the organization’s aim to become the global health agency that protects the health of its own citizens as well as the health of the whole world from threatening dangers (FDA, 2012). Currently, the FDA has offices in Africa, Asia, Europe, America and the Middle East and is strengthening its international functions to ensure that the imported foodstuff, medicines and medical equipment fulfill the same safety and quality requirements as those in the USA. Although pharmaceutical anti-counterfeiting interventions are dominated by global governors or governmental agencies such as the FDA, national and regional bodies are increasingly gaining voice, recognition and inclusiveness, given the institutional transformation, albeit in small measures (Fan and Liang, 2012). The major problem with the renounced sovereignty and surrendered power is that the institutional contexts breed “fragile varieties” of organizational models. When this adds up to the employment of the first best approaches (standard approaches used in high-income countries) by INGOs in the developing world, it produces the least desirable results. This represents a huge setback to healthcare transformation. Containing the issue of pharmaceutical counterfeiting is clearly possible but, as highlighted by Shepherd (2010), “it is a technological and human resource challenge” that must be met with cooperation or effective architecture of global health governance.
Theorizing the ultimate preference for non-optimal solutions in global health governance

This section develops a theory of ultimate preference for non-optimal solutions in global health governance in general and pharmaceutical supply chains in particular. It explains how global health governance has maintained its old manias and, hence, that of global health inequality. Here, macro-politics, power asymmetry and maniacal behaviors are the explanatory variables. More precisely, for any given set of global health solutions for creating social value, a range of market, medico-techno-scientific, political and institutional possibilities always exist but non-optimal choices (quick, late fixes) are preferred to sustainable ones. This means that the solutions are not optimal for society but essential for the actors' long-term survival, maintenance of the status quo and the attendant incentive structures (profits, power and legitimacy) of firms, INGOs and governments.

That is, in global health governance, principles of equity and equality are not prioritized by design but the interests of the powerful actors. This is consistent with Schemeil's (2013) reasoning about how these organizations reinvent themselves even when their original mandates have expired. Their prescriptions are mostly far-removed from the desired maximum social benefits. Rather, their preferences are modeled by maneuvers that will call for their direct/indirect re-involvement through consultation, medico-techno-scientific assistance and finance (especially aid) from the centers of power. At the micro-level, individuals (managers/policymakers) and groups (boards and executives) with micro-political power make the same choice to reflect the organizational character in order to:

- maintain the survival of their organizations;
- remain relevant; and
- maintain the status quo of the professionals and epistemic communities of experts as well as their associated influential networks in their quest for legitimacy (Ordeix-Rigo and Duarte, 2009; Suchman, 1995).

At the structural level, beyond the allocation of medico-techno-scientific resources, global health is designed to prevent diseases from the south from spreading to the north and to protect the foreign policy interests of the core region in the periphery (i.e. firms and their employees) and, therefore, to facilitate international trade – capturing profits and taking resources from the periphery. The constant dependence on imported best practices in some cases ignores essential local nuances and complexities. Consistent with Shim et al. (2011), there is theoretical and empirical evidence with direct causes and effects to explain the skewed nature of the national–global linkages between supranational organizations and national health organizational systems in emerging Africa. In Figure 5, the solid arrows indicate how the core region with the centers of policy and medico-techno-scientific resources exerts influence on the periphery. The dashed arrows show the weakness of the periphery and the modest or total absence of influence on the core region. The longstanding manias such as the surrendered power and renounced responsibility, therefore, serve as the weak link between national and global health governance. This can be attributed to the historical durability of the global health policy structure, power asymmetry, the complacency with the culture of dependency in national–global linkages, as well as national healthcare governance paralysis in emerging economies of Africa.

As a result, healthcare solutions are used as geopolitical commodities with which the powerful actors have a competitive edge and a bargaining power while legitimating their actions. As Stuckler and McKee (2008) put it: "Global health as a foreign policy is based on
politicians using global health policy to create a worldwide reputation and exert political influence, forging alliances with countries where they have strategic interests, opening new markets for trade, and protecting domestic pharmaceutical companies.” In summary, survival-seeking, relevance-seeking and incentive-seeking as well as the foreign policy interests of the core region define the asymmetric power relations in global health governance. This is a rational approach but for the global South, this is a destructive mania that offers sub-optimal outcomes.

**Conclusions**

Understanding manias helps to acknowledge the limits of model-based rational behavior as a structure for accumulating incentives notwithstanding the social costs involved. Manias are maintained because the major actors in global health have the power to both rationalize and institutionalize them. Power asymmetry in global health governance defines the gulf of inequalities between populations in the global south and those in the global north. Unrestrained power asymmetry corrupts global health governance and creates extreme manias. Manias demonstrate that pandemics are not just sudden and casual crises but an inevitable result of a pattern of institutionalized structural flaws. This is only part of the larger problem regarding socio-economic determinants of health that undermines local/global health. Taking a cue from North (1990), it is hard to find proof to fit any novel hypothesis that global health governance has shifted toward a new trajectory other than the known (colonial structures)—weak vs powerful actors. There is an infinite list of contradictions in global health governance. Major actors who operate within health institutions are tasked with the responsibility of care but prioritize profits and political expediency over the bioethical issues (the value of human life) inherent in global health. Public intervention in the market is suppressed by private maneuvers in the policy sphere. Thus, Pharma MNCs and certain INGOs consciously skew global health governance to their favor, thereby preventing adequate preparedness for the containment of a novel contagious disease. This allows the generation of super-normal profits from the exploitation of the...
desperation resulting from the pandemic. Constantly aware that we are always between outbreaks, Pharma MNCs engender the dysfunction in public health systems with the complicity of certain governments and a not-so-independent WHO. The use of post-colonial and critical approaches boldly interferes with the spheres of exceptionalism inherent in the objectionable neoliberal display of power in global health governance. This succeeds in fashioning liberation from colonially imposed global health inequalities exacerbated by the pandemic. It further highlights the need for investments in novel herbal alternatives to the current paradigm of normalized manias.

The findings suggest that whilst power is mostly attributed to the ability of some actors (Big Pharma, WHO, etc.) to influence other actors in global health, it can also be attributed to developing nation’s surrendered power to well-endowed institutions through policies, treaties and political inaction. The manias and ultimate preference for non-optimal solutions also consist of other inertial conditions that block fundamental changes. These include protectionism by industrialized nations and misallocation of medico–techno–scientific endowments. Global pharmaceutical supply chains use resource concentration and power asymmetry as the geopolitical commodities in framing solutions and gaining competitive advantage. That means global health interventions are still top-down, slow by design, are disease-specific, wealthy nations first and non-holistic. Further, surveillance, medico-techno-scientific, decisional, discursive and agenda-setting processes hinge on the asymmetric power, whose pendulum swings in favor of the strongest actors in global health governance.

What is required to decolonize (Wainwright, 2008) and deinstitutionalize the current system (Oliver, 1992) are disruptive health policy innovations aimed at overhauling and revolutionizing the antiquated trap of dependency in global health/pharmaceutical value and supply chains by, namely, renegotiating global health treaties that no longer serve the needs of the 21st century populations of the global South, stable and accountable financing of local pharma SMEs to fill gaps in local pharmaceutical supply and value chains and to ultimately ensure self-sufficiency. As global health and IB are intertwined (Ahen, 2019) unfair trade must be radically renegotiated to bring seminal changes to global health inequalities through investments in both traditional/herbal, modern health innovations and social determinants of health. There is also the need to make WHO more independent by restructuring the existing governance architecture. This will truly reflect the visions of all the signatory nations rather than a few rich ones who now hoard COVID-19 vaccines while putting the global South in second place. This has the potential to ignite a potential demand and supply of counterfeit medicines/vaccines. Sweeping solutions may be remote but a pro-health equality tradeoff is a possibility.

Notes

1. Using an illustration from Ghana as a proxy for West, East, Central and Southern Africa, i.e. WECS Africa, primary data were collected through semi-structured interviews from diverse global health-related organizations, industry (MNCs/SMEs) and INGO experts. The field study comprises a total of 70 interviews (ranging from 20 to 100 min besides interviews via emails) conducted between 2010 and 2014 (Ahen, 2015) and 2015-2020. The recurrent interview questions, which were modified for each interview session, were: (a) for global actors: How would you describe your changing role in global health in emerging Africa? (b) for national actors: What difficulties do you encounter in collaborating with international organizations in mitigating counterfeits? Discourse analyses (Maguire and Hardy, 2006) were used as tools for analyzing data from fieldwork in a “developing economy.” Data analysis involved constructing discourses based on the iteration between literature, interviews and documents. This offered deep insights into the rich historical-institutional tapestry and current trends in global pharmaceutical security and how power works.
2. “After decades of prioritizing Western medicine only, diversification to take advantage of the local alternative medicines with great potential for the cure of tropical diseases is only gradually beginning to gain momentum in Ghana now. The approval and dispensary of such herbal medicines started in 2012 by the procurement division of the Ministry of Health” (Expert/Ministry of Health/Ghana).

3. “There have also been remarkable advances based on development assistance (e.g. United Nations Millennium Development Goals) which non-experts interpret as government success. You see, we are very aware of the health problems our country faces and we have programs on the table, but we have to wait for a long time before we hear something from those who make the budget. As a pharmacist, this is really frustrating” (Expert/Ministry of Health, Ghana).

4. “The government puts less money in healthcare. That is why healthcare in developing countries is donor-driven. But you see, Ghana is now an emerging economy, so those donors such as DFID [UK Department for International Development], DANIDA [Denmark’s development cooperation] and USAID are withdrawing their resources slowly. Another reason for this is that Ghana and many other African countries have natural resources whose profits could be channeled into the healthcare sector. As you know, the politicians cannot always be trusted to do what seems logical. So we envisage massive financial challenges in the coming years. They [donors] give promises but they don’t act on them. Within the institutions, you have less innovation and less learning because everyone wants to control his turf. For any organization to be successful much depends on the leader” (Expert/WHO/Ghana).

5. Ghanaian experts are even more perplexed about the third point: “If you want statistical data you need to consult the world governing bodies such as the WHO [or their websites]. We don’t even have the finance for conducting major surveys, let alone embark on projects” (Experts/Ministry of Health/Food and Drug Authority/Ghana Statistical Service).

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Further reading

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