

Health as a Power Issue in the International System: Deconstructing the Authority of Big Pharma



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Abstract:

This article argues that health has moved from a matter of human welfare to a central dimension of power in the international system. The ability to develop medicines and vaccines and to control their circulation now functions as a strategic resource for states and large private actors. The article conceptualizes "health power" as three-dimensional: materially, it rests on technological monopolies and control over production and supply chains; institutionally, it is embedded in intellectual property rules, trade agreements, and pricing regimes; discursively, it relies on the authority to define scientific truth and to frame the meaning and limits of the right to health. Drawing on International Relations theory and Steven Lukes's three-dimensional view of power, the article examines how Big Pharma exercises authority through lobbying and confidential contracting, by shaping market rules, intellectual property and financial arrangements, and by steering procurement, clinical evidence, and ethical standards that govern medical knowledge. It concludes that reforming global health governance requires redistributing this power through legal and institutional change and through the democratization of knowledge production and circulation. Any serious critical agenda must connect the dismantling of pharmaceutical monopolies with sustained support for Global South initiatives in pharmaceutical manufacturing and open, non-proprietary innovation.

Keywords: *Health power; Big Pharma; global health governance; intellectual property regimes; pharmaceutical monopolies.*

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Introduction:

In the last two decades, health has moved beyond the language of welfare and humanitarianism and into the core of international politics. COVID-19 made this shift visible, but it did not create it. The capacity to innovate, manufacture, and distribute medicines can translate into bargaining leverage, strategic advantage, and domestic political stability. In this sense, pharmaceuticals are not only commodities; they can become instruments through which power is exercised in an unequal international system (Fidler, 2007; Youde, 2018).

This article addresses a focused problem: how is the authority of Big Pharma organized and exercised in the international system, and what does it do to accountability and global health governance? More specifically, it examines how pharmaceutical authority forms at the intersection of state interests, market structures, and the institutional and normative arrangements that confer legitimacy on emergency decisions. The article argues that Big Pharma's power cannot be explained adequately through lobbying alone, nor through an innovation narrative alone, because major parts of authority operate through rules, structures, and meanings that shape what actors perceive as "normal" and "feasible" (Lukes, 2005; Barnett & Duvall, 2005).

Methodologically, the study uses a theory-guided qualitative analysis and operationalizes power through Steven Lukes's three-dimensional framework—instrumental, structural, and discursive—because it captures influence over decisions, the rule-architectures that pre-structure bargaining, and the knowledge practices that define truth and obligation (Lukes, 2005). The analysis is grounded in structured readings of governance texts that map policy space and legitimacy: global trade and intellectual property rules (World Trade Organization, 1994), pandemic prioritization and ethical reasoning under scarcity (World Health Organization, 2020), and scholarship on global health governance and medical knowledge production that clarifies how partnerships, expertise, and evidence standards shape authority (Jin, 2021; Youde, 2018; Sismondo, 2007).

The article's structure follows the research problem in three connected steps. Section 1 reviews competing theoretical perspectives on pharmaceutical power—from realist and institutionalist views to critical political economy, constructivism, and post-positivist approaches—showing that each captures a distinct pathway of authority rather than a complete explanation. Section 2 then applies the three-dimensional model to trace instrumental power in procurement and regulation, structural power in patents and dependence, and discursive power in the construction of credible science and legitimate public interest, before clarifying how these dimensions reinforce one another and complicate accountability. Section 3 reflects on the methodological challenges of studying power in a transnational, hybrid field, and closes by drawing implications for the future of global health governance (de Bengy Puyvallée et al., 2025; Nour et al., 2025).

1. Theoretical Framework: Competing Perspectives on Big Pharma's Power

This article treats Big Pharma's authority as a power configuration that cannot be reduced to a single mechanism. A useful starting point is to combine (i) visible influence over decisions, (ii) deeper institutional and economic structures, and (iii) control over meaning and knowledge—an approach consistent with Lukes's three-dimensional model of power (Lukes, 2005) and with broader debates on how power operates through multiple "faces" and social relations in global governance (Barnett & Duvall, 2005). In global health, these dimensions interact with international regimes and organizations that structure cooperation and contestation (Jin, 2021; Youde, 2018), with partnership models that reshape priorities and accountability (de Bengy Puyvallée et al., 2025), and with the politics of evidence-production in medicine (Sismondo, 2007). This theoretical pluralism matters because Big Pharma's authority is simultaneously geopolitical, institutional, economic, and epistemic—so competing perspectives illuminate different causal pathways rather than offering mutually exclusive explanations (Dearden, 2023; Dosi et al., 2023).

a. (Neo-)Realism: Health as State Power

From a (neo-)realist angle, health technologies become instruments of state power because they affect national resilience, crisis bargaining, and relative gains. In a system defined by uncertainty and competition, governments have strong incentives to secure preferential access to medicines and vaccines, to protect supply chains, and to sustain domestic industrial capacity—especially during emergencies when scarcity turns procurement into a distributional struggle. The legal–institutional backbone of this logic is visible in the centrality of intellectual property rules in global trade governance, notably TRIPS (World Trade Organization, 1994), which can operate as a strategic asset for states with innovative firms. Likewise, pandemic allocation debates highlight how "who gets what first" is treated as a governance problem under scarcity, with prioritization frameworks acknowledging hard trade-offs rather than assuming automatic solidarity (World Health Organization, 2020). Empirically, the post-2020 period sharpened this dynamic: disputes over vaccine equity and national prioritization became core critiques of the global response (Borowicz et al., 2022; Nour et al., 2025).

The counter-argument is that realism can overstate state control by underestimating how corporate capabilities and transnational arrangements condition what states can actually do. Pharmaceutical production and R&D are not simply national levers: they are embedded in globalized supply chains, contracting practices, and public–private partnerships that may fragment authority and diffuse accountability (de Bengy Puyvallée et al., 2025; Youde, 2018). In practice, states often depend on private firms for speed, scale, and know-how, while firms depend

on states for advance purchase commitments, regulatory fast-tracks, and liability or market guarantees—so “state power” is frequently exercised through corporate capacity rather than over it. This dependence also creates openings for opacity and informational asymmetries, particularly where the production of scientific evidence and its policy framing are shaped by industry-linked practices (Sismondo, 2007), and where governance reforms are pursued partly to reduce corruption risks and strengthen public oversight in pharmaceutical systems (Baghdadi-Sabeti & Serhan, 2010).

b. Liberal Institutionalism: Interdependence and Global Health Governance

Liberal institutionalism frames pharmaceutical power through interdependence and the rules that manage it. Because cross-border disease risks, supply chains, and regulatory decisions are tightly linked, institutions and regimes become central arenas where access, standards, and cooperation are negotiated. From this view, global health governance is a dense institutional field—international organizations, regimes, and hybrid partnerships—designed to coordinate action and reduce collective-action problems (Youde, 2018; Jin, 2021). Core legal instruments such as TRIPS shape what policy tools states can use, while WHO guidance seeks to structure priority-setting and legitimacy under scarcity (World Trade Organization, 1994; World Health Organization, 2020).

The counterpoint is that institutional density can also dilute accountability and widen asymmetries. Public–private partnerships may mobilize resources quickly, yet they can impose reporting burdens, pull attention toward measurable technological fixes, and leave persistent questions about transparency and legitimacy (de Bengy Puyvallée et al., 2025). In parallel, critiques of the COVID-19 response emphasize delays, communication problems, and vaccine equity failures—suggesting that institutional design and authority are contested, not simply coordination-enhancing (Nour et al., 2025). Anti-corruption and “good governance” initiatives in the medicines sector reflect this tension: institutions are needed, but their credibility depends on oversight and integrity safeguards (Baghdadi-Sabeti & Serhan, 2010).

c. Critical and Marxian Perspectives: Monopoly Capitalism and Dependency

Critical and Marxian approaches locate pharmaceutical authority in capitalism’s structural features: monopoly rents, intellectual property, and uneven development. Here, Big Pharma’s power is less about episodic lobbying and more about durable control over innovation pipelines, pricing, and market access—often defended through global rules that privilege patent-based competition and profitability. Long-run political-economy accounts argue that monopoly dynamics and corporate concentration shape both what gets researched and what becomes

affordable, reinforcing North–South hierarchies (Dosi et al., 2023; Dearden, 2023). The global IP regime is central to this story: it can protect monopoly positions internationally, with distributional consequences that fall heavily on countries with limited bargaining power and manufacturing capacity (World Trade Organization, 1994; t’Hoen, 2009).

A common rebuttal is that monopoly protections are partly justified as innovation incentives, and that private firms can deliver breakthroughs that public sectors cannot easily replicate at scale. Yet critical accounts answer that the innovation narrative often hides how public money, guaranteed markets, and regulatory advantages socialize risk while profits remain privatized—and that high prices and shortages are not accidental “market failures” but predictable outcomes of power and rent extraction (Boggs, 2015; Dearden, 2023). Whistleblower and investigative narratives further underline how corporate misconduct and regulatory vulnerability can accompany concentrated market power, complicating any simple “innovation-for-patents” bargain (Pratta, 2025; Bazin, 2021).

d. Constructivism: Meaning, Norms, and the “Pharmaceutical Imaginary”

Constructivism treats pharmaceutical power as partly made through norms, narratives, and shared expectations about what health problems are and what solutions count as legitimate. The “right to health,” “health security,” and “global solidarity” are not only moral claims; they are political resources that shape how actors justify decisions and evaluate legitimacy in crises (Youde, 2018; Fidler, 2007). In this frame, a “pharmaceutical imaginary” can emerge: a taken-for-granted assumption that the primary route to health protection runs through drugs and vaccines, narrowing the policy imagination and elevating actors who control these technologies (de Bengy Puyvallée et al., 2025).

The counter-argument is that norms and language cannot substitute for material capacity: even the best solidarity rhetoric cannot manufacture doses, expand cold chains, or override contract law overnight. Constructivists generally accept this, but stress that meaning still matters because it guides which constraints are treated as “natural” and which are treated as politically negotiable—especially around patents, pricing, and transparency (World Trade Organization, 1994; Baghdadi-Sabeti & Serhan, 2010). Debates on vaccine equity show how contestation over fairness and responsibility can become a struggle over the definition of legitimate global action, not merely a dispute over quantities (Borowicz et al., 2022; Nour et al., 2025).

e. Post-Positivist and Foucauldian Approaches: Power/Knowledge and Biopolitics

Post-positivist and Foucauldian approaches start from a simple claim: knowledge is never produced in a political vacuum. What counts as “objective evidence,” which questions are treated as legitimate, and which uncertainties are ignored are shaped by institutions, language, and authority. In this sense, power and knowledge support each other: expertise does not only inform governance, it

also organizes it by setting the limits of what can be said and done (Devetak, 2022, pp. 343–344). This connects directly to biopolitics, understood as the ways governments manage the biological health of populations for social order and productivity (Devetak, 2022, p. 385). In global governance terms, biopolitics works through routines that classify risks, normalize interventions, and produce “responsible” subjects—often via expert systems and market-centered rationalities rather than overt coercion (Barnett & Duvall, 2005, pp. 243–245).

Applied to pharmaceuticals, this lens shifts attention from “who lobbies whom” to how truths are built and stabilized—and how those truths enable population-level decisions. Clinical trials, publication practices, guideline-making, and regulatory categories can function as technologies of power/knowledge: they define what is “effective,” what is “safe enough,” and what counts as an acceptable trade-off. Sismondo’s analysis of “ghost management” shows how influence can operate behind the scenes across study design, analysis, writing, and publication; he reports evidence of ghost authorship in 75% of a set of industry-initiated trial publications examined in one benchmark study (Sismondo, 2007, p. 1430). These knowledge practices matter biopolitically because they feed into policies that govern populations—such as prioritizing some groups before others under scarcity (WHO, 2020). The counter-argument is that emergencies require fast expert communication and coordinated messaging, and that heavy skepticism can damage trust. The Foucauldian reply is not “science is false,” but that expert rule is always political in its effects; therefore, transparency about evidence-making (data access, authorship, conflicts, contracting conditions) becomes part of legitimate governance, not an optional add-on (Devetak, 2022, pp. 343–344; Barnett & Duvall, 2005, pp. 243–245; Sismondo, 2007).

f. Synthesis: Toward a Plural Understanding of Pharmaceutical Power

Taken together, these perspectives suggest that pharmaceutical authority is multi-dimensional rather than single-cause. Realist logics illuminate how states treat medicines as strategic assets; institutionalism explains why dense regimes and partnerships structure bargaining; critical political economy shows how patents and monopoly dynamics embed inequality; constructivism reveals how norms and narratives shape legitimacy; and post-positivist approaches uncover power/knowledge effects that operate through evidence and expertise. A coherent integration is to treat Big Pharma’s authority as simultaneously decision-making power, structural power, and discursive power—a framing compatible with Lukes’s layered model of how power works beyond visible coercion (Lukes, 2005) and with analyses of power in global governance that emphasize multiple modalities and relations (Barnett & Duvall, 2005).

This plural synthesis also prevents one-sided conclusions. It avoids portraying firms as all-powerful puppet masters (because states, regimes, and crises constrain them), while also avoiding the view that markets and institutions are neutral problem-solvers (because monopoly structures, accountability gaps,

and knowledge politics shape outcomes). The analytical payoff is practical: reforms must target all dimensions—rules and incentives (World Trade Organization, 1994; t’Hoen, 2009), institutional accountability and integrity (Baghdadi-Sabeti & Serhan, 2010; Nour et al., 2025), and the epistemic conditions under which evidence becomes authoritative (Sismondo, 2007; Attkisson, 2024).

2. Structural Analysis: The Three Dimensions of Pharmaceutical Power

To move from theory to mechanism, the article operationalizes “pharmaceutical power” as a three-dimensional structure: instrumental power (observable influence over decisions), structural power (the rules and market architectures that shape options before bargaining begins), and discursive power (authority over evidence and problem definitions). This approach follows the logic that power is not only exercised in visible conflicts, but also embedded in institutions and in the production of legitimacy (Lukes, 2005; Barnett & Duvall, 2005). The next two sub-sections focus on the first two dimensions, which are often the most tangible in policy disputes and crises (Youde, 2018; Jin, 2021).

a. Instrumental Power: Lobbying, Regulatory Capture, and Procurement

Instrumental power is the most “visible” layer: it refers to direct efforts to shape decisions through lobbying, revolving-door dynamics, agenda access, and strategic communication. In pharmaceuticals, this power is amplified because regulatory choices (approval standards, market exclusivities, pricing rules) and public purchasing decisions can create or destroy markets quickly, especially during emergencies (Lukes, 2005; Youde, 2018). The result is a policy environment where influence is not only about persuasion, but also about timing, access, and the ability to frame what is “feasible” for governments under pressure (Barnett & Duvall, 2005; Fidler, 2007).

A central concern in this domain is the risk of regulatory capture—not necessarily as a single conspiracy, but as a gradual alignment of regulatory priorities with industry logics. When the same actors dominate technical expertise, data access, and consultation processes, regulators may end up relying heavily on corporate-produced evidence and interpretations. This problem becomes sharper where publication practices and medical knowledge-production are partly managed in ways that favor commercial narratives, making it harder for outsiders to detect bias or contest core assumptions (Sismondo, 2007; Borch-Jacobsen, 2013). The counter-argument is that regulators and firms must collaborate because drug development is complex and highly specialized; however, collaboration without robust transparency and conflict-of-interest safeguards can still tilt outcomes toward private interests (Baghdadi-Sabeti & Serhan, 2010; Attkisson, 2024).

Procurement is the most concrete expression of instrumental power because it converts political urgency into contractual authority. During crises, public buyers often accept speed over bargaining leverage, and contracts can lock

in pricing, delivery schedules, liability allocations, and secrecy provisions that are difficult to renegotiate later. From an institutional perspective, this is not simply a "bad deal" story; it is a predictable outcome of asymmetric information and scarcity, where firms can leverage their control over production capacity and timelines (de Bengy Puyvallée et al., 2025; Nour et al., 2025). Yet a fair objection remains: advance purchasing and fast contracting can also be defensible if they accelerate access and reduce uncertainty. The governance question, then, is not whether procurement should be rapid, but whether it can be rapid and accountable—through integrity measures, disclosure norms, and stronger public negotiating capacity (Baghdadi-Sabeti & Serhan, 2010; World Health Organization, 2020).

b. Structural Power: Patents, Financialization, and Global Dependence

Structural power works "upstream" of bargaining. It is the ability to shape the rules of the game—what is legally permitted, what is economically viable, and which actors are systematically advantaged. In pharmaceuticals, this power is anchored in intellectual property regimes, market concentration, and the architecture of global production and distribution networks. Even before any lobbying occurs, these structures condition policy space and define what counts as a realistic option for states, especially those with limited manufacturing capacity (Barnett & Duvall, 2005; Lukes, 2005; Youde, 2018).

The strongest structural lever is the global patent and trade framework. TRIPS establishes baseline obligations that internationalize patent protections and thus shape access strategies, industrial policy, and pricing environments (World Trade Organization, 1994). Critical accounts argue that this framework helps sustain monopoly rents and reinforces dependency relationships: countries that lack domestic R&D and manufacturing face a constrained menu—import at high prices, negotiate under urgency, or pursue contested flexibilities (t'Hoen, 2009; Dearden, 2023). Defenders reply that patents are necessary to incentivize innovation and future therapeutics. The structural critique does not deny innovation incentives, but questions who pays, who benefits, and whether the present balance systematically privileges profitability over global health equity—especially for neglected conditions and poorer markets (Dosi et al., 2023; Dearden, 2023).

Financialization and global dependence deepen these dynamics by prioritizing shareholder value, pipeline control, and strategic portfolio management over broad public-health objectives. Long-term analyses of monopoly capitalism suggest that corporate concentration and profit strategies can steer research agendas, shape pricing norms, and normalize high-rent models that are difficult for public systems to discipline (Dosi et al., 2023; Boggs, 2015). At the same time, global health is increasingly organized through complex partnerships and overlapping institutions that can unintentionally fragment national health systems, impose heavy reporting burdens, and incentivize "measurable" technological

interventions at the expense of system-wide strengthening (de Bengy Puyvallée et al., 2025; Jin, 2021). The counter-argument is that these arrangements mobilize resources that many states cannot generate alone; but the structural concern remains that dependence—on patents, capital markets, and transnational supply—can convert interdependence into hierarchy when crises hit and scarcity returns (Borowicz et al., 2022; Nour et al., 2025).

c. Discursive Power: Constructing Truth, Normality, and Obligation

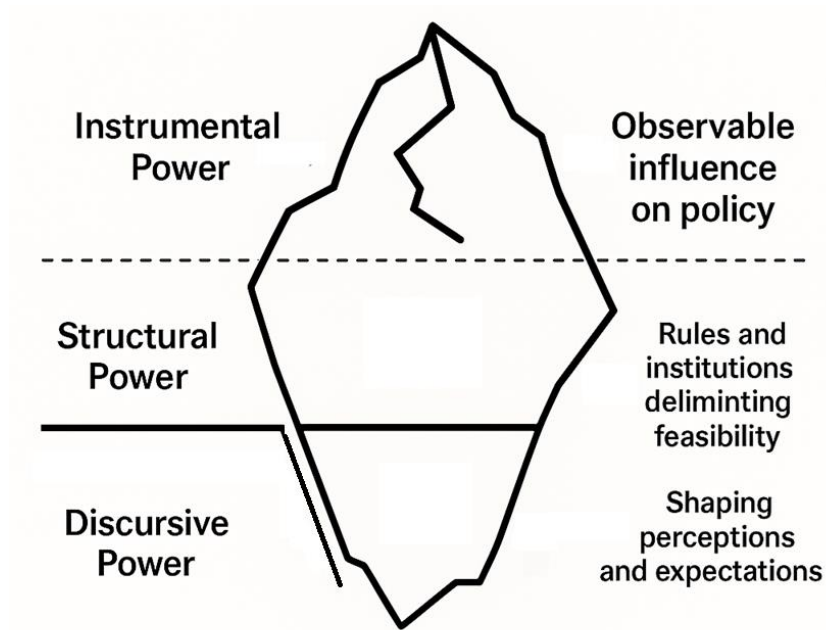
Discursive power is the capacity to define what is "true," what is "normal," and what actors "ought" to do—often without appearing coercive. In pharmaceuticals, this power operates through the authority of scientific language, regulatory categories, and expert consensus. It matters because once a problem is framed as primarily solvable through specific medicines or vaccines, alternatives can look unrealistic or irresponsible, even if they are technically possible. In Lukes's terms, this is power that works by shaping preferences and perceived options rather than by openly winning a policy fight (Lukes, 2005). It is also consistent with broader accounts of power in global governance that emphasize how legitimacy and meaning structure behavior (Barnett & Duvall, 2005; Youde, 2018).

A key mechanism is how evidence is produced and circulated. Pharmaceutical debates are rarely settled only by "data"; they are settled by what counts as reliable evidence, which endpoints are treated as decisive, and how uncertainty is communicated to policy audiences. Work on ghost management shows how scientific publications and communication can be organized in ways that strengthen particular narratives while preserving the appearance of neutral expertise (Sismondo, 2007). Critics extend this by arguing that selective transparency and public-relations strategies can blur the line between independent science and managed persuasion, especially when controversies emerge over safety, efficacy, or procurement choices (Borch-Jacobsen, 2013; Attkisson, 2024). The fair objection is that strong communication is not automatically manipulation; during emergencies, coordination depends on clear messaging. But the problem is that the same tools that stabilize trust can also be used to narrow debate and to make some questions—pricing, patents, accountability—seem secondary or even inappropriate (Baghdadi-Sabeti & Serhan, 2010; Nour et al., 2025).

Discursive power also constructs obligation: it shapes what governments feel compelled to do under crisis conditions. When the dominant frame is "speed saves lives," urgency becomes a moral argument that can justify secrecy in contracting, exceptional regulatory shortcuts, or limited scrutiny of corporate practices. WHO's allocation frameworks explicitly acknowledge that prioritization is not only technical but also ethical and political, which shows that obligation is constructed and contested, not merely "given by science" (World Health Organization, 2020). Yet the pandemic debate over equity demonstrates how competing moral frames collide: national protection, global solidarity, and market

realism each claim legitimacy, and discursive struggle becomes part of the distributional outcome (Borowicz et al., 2022; Nour et al., 2025).

Figure 1. Beyond Observable Influence: The Instrumental, Structural, and Discursive Power of Big Pharma



Source: Authors' adaptation of Lukes's three-dimensional view of power.

d. Interactions and Implications

The three dimensions rarely operate separately. Instrumental influence can secure favorable rules, and those rules then become structural constraints that make similar outcomes easier next time. Discursive authority, in turn, can legitimate both the lobbying that shaped decisions and the institutional architecture that locks them in. This interaction is precisely why a multi-dimensional view of power is analytically useful: it shows how visible decisions, deep structures, and knowledge regimes reinforce one another, often producing effects that look "natural" rather than politically constructed (Lukes, 2005; Barnett & Duvall, 2005).

A typical interaction runs like this: IP and trade rules set the baseline of exclusivity (structural power), firms and states negotiate procurement under urgency (instrumental power), and then expert narratives justify the terms as necessary to deliver innovation and speed (discursive power). TRIPS provides the

global legal backbone for exclusivity claims (World Trade Organization, 1994), while accounts of pharmaceutical monopoly power argue that rent-based models become self-reinforcing through market concentration and long-run profit logics (Dosi et al., 2023; Dearden, 2023). Public–private partnership governance can intensify these feedback loops by tying resources and legitimacy to technocratic deliverables and measurable outcomes, sometimes sidelining slower systemic reforms (de Bengy Puyvallée et al., 2025; Jin, 2021). None of this proves a single hidden hand; it shows how incentives and institutional designs can produce patterned outcomes even without total coordination.

The implication is accountability drift. When outcomes are produced by intertwined dimensions of power, responsibility becomes harder to locate: governments can point to market constraints, firms can point to legal rights and contract terms, and institutions can point to limited mandates. This diffusion is visible in the way WHO's COVID-19 response has been criticized across multiple themes—timing, communication, coordination, and equity—none of which can be reduced to one actor's failure (Nour et al., 2025). A reasonable counterpoint is that complex emergencies inevitably require shared responsibility. The problem is that shared responsibility can become no responsibility unless transparency and oversight are built into each layer—contracts, rules, and evidence production (Baghdadi-Sabeti & Serhan, 2010; Sismondo, 2007).

e. Consequences for Global Health Governance

For global health governance, pharmaceutical power reshapes both the agenda and the instruments of cooperation. When medicines and vaccines are treated as the central solutions, governance tends to prioritize financing mechanisms, procurement platforms, and regulatory harmonization—often through partnerships that blend public authority with private capacity. This is not inherently negative: institutional coordination can reduce duplication and enable rapid scale-up (Youde, 2018; Jin, 2021). Yet partnership governance has also been criticized for privileging vertical, technologically centered interventions that deliver measurable outputs while fragmenting recipient systems and straining administrative capacity (de Bengy Puyvallée et al., 2025). The longer-run risk is a governance style that becomes excellent at buying products but weaker at building resilient public health infrastructures.

Distributional conflict becomes sharper because global rules do not erase unequal bargaining power. IP regimes and trade obligations define a baseline that often favors holders of patents and manufacturing capacity, while states without those assets face tighter policy space and higher exposure to price and supply shocks (World Trade Organization, 1994; 't Ho_regen, 2009). During COVID-19, this imbalance was reflected in recurring debates over vaccine equity and national prioritization, which became a focal point of both scholarly and public critique (Borowicz et al., 2022; Nour et al., 2025). The counter-argument is that equity debates sometimes ignore logistical realities and the role of innovation incentives.

But governance cannot treat equity as optional rhetoric: once inequities become visible, they can erode institutional legitimacy and compliance, weakening cooperation precisely when it is most needed (Youde, 2018; Nour et al., 2025).

Finally, legitimacy depends increasingly on transparency and integrity safeguards, not only on technical expertise. If evidence production, contracting, and regulatory choices are perceived as opaque or conflicted, trust becomes fragile and politics becomes more polarized. Good-governance initiatives in the medicines sector point to concrete reform levers—procurement integrity, conflict-of-interest management, and disclosure practices—designed to reduce corruption risks and improve accountability (Baghdadi-Sabeti & Serhan, 2010). At the knowledge level, critiques of ghost management and managed science suggest that openness about trials, authorship, and data is not a “nice-to-have” but part of governance capacity itself (Sismondo, 2007; Attkisson, 2024). WHO’s prioritization framework underscores the same message in a different register: legitimacy must be built through fair procedures and explicit value choices, not by claiming that science alone can settle political trade-offs (World Health Organization, 2020).

3. Methodological Reflections: Studying Pharmaceutical Power in a Transnational Field

Studying pharmaceutical power is methodologically difficult because the field is transnational, hybrid, and partly opaque. Key decisions are distributed across states, international organizations, partnerships, and firms, while the most consequential “rules” often sit in legal instruments and institutional routines rather than in a single command center (Youde, 2018; Jin, 2021). A workable strategy is to operationalize power in layers—visible decisions, structural constraints, and discursive authority—so the analysis does not collapse into either “everything is lobbying” or “everything is structure” (Lukes, 2005; Barnett & Duvall, 2005). That framing also helps keep causal claims disciplined: it encourages the researcher to ask which mechanism is doing the work in a given episode.

Data selection and triangulation are especially sensitive in this domain. Trade texts such as TRIPS provide a stable, citable baseline for structural claims (World Trade Organization, 1994), while WHO guidance documents clarify how priority-setting and ethical justification are formally articulated under scarcity (World Health Organization, 2020). But many influence pathways are not fully visible in public records. This is where scholarship on knowledge production becomes useful: if parts of medical publishing and communication can be strategically managed, then “the evidence” must be treated as a social and institutional product, not only as neutral input (Sismondo, 2007; Borch-Jacobsen, 2013). The methodological implication is straightforward: when possible, separate claims about outcomes (prices, access, timelines) from claims about narratives and credibility, and show how they connect rather than assuming the connection.

Finally, the researcher has to avoid two common errors: conspiracy inflation and naïve technocracy. Whistleblower and investigative accounts can illuminate practices and incentives that formal documents obscure, but they should be used carefully—tested against institutional patterns and broader political-economy dynamics rather than treated as self-sufficient proof (Pratta, 2025; Attkisson, 2024; Dosi et al., 2023). At the other extreme, purely technocratic readings risk mistaking contested value choices for neutral expertise, especially when legitimacy is being managed through procedural language and expert authority (Baghdadi-Sabeti & Serhan, 2010; World Health Organization, 2020). The most credible approach is therefore plural in methods and cautious in inference: it treats governance, markets, and knowledge as interacting sites of power rather than competing "explanations."

Conclusion

This study has argued that health has become a core arena of power politics in the international system, and that Big Pharma's authority is best understood as multi-dimensional rather than purely economic or purely political. Pharmaceutical power operates through visible influence over decisions (contracts, lobbying, regulatory access), through deeper structures that shape what states can realistically do (patents, market concentration, global supply dependence), and through discursive authority that defines what counts as credible science and responsible policy. When these dimensions interact, accountability often becomes blurred: responsibility is dispersed across governments, firms, international organizations, and partnership networks, making it difficult to identify who should answer for shortages, inequitable access, or contested emergency choices.

The analysis also suggests that reform debates fail when they treat the problem as a single issue. Focusing only on lobbying risks ignoring the structural architecture that reproduces asymmetry even after transparency reforms. Focusing only on patents risks overlooking how procurement urgency, partnership governance, and expertise-based legitimacy can reproduce dependence even when legal rules are formally unchanged. And focusing only on "bad science" risks sliding into generalized distrust rather than building stronger institutional safeguards for reliable evidence, integrity, and public oversight. A more realistic conclusion is that meaningful accountability and equity require a combined approach: improving public bargaining capacity and procurement integrity, widening policy space for competition and local production, and strengthening the credibility of knowledge through openness and independent scrutiny.

Future research can deepen this agenda in at least three directions. First, comparative case studies could trace how different states convert pharmaceutical dependence into bargaining power—or fail to—by examining procurement strategies, industrial policy, and crisis governance across regions. Second, network and regime-complex analysis could map

how authority actually travels across overlapping institutions, partnerships, and legal venues, identifying where accountability is lost and where it can be rebuilt. Third, a more systematic "political economy of evidence" is needed: studies that link clinical trial transparency, publication practices, and expert advisory systems to concrete policy outcomes such as pricing decisions, emergency authorizations, and equity patterns. Together, these research paths would move the field beyond moral critique toward a clearer explanation of how pharmaceutical power is organized, how it is legitimized, and where it can be democratically constrained.

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