

**Health Policy Without Accountability: The Rise of
Global Health DoDOs**

Julian Morris, Roger Bate & Christopher Snowdon

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Executive Summary

Global health governance has shifted in ways that weaken democratic accountability while concentrating policy influence. The World Health Organization (the WHO), once a technical coordinating body, now operates within a broader ecosystem of Democratically Deficient Organizations (DoDOS)—intergovernmental institutions, philanthropic foundations, NGOs, and private actors that shape policy without meaningful public oversight. The move from assessed contributions to donor-driven, earmarked funding has severed the link between WHO priorities and member-state control. In its place, a small group of funders—most notably the Bill & Melinda Gates Foundation and Bloomberg Philanthropies—now exert outsized influence over global health agendas.

This brief shows how that system operates in practice. In tobacco control and pandemic governance, foundation funding, WHO authority, NGO advocacy, and academic research reinforce one another to produce policy consensus insulated from scrutiny. Law & economics frameworks help explain the result: incentives favor persistence over performance. The WHO's Framework Convention on Tobacco Control (FCTC) has not accelerated global declines in smoking, while discouraging harm-reduction approaches that have succeeded in countries such as Sweden. Proposals to expand WHO authority in pandemic preparedness risk replicating the same institutional failures revealed during COVID-19.

The problem is not insufficient resources, but weak accountability. The brief proposes reforms to restore it: rebalance WHO funding toward assessed contributions, strengthen transparency and conflict-of-interest rules, open governance processes, embrace harm reduction, and return policy-making authority to domestic democratic institutions. Without such changes, the continued expansion of the DoDO model will deepen existing failures—with consequences measured in human lives.

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“The urge to save humanity is almost always a false front for the urge to rule.”

– H.L. Mencken

I. Introduction

The World Health Organization was founded in 1948 with a mandate to coordinate international efforts to combat disease and improve public health. In its early decades, it built considerable prestige through tightly targeted, outcome-oriented vertical programs: mass vaccination campaigns, technical assistance to developing nations, and focused assaults on diseases such as smallpox, malaria, yaws, and tuberculosis.¹ The eradication of smallpox in 1980 remains the WHO’s signature achievement—and arguably the greatest accomplishment of any international organization.²

The seeds of institutional decay, however, were already taking root. In 1978, the Alma-Ata Declaration announced the goal of “Health for All by the Year 2000,” shifting the WHO’s strategy from vertical disease control to a comprehensive, horizontal model centered on primary health care and the social determinants of health.³ This was not a marginal adjustment. It marked a shift in institutional character. Health policy became as political as scientific. In that arena, the advantage rarely goes to those with the best evidence; it goes to those with the loudest voices and the deepest pockets.⁴

This strategic pivot opened the door to broader structural changes in global health governance—changes that fit squarely within the framework of Democratically Deficient Organizations (DoDOs).⁵ As explained in the introductory paper in this series, the DoDO concept describes how intergovernmental bodies, NGOs, foundations, and corporations exercise substantial policy-shaping authority while remaining largely insulated from democratic accountability. The result is a self-reinforcing ecosystem: failure justifies expansion, dissent is recast as moral deviance, and those most affected by policy decisions have little meaningful voice in shaping them.

This paper applies the DoDO framework to global health. The global health DoDO ecosystem centers on the WHO, alongside a constellation of philanthropic foundations (led by the Bill & Melinda Gates Foundation and Bloomberg Philanthropies), advocacy NGOs (often funded by those same foundations), pharmaceutical companies, and a revolving cadre of public health academics whose careers depend on the regulatory apparatus they help design.

¹ World Health Org., *The Third Ten Years of the World Health Organization: 1968–1977*, 45–60 (1978).

² FRANK FENNER ET AL., *SMALLPOX AND ITS ERADICATION 1345–48* (World Health Org. 1988).

³ World Health Org., *Declaration of Alma-Ata*, INT’L CONF. ON PRIMARY HEALTH CARE (Sept. 12, 1978), <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>.

⁴ Marcos Cueto, *The Origins of Primary Health Care and Selective Primary Health Care*, 94 AM. J. PUB. HEALTH 1864, 1864–74 (2004).

⁵ Julian Morris, *Defending Democracy from the DoDOs: How Power Escapes Democratic Control*, INT’L CTR. FOR L. & ECON. 4–6 (Mar. 12, 2026), <https://laweconcenter.org/wp-content/uploads/2026/03/Defending-Democracy-from-the-DoDOs.pdf>.

Bruce Yandle’s “Baptists and bootleggers” analogy provides a useful complement. Baptists supply the moral justification for regulation, while bootleggers quietly profit from it.⁶ In global health governance, the “Baptists” include public health campaigners, WHO officials, and celebrity philanthropists who frame every policy question in terms of lives saved or children protected. The bootleggers include pharmaceutical companies that benefit from regulatory choices, consulting firms that administer programs, NGOs whose funding depends on sustained crisis, and academics whose grants and publications flow from institutional consensus. No conspiracy is required. Incentives do the work.

II. The Political Economy of WHO Financing

To understand how the WHO became a DoDO, follow the money. The organization’s original design relied on assessed contributions from member states—mandatory dues based on national income. The World Health Assembly (WHA) retained collective control over how those funds were spent.⁷ The system was imperfect, but it preserved at least a loose connection between the WHO’s priorities and the collective will of its members. That connection has now been severed.

By the 2023–2024 biennium, roughly 84% of the WHO’s budget came from voluntary contributions, most of them earmarked by donors rather than the WHA.⁸ In that same period, the United States was the largest contributor, followed by the Bill & Melinda Gates Foundation and Germany. Each of those three donors individually provided more funding than most member states combined.⁹ Lawrence Gostin, himself a WHO collaborating center director, noted in 2015 that the organization fully controlled only about 20% of its budget.¹⁰ Donors effectively dictate the rest.

This is not just a shift in financing. It is a quiet transformation in governance. When a private foundation contributes more to a UN agency than nearly every sovereign state—and specifies how the money must be spent—it acquires policymaking authority without any of the constraints that bind even the most dysfunctional governments. The Gates Foundation faces no elections, no parliamentary scrutiny, no freedom-of-information requests, and no judicial review. It answers only to its founders.¹¹

⁶ Bruce Yandle, *Bootleggers and Baptists—The Education of a Regulatory Economist*, 7 REGULATION 12, 12–16 (1983); ADAM SMITH & BRUCE YANDLE, BOOTLEGGERS AND BAPTISTS: HOW ECONOMIC FORCES AND MORAL PERSUASION INTERACT TO SHAPE REGULATORY POLITICS 15–40 (Cato Inst. 2014).

⁷ Devi Sridhar & Ngaire Woods, *Trojan Multilateralism: Global Cooperation in Health*, 4 GLOBAL POL’Y 325, 325–35 (2013).

⁸ World Health Org., *Programme Budget 2022–2023: Financial Overview and Contributors* (2023), <https://open.who.int> (last visited Mar. 10, 2026); see also *Flexibly Funding WHO? An Analysis of Its Donors’ Voluntary Contributions*, 8 BMJ GLOB. HEALTH e011232 (2023).

⁹ *Id.*

¹⁰ Lawrence O. Gostin *et al.*, *The Normative Authority of the World Health Organization*, 129 PUB. HEALTH 854, 856–58 (2015).

¹¹ Sophie Harman, *The Bill and Melinda Gates Foundation and Legitimacy in Global Health Governance*, 22 GLOBAL GOVERNANCE 349, 349–68 (2016).

Devi Sridhar and Ngaire Woods describe this arrangement as “trojan multilateralism”: the use of multilateral institutions to advance bilateral and private donor agendas.¹² The pattern is familiar. A foundation selects a priority—polio eradication, pandemic preparedness, vaccine delivery. It funds WHO programs aligned with that priority, often building parallel structures such as GAVI (the Global Alliance for Vaccines and Immunization) and CEPI (the Coalition for Epidemic Preparedness Innovations) that sit alongside, and often sidestep, the WHO’s formal governance. It also funds academic research to validate the approach, NGOs to advocate for it, and media coverage to amplify it. The appearance of multilateralism remains. The substance does not. Accountability to member states—let alone voters—evaporates.¹³

The concern here is not philanthropy as such. Foundations can and often do support valuable health interventions. A foundation that builds clinics or expands vaccine access raises few objections. The problem arises when funding comes with policy conditions. At that point, financial support becomes a vehicle for influence. In intergovernmental bodies and executive agencies—already distant from democratic oversight—those conditions further dilute accountability. In the case of the WHO, earmarked funding has compounded weak WHA oversight and accelerated its evolution into a DoDO.

III. Gates and the Philanthropic Policy Model

The Bill & Melinda Gates Foundation warrants particular scrutiny—not because its intentions are necessarily malign, but because its influence is so extensive that it reshapes the structure of global health governance. With annual spending on health-related activities averaging roughly \$4 billion in recent years, much of it directed to NGOs and academic researchers, the foundation is not merely a major donor. It operates as a *de facto* health policy institution, shaping spending priorities and regulatory agendas, especially at the WHO and in lower-income countries.¹⁴

Anne-Emanuelle Birn traces the origins of this model to the Rockefeller Foundation’s dominance of international health in the early 20th century.¹⁵ Linsey McGoe’s analysis of the Gates Foundation shows how its grant-making creates a dense web of financial dependencies that discourages dissent.¹⁶ Universities, think tanks, NGOs, and media organizations that receive Gates funding have strong incentives to endorse its approach and equally strong incentives to avoid scrutinizing it. McGoe’s

¹² Sridhar & Woods, *supra* note 7.

¹³ Devi Sridhar, *Who Sets the Global Health Research Agenda? The Challenge of Multi-Bi Financing*, 9 PLOS MED. e1001312 (2012).

¹⁴ Calculations by authors based on Bill & Melinda Gates Found., *2023 Annual Report* (2024), and Bill & Melinda Gates Found., *2024 Annual Report* (2025) (finding roughly \$2 billion in annual spending classified as “global health,” with comparable additional spending on closely related categories such as vaccine development, malaria, and tuberculosis).

¹⁵ Anne-Emanuelle Birn, *Philanthrocapitalism, Past and Present: The Rockefeller Foundation, the Gates Foundation, and the Setting(s) of the International/Global Health Agenda*, 12 HYPOTHESIS e8 (2014).

¹⁶ LINSEY MCGOEY, *NO SUCH THING AS A FREE GIFT: THE GATES FOUNDATION AND THE PRICE OF PHILANTHROPY* (Verso 2015).

conclusion is blunt: there is “no such thing as a free gift.” Every grant carries strings, whether acknowledged or not.

The foundation’s influence on the WHO raises sharper concerns. It funds not only the academics and NGOs whose research and advocacy inform WHO decision making, but also the WHO itself—both directly and indirectly. For example, it funds GAVI, which the WHO helps govern.¹⁷ More importantly, as David McCoy and his co-authors document in *The Lancet*, the foundation participates directly in policymaking across the system:¹⁸

The foundation actively engages in policy making and agenda setting activities; it has representatives that sit on the governing structures of many global health partnerships; it is part of a self-appointed group of global health leaders known as the H8 (together with WHO, the World Bank, GAVI Alliance, the Global Fund, UNICEF, the United Nations Population Fund [UNFPA], and UNAIDS); and has been involved in setting the health agenda for the G8. The Gates Foundation is also involved in setting the research agenda of several public health priorities, a role that was controversially criticised by the former head of WHO’s malaria programme, who complained that the dominance of the Gates Foundation in malaria research risked stifling the diversity of views among scientists.¹⁹

This is the DoDO ecosystem in full view. A large philanthropic foundation—accountable primarily to its founders and board—funds research, advocacy, and media, while also participating directly in policymaking and agenda setting. The foundation and its institutional allies operate largely outside democratic oversight, yet shape regulatory and policy decisions that affect billions.

IV. Bloomberg and the Financing of Tobacco Control

If the Gates Foundation shows how one large DoDO can shape health policy broadly, Bloomberg Philanthropies shows how a single DoDO can dominate a narrow regulatory domain. Since 2005, Michael Bloomberg has committed more than \$1.6 billion to global tobacco-control initiatives through the Bloomberg Initiative to Reduce Tobacco Use.²⁰

The initiative operates through a network of implementing partners, including the Campaign for Tobacco-Free Kids (CTFK), Vital Strategies, the Johns Hopkins Bloomberg School of Public Health,

¹⁷ David McCoy et al., *The Bill & Melinda Gates Foundation’s Grant-Making Programme for Global Health*, 373 LANCET 1645, 1645–53 (2009).

¹⁸ Judith Richter, *Public-Private Partnerships and International Health Policy-Making: How Can Public Interests Be Safeguarded?* 31–50 (World Health Org. 2004).

¹⁹ McCoy et al., *supra* note 17, at 1650.

²⁰ Bloomberg Philanthropies, *Bloomberg Initiative to Reduce Tobacco Use*, <https://www.bloomberg.org/public-health/reducing-tobacco-use> (last visited Apr. 2, 2026); Philanthropy N.Y., *Bloomberg Philanthropies Launches \$420 Million Initiative to Reduce Tobacco Use Globally* (Feb. 2, 2023), <https://philanthropynewyork.org/news/bloomberg-philanthropies-commits-additional-420-million-reduce-tobacco-use-globally> (last visited Apr. 2, 2026).

the CDC Foundation, and the WHO.²¹ These organizations provide technical assistance, fund advocacy campaigns, support research, and help governments implement tobacco-control policies in low- and middle-income countries.

Through this structure, philanthropic funding supports both the development of global norms—particularly those associated with the WHO’s Framework Convention on Tobacco Control (FCTC)—and the domestic advocacy needed to entrench those norms in national regulatory systems.

Adopted in 2003, the FCTC was the first treaty negotiated under WHO auspices and remains the organization’s most ambitious exercise of normative authority. More than 180 countries are parties. Its objectives were straightforward: reduce tobacco use, limit exposure to secondhand smoke, and address the global burden of tobacco-related disease.²²

The results have fallen short. When the FCTC entered into force in 2005, the world had roughly 1.1 billion smokers. Nearly two decades later, that number remains largely unchanged.²³ Population growth of about 20% has produced a corresponding decline in prevalence, but that decline largely reflects trends already underway before the treaty.

Steven Hoffman and his co-authors confirm this point in a rigorous quasi-experimental analysis published in the *BMJ*, finding “no evidence to indicate that global progress in reducing cigarette consumption has been accelerated by the FCTC treaty mechanism.”²⁴

Some countries have achieved sharper declines in smoking prevalence—notably Sweden, the United Kingdom, and Japan. These outcomes largely reflect the availability of lower-risk nicotine alternatives, including snus, e-cigarettes, and heated tobacco products, which enable substitution away from combustible cigarettes.

Sweden provides the clearest population-level example. Since the introduction of snus in the 1970s, Swedish consumers have steadily shifted toward this lower-risk form of smokeless tobacco. Most EU countries banned snus in 1992, preventing similar substitution. Sweden secured an exemption when it joined the EU in 1995.

²¹ Campaign for Tobacco-Free Kids, *Bloomberg Initiative to Reduce Tobacco Use*, <https://www.tobaccofreekids.org/what-we-do/global/bloomberg> (last visited Apr. 2, 2026).

²² WHO Framework Convention on Tobacco Control art. 5.3, May 21, 2003, 2302 U.N.T.S. 166.

²³ GBD 2019 Tobacco Collaborators, *Spatial, Temporal, and Demographic Patterns in Prevalence of Smoking Tobacco Use and Attributable Disease Burden in 204 Countries and Territories, 1990–2019*, 397 *LANCET* 2337 (2021); World Health Org., *Global Report on Trends in Prevalence of Tobacco Use 2000–2030* (4th ed. 2021).

²⁴ Steven J. Hoffman et al., *Impact of the WHO Framework Convention on Tobacco Control on Global Cigarette Consumption: Quasi-Experimental Evaluations Using Interrupted Time Series Analysis and In-Sample Forecast Event Modelling*, 365 *BMJ* 12287 (2019); see also Steven J. Hoffman & Cigdem Tan, *Overview of Systematic Reviews on the Health-Related Effects of Government Tobacco Control Policies*, 15 *BMC PUB. HEALTH* 744 (2015).

The divergence is stark. Adult male smoking prevalence in Sweden has fallen below 5%, far below the EU average of more than 20%.²⁵ Smoking-related mortality among Swedish men is correspondingly the lowest in the EU, a pattern Lars Ramström and Tom Wikmans link to substitution from cigarettes to snus.²⁶

The EU ban on snus created a decades-long natural experiment across an entire customs union. The outcome is clear: harm reduction works.²⁷ Continuing the experiment looks less like caution than inertia bordering on negligence. (Proposed as a formal trial, it would likely fail any ethics review.)

The FCTC and the WHO have nonetheless rejected snus as a harm-reduction tool. A 2003 WHO report states: “There is no evidence to recommend that any smokeless tobacco product should be used as part of a harm reduction strategy.”²⁸ More recent guidance reiterates the position,²⁹ emphasizing risks while discouraging comparative claims about relative harm.³⁰

The WHO applies an even more precautionary approach to e-cigarettes—rebranded as “electronic nicotine delivery systems,” or ENDS—despite evidence that they are far less harmful than cigarettes and more effective than conventional nicotine-replacement therapies at supporting cessation.³¹

The FCTC sits at the center of Bloomberg’s campaign. The institutional architecture is a textbook DoDO. Bloomberg funds academic research that provides intellectual support. It funds NGOs such as CTFK and members of the Global Alliance for Tobacco Control (GATC), which lobby governments to adopt FCTC-aligned policies. It also funds the WHO, which supplies the normative framework those NGOs deploy.

²⁵ Eur. Comm’n, *Special Eurobarometer 539: Attitudes of Europeans Towards Tobacco and Related Products* (2023).

²⁶ Lars Ramström & Tom Wikmans, *Mortality Attributable to Tobacco Among Men in Sweden and Other European Countries: An Analysis of Data in a WHO Report*, 12 *TOBACCO INDUC. DIS.* 14 (2014).

²⁷ *Id.*; see also Karl Fagerström & Elsy-Britt Schildt, *Should the European Union Lift the Ban on Snus? Evidence from the Swedish Experience*, 98 *ADDICTION* 1191, 1191–95 (2003).

²⁸ World Health Org., *Scientific Advisory Committee on Tobacco Product Regulation (SACTob), Recommendation on Smokeless Tobacco Products* 4 (2003).

²⁹ World Health Org. Framework Convention on Tobacco Control Secretariat, *Smokeless Tobacco Products: Guide to Drafting Regulation to Implement the WHO FCTC* 4, 8 (2024).

³⁰ *Id.* at 22.

³¹ Julian Morris, *The World Health Organization’s Opposition to Tobacco Harm Reduction: A Threat to Public Health?*, REASON FDN. (2016); Ann McNeill et al., *E-Cigarettes: An Evidence Update—A Report Commissioned by Public Health England* (Aug. 2015) (finding vaping approximately 95% less harmful than combustible cigarettes); Royal Coll. of Physicians, *Nicotine Without Smoke: Tobacco Harm Reduction* 56–75 (2016) (endorsing e-cigarettes as a cessation tool); Peter Hajek et al., *A Randomized Trial of E-Cigarettes Versus Nicotine-Replacement Therapy*, 380 *NEW ENG. J. MED.* 629, 629–37 (2019) (finding e-cigarettes nearly twice as effective as nicotine-replacement therapy for smoking cessation); Angela Difeng Wu et al., *Electronic Cigarettes for Smoking Cessation: An Overview of Systematic Reviews and Evidence and Gap Map*, *ADDICTION* (Mar. 26, 2026) (reporting higher ≥6-month cessation rates with nicotine e-cigarettes across multiple comparisons); Renée O’Leary et al., *Examining E-Cigarettes as a Smoking Cessation Treatment: A Critical Umbrella Review Analysis*, 266 *DRUG ALCOHOL DEPEND.* 112520 (2025) (finding e-cigarettes more effective than other cessation treatments).

Bloomberg Philanthropies is not the only funder. The Gates Foundation, the Wellcome Trust, the Robert Wood Johnson Foundation, and various governments also contribute.³² In some cases, government agencies fund NGOs that advocate for the agencies' own policies, creating the appearance of grassroots support and short-circuiting democratic scrutiny.³³

Pharmaceutical companies add another layer. Firms that manufacture nicotine-replacement therapies and cessation drugs benefit from regulatory limits on competing nicotine products. Some have funded advocacy organizations that lobby for those restrictions.³⁴ The logic of Yandle's model becomes visible: bootleggers underwriting Baptists.

Taken together, this ecosystem reflects a top-down agenda shaped by a small group of funders, with Bloomberg at its center. Money flows through academics and NGOs that generate and promote policy arguments,³⁵ creating the appearance of broad consensus while narrowing the range of acceptable views.

This manufactured consensus is reinforced by expansive interpretations of FCTC Article 5.3. Intended to shield policy from tobacco-industry influence, it has been applied so broadly that it restricts engagement with entities only tangentially connected to tobacco.

The result borders on the absurd. The FCTC Conference of the Parties has met behind closed doors since 2010, excluding journalists and the public,³⁶ while NGOs aligned with the prevailing framework participate and publicly shame dissenting countries through "Dirty Ashtray Awards."³⁷

³² See, e.g., Bill & Melinda Gates Found., *Michael Bloomberg and Bill Gates Join to Combat Global Tobacco Epidemic*, <https://www.gatesfoundation.org/ideas/media-center/press-releases/2008/07/michael-bloomberg-and-bill-gates-join-to-combat-global-tobacco-epidemic> (last visited Apr. 2, 2026); Wellcome Tr., *Commercial Determinants of Health Programme*; Robert Wood Johnson Found., *Tobacco Policy Research and Advocacy Programs*, <https://www.rwjf.org> (last visited Mar. 10, 2026). Philanthropic funding for global tobacco-control advocacy often flows through a small set of intermediary organizations—such as the Campaign for Tobacco-Free Kids, Vital Strategies, and the International Union Against Tuberculosis and Lung Disease—that distribute grants, coordinate advocacy campaigns, and provide technical assistance to governments. This structure creates a tightly integrated policy network aligning funding, research, and advocacy. See Sridhar & Woods, *supra* note 8.

³³ Christopher Snowden, *Sock Puppets: How the Government Lobbies Itself and Why* 8–18 (Inst. of Econ. Aff. 2012).

³⁴ See, e.g., Pfizer Inc., *U.S. Medical, Scientific, Patient and Civic Organization Funding Report: Fourth Quarter 2014* (2015) (listing grants to the Campaign for Tobacco-Free Kids, including \$25,000 for the "2014 Youth Advocates of the Year Event"), https://cdn.pfizer.com/pfizercom/responsibility/grants_contributions/Yes_Report-2014-08.29.2017.pdf (last visited Apr. 2, 2026).

³⁵ Bloomberg Philanthropies, *E-cigarettes*, <https://www.bloomberg.org/public-health/reducing-tobacco-use/e-cigarettes> (last visited Apr. 4, 2026).

³⁶ See, e.g., World Health Org. Framework Convention on Tobacco Control, Conf. of the Parties, Fifth Sess., *Summary Record of the Second Committee B Meeting*, ¶ 2, FCTC/COP/5/REC/2 (Nov. 17, 2012), https://apps.who.int/gh/fctc/PDF/cop5/FCTC_COP5_REC2.pdf (last visited Apr. 4, 2026); World Health Org. Framework Convention on Tobacco Control, Conf. of the Parties, *Rules of Procedure*, Rule 5 (providing that sessions may be closed to the public).

³⁷ See Framework Convention Alliance (now Global Alliance for Tobacco Control), *Dirty Ashtray Awards*, COP advocacy materials (issued at successive Conferences of the Parties).

Interpol was denied observer status at COP6 in 2014 because it had accepted funding from Philip Morris International for anti-smuggling efforts.³⁸ The WHO's Tobacco Cessation Consortium, launched in 2022, excludes tobacco and non-medical nicotine firms under Article 5.3 while including pharmaceutical and technology companies as partners.³⁹

The contrast is stark. Companies that profit from medically sanctioned cessation products are welcomed. Companies that produce lower-risk alternatives—often more effective at helping smokers quit—are excluded.

The consequences can be perverse. In 2022, the WHO refused Emergency Use Listing for Covifenz, a COVID-19 vaccine developed by the Canadian company Medicago, because Philip Morris International held roughly a one-third stake in the firm. Health Canada had already authorized the vaccine, with efficacy exceeding 70%.⁴⁰ The WHO's objection was not safety, but institutional policy under the FCTC.

The result was that low- and middle-income countries lost access to a viable vaccine during a pandemic because of a tobacco company's investment. It is difficult to imagine a clearer case of policy overriding public health.

Some insiders have begun to question the system. Former WHO department directors Robert Beaglehole and Ruth Bonita conclude in *The Lancet* that the FCTC “is no longer fit for purpose, especially for low-income countries,” and call for harm reduction to be integrated into the framework.⁴¹

The treaty now functions less as a tool for harm reduction than as an institution oriented toward its own preservation.⁴² The incentives embedded in the DoDO ecosystem have, so far, impeded reform.

³⁸ WHO Framework Convention on Tobacco Control, *Guidelines for Implementation of Article 5.3* (2008) (recommending that governments limit interactions with the tobacco industry and avoid partnerships with tobacco-related entities); see also WHO Framework Convention on Tobacco Control, Conf. of the Parties, Sixth Sess., *Interpol's Application for Observer Status*, FCTC/COP/6/4 (July 24, 2014); see also Interpol, *Interpol Global Complex for Innovation and Cooperation on Illicit Trade* (discussing cooperation on illicit tobacco trade).

³⁹ World Health Org., *Pharma, Tech and Social Media Companies Join Forces with WHO to Launch the Tobacco Cessation Consortium During World Health Summit in Berlin, Germany* (Oct. 20, 2022), <https://www.who.int/news/item/20-10-2022-pharma-tech-and-social-media-companies-join-forces-with-who-to-launch-the-tobacco-cessation-consortium-during-world-health-summit-in-berlin-germany>.

⁴⁰ Tony Kirby, *Philip Morris Ejected from Canadian Vaccine Collaboration*, 11 LANCET RESPIRATORY MED. e40 (2023); see also WHO Refuses Emergency Use Listing for Medicago COVID-19 Vaccine Due to Philip Morris International Ties, TOBACCO ASIA (Mar. 18, 2022).

⁴¹ Robert Beaglehole & Ruth Bonita, *Tobacco Control: Getting to the Finish Line*, 399 LANCET 1865 (2022).

⁴² CHRISTOPHER SNOWDON, KILLJOYS: A CRITIQUE OF PATERNALISM 85–96 (Inst. of Econ. Aff. 2017) (discussing the “closed shop” dynamics of FCTC COP meetings).

V. Cascades, Consensus, and Policy Entrenchment

The persistence of failed policies in the face of contrary evidence demands explanation. Timur Kuran and Cass Sunstein's concept of availability cascades offers a useful framework.⁴³ An availability cascade occurs when repetition, not evidence, drives belief. The more often a claim circulates in public discourse, the more cognitively "available" it becomes—and the more likely people are to accept it as true.⁴⁴

In the global health DoDO ecosystem, these cascades are driven by availability entrepreneurs. The mechanism is straightforward. A foundation funds research at a prestigious university. The research supports the foundation's preferred policy. The foundation funds NGOs to promote the findings. Those NGOs lobby the WHO. The WHO issues guidance citing the research. Governments implement the guidance. The foundation then funds further research showing that implementation falls short, justifying additional funding and renewed intervention.

This circuit operates with minimal external constraint. At no point does meaningful democratic accountability enter the process. Research circulates within a closed funding network. NGOs answer to donors, not the populations they claim to represent. The WHO's governance structures are dominated by health ministry officials rather than elected representatives. Governments often implement WHO guidance through administrative action rather than legislation, further insulating the process from political scrutiny.

Christopher Snowdon has documented a related phenomenon in the form of "sock puppet" NGOs—organizations that present as independent but rely on funding from the same entities whose policies they promote.⁴⁵ In that setting, a government agency uses an NGO to advance policies that would struggle under direct political scrutiny.

In global health, the pattern is broader and less transparent. Funding often originates from private foundations rather than governments, obscuring the underlying relationships.

The Gates Foundation's simultaneous funding of the WHO, GAVI, academic research centers, and advocacy NGOs creates what can fairly be described as full-spectrum dominance of the policy space. Nearly every voice in the conversation is, directly or indirectly, funded by the same source.

VI. Institutional Expansion Without Reform

The FCTC model is now spreading across global health governance with notable speed. The same DoDO architecture—WHO normative authority, foundation funding, NGO advocacy, and closed-

⁴³ Timur Kuran & Cass R. Sunstein, *Availability Cascades and Risk Regulation*, 51 STAN. L. REV. 683, 683-768 (1999).

⁴⁴ *Id.* at 720-35.

⁴⁵ Snowdon, *supra* note 33, at 15-18 (describing how government-funded NGOs can create an "astroturf" effect that simulates grassroots support for policies originating within the bureaucracy).

door decision making—has expanded beyond tobacco to alcohol, sugar, ultra-processed foods, and pandemic governance.⁴⁶

The proposed WHO Pandemic Agreement (formerly the “Pandemic Treaty”) marks the most ambitious extension of this model to date.⁴⁷ Drawing on the FCTC precedent, it would expand the WHO’s role in pandemic preparedness and response. Proposed provisions include surveillance obligations, benefit-sharing requirements for pathogen data, and “sustainable financing” mechanisms that would further entrench reliance on voluntary contributions—and with it, donor influence over priorities.

The COVID-19 pandemic exposed the institutional weaknesses the DoDO framework predicts. The WHO’s delayed response to the initial outbreak, its acceptance of Chinese government assurances, and its reluctance to investigate the laboratory-leak hypothesis reflected structural constraints, not isolated errors. An organization dependent on the goodwill of powerful member states and donors will predictably hesitate to challenge them.⁴⁸

The Independent Panel for Pandemic Preparedness and Response reached a similar conclusion: the WHO lacked both the authority and the independence to respond effectively. The proposed remedy—more authority, more funding, more institutional machinery—misses the point. Expanding the powers of an institution already shaped by donor influence does not resolve the underlying problem.⁴⁹ It reinforces it.

The pattern extends to pharmaceutical regulation. The WHO’s prequalification program, funded in significant part by the Gates Foundation through UNITAID, plays a central role in determining which drugs and vaccines qualify for purchase with international donor funds.⁵⁰

⁴⁶ Ilona Kickbusch et al., *The Commercial Determinants of Health*, 401 LANCET 1223 (2023); Jeff Collin, Kelley Lee & Karen Bissell, *The Framework Convention on Tobacco Control: The Politics of Global Health Governance*, 23 THIRD WORLD Q. 265 (2002); CHRISTOPHER SNOWDON, *THE ART OF SUPPRESSION: PLEASURE, PANIC AND PROHIBITION SINCE 1800* 185–220 (Little Dice 2011).

⁴⁷ World Health Org., *WHO Pandemic Agreement: Zero Draft*, WHO Doc. A/INB/4/3 (Feb. 1, 2023).

⁴⁸ Indep. Panel for Pandemic Preparedness & Response, *COVID-19: Make It the Last Pandemic* 22–40 (2021); Lawrence O. Gostin, Suerie Moon & Benjamin M. Meier, *Reimagining Global Health Governance in the Age of COVID-19*, 110 AM. J. PUB. HEALTH 1615 (2020); World Health Org., *WHO-Convended Global Study of Origins of SARS-CoV-2: China Part* (2021) (describing the laboratory-incident hypothesis as “extremely unlikely,” a conclusion later questioned by governments and scientific commentators); David Relman, *Opinion: To Stop the Next Pandemic, We Need to Unravel the Origins of COVID-19*, 375 SCIENCE 1262 (2021).

⁴⁹ Lawrence O. Gostin, *The Future of the World Health Organization: Lessons Learned from Ebola*, 93 MILBANK Q. 475, 480–82 (2015).

⁵⁰ ROGER BATE, *PHAKE: THE DEADLY WORLD OF FALSIFIED AND SUBSTANDARD MEDICINES* 145–70 (AEI Press 2014).

Despite decades of WHO involvement, substandard and falsified medicines remain widespread in low- and middle-income countries. Institutional incentives emphasize process compliance—reports, meetings, and grant disbursement—over measurable outcomes.⁵¹

The system excels at coordination and documentation. It performs less well at ensuring that patients in Lagos or Dhaka receive effective medicines.⁵²

VII. Incentives, Insulation, and Persistence

The preceding analysis reveals a consistent structural logic that defines health DoDOs. Several reinforcing mechanisms sustain the system and explain its persistence.⁵³

Incentive misalignment. Every actor in the health DoDO ecosystem benefits from the continuation of the problem rather than its resolution. The WHO's budget expands with each new health crisis. Foundations justify their existence by identifying new threats. NGOs rely on ongoing emergencies to sustain funding. Pharmaceutical companies profit from both disease and treatment. Academics build careers around an expanding regulatory apparatus. This is not conspiracy but ecology. Each actor pursues its own incentives, and those incentives align in ways that perpetuate the system.⁵⁴

Democratic insulation. The system operates at a remove from democratic accountability. International agreements bind successor governments. Voluntary contributions bypass legislative appropriations. Expert committees, rather than elected officials, set technical standards. The populations most affected—often in developing countries—have little or no voice in the institutions that shape the policies governing their health.

Knowledge monopoly. Foundations influence not only policy, but the production of policy-relevant knowledge. By funding research, training researchers, and shaping institutional prestige, they exercise significant agenda-setting power. Dissent rarely faces direct censorship. It is filtered out through funding decisions. Researchers who challenge prevailing assumptions risk losing grants, publication opportunities, and career advancement. The result is a self-reinforcing consensus.

Failure as justification. Failure does not trigger reform; it triggers expansion. When the FCTC falls short of reducing global tobacco use, the response is to call for stronger implementation and additional funding. When the WHO underperforms during crises such as Ebola or COVID-19, the response is to expand its authority and resources. Mancur Olson's logic of collective action explains

⁵¹ World Health Org., *Substandard and Falsified Medical Products (Fact Sheet)* (updated 2023), <https://www.who.int/news-room/fact-sheets/detail/substandard-and-falsified-medical-products>; Shinobu Ozawa et al., *Prevalence and Estimated Economic Burden of Substandard and Falsified Medicines in Low- and Middle-Income Countries*, 1 JAMA NETWORK OPEN e181662 (2018); Roger Bate et al., *Substandard and Falsified Anti-Tuberculosis Drugs: A Preliminary Field Analysis*, 17 INT'L J. TUBERCULOSIS & LUNG DISEASE 308, 308–11 (2013).

⁵² Amir Attaran et al., *How to Achieve International Action on Falsified and Substandard Medicines*, 345 BMJ e7381 (2012).

⁵³ Morris, *supra* note 5, at 15–18.

⁵⁴ Yandle, *supra* note 6, at 14–15; Morris, *supra* note 5, at 4–7.

why.⁵⁵ The beneficiaries of the system—bureaucrats, consultants, NGOs—are concentrated, organized, and motivated. The costs fall on diffuse populations that face high barriers to collective action. The system therefore persists, even when its results do not justify its expansion.

VIII. Accountability Before Expansion

The health DoDO complex may be the most consequential of all DoDO ecosystems because its failures are measured in human lives. Eight million tobacco deaths annually. Millions more from malaria, tuberculosis, and childhood diseases that persist not for lack of effective interventions, but because the institutional apparatus prioritizes process over outcomes. A pandemic response that too often deferred to institutional constraints. And now a proposed Pandemic Agreement that would entrench the same structures that failed.

The path forward requires more than marginal reform. It requires restructuring international health cooperation around accountability and subsidiarity.

Funding reform. The WHO's financing model must restore the primacy of assessed contributions. As long as the organization depends on voluntary, earmarked funding from a small group of donors, it will reflect their priorities rather than those of its members. If governments are unwilling to fund the WHO through assessed contributions, that reluctance is itself informative. It suggests they do not value its activities enough to support them through democratic fiscal processes.

Transparency and conflicts of interest. The revolving door among foundations, the WHO, and the NGO sector should be transparent and subject to conflict-of-interest rules at least as stringent as those applied to the tobacco industry under Article 5.3. If influence from Philip Morris is unacceptable, influence from major foundations should face comparable scrutiny. At a minimum, equivalent standards of transparency and accountability should apply.

Open governance. The FCTC's decision-making process must be opened to public scrutiny. Closed-door negotiations on policies affecting billions are incompatible with democratic governance. Excluding journalists, independent researchers, and dissenting voices protects institutional incumbents, not the public.

Harm reduction. Harm reduction should be treated as a core principle of health policy, not a deviation from orthodoxy. Evidence from Sweden, the United Kingdom, Japan, and New Zealand shows that risk-proportionate regulation saves lives. The FCTC's refusal to incorporate this evidence reflects institutional incentives, not scientific caution.

Democratic control. Health policies that affect domestic populations should be determined by domestic democratic institutions, not delegated to international bodies with attenuated accountability.

⁵⁵ MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* 53–65 (Harvard Univ. Press 1965).

International cooperation has a role in coordination, information sharing, and technical assistance. It is not a substitute for democratic self-governance.

The architects of the postwar international order understood that legitimacy flows from accountability. They designed the WHO to serve its member states, not to direct them. That relationship has reversed. Restoring it will require confronting not only entrenched institutional interests, but also the assumption that technical expertise and good intentions can substitute for democratic consent.

They cannot. They never have. In global health, where the stakes are measured in millions of lives, the cost of that assumption is too high to ignore.