1
Global Governance and Health

Abstract: *This chapter discusses the relationship, in an age of globalisation, between global health governance and the governance of individual health issues such as HIV/AIDS, pandemic influenza, tobacco control and access to medicines. It does this within the context of changes to global governance more generally. It proposes a new way of envisaging this relationship, which captures the evolving political dynamics. In particular the chapter identifies a narrative of transformative change in global health governance based on three elements: the globalisation of health; the emergence of competing visions of global health governance; and the changing institutional landscape.*

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Introduction

In early 2007, Indonesia's Minister of Health, Siti Fadilah Supari, announced her country's decision to stop sharing its samples of the H5N1 influenza ('bird flu') virus with the World Health Organization (WHO). What appeared at first sight to be a fairly innocuous, technical decision, sparked a major diplomatic crisis. Since 1952, the WHO has been identifying circulating strains of the influenza virus to allow the development of vaccines and warn of novel strains with the potential to become pandemic. Central to this is the manner in which samples of the influenza virus are shared on a systematic and regular basis, from 135 recognised National Influenza Centres located in 105 areas, to one of six regionally distributed WHO Collaborating Centres. Here they are analysed to determine which strains are in active circulation and whether a new strain may be emerging (WHO, no date). Virus sharing was therefore widely accepted as a global public good, where mutual interests had produced global norms and institutions to mitigate the potential human and economic costs of influenza.

In this context, the Indonesian decision not only appeared to undermine an example of an effective global regime, but also came at a time when fears of a highly pathogenic influenza pandemic were high, and Indonesia was among the countries seen as a highly likely source of such an outbreak. The general reaction, especially from the United States, was extremely hostile, portraying Indonesia's actions as reckless and threatening to global health security. Siti Supari, however, argued that virus samples were being passed on, without Indonesia's knowledge or permission, to private pharmaceutical companies to develop highly lucrative vaccines. Moreover, despite widespread recognition that Indonesia could potentially be the front line of an influenza pandemic, and therefore in greatest need of vaccine supplies, the price set by pharmaceutical companies lay beyond the means of most Indonesians. Further, patent protections had been taken out by companies on the avian influenza virus itself, and Material Transfer Agreements concluded between WHO and pharmaceutical companies, without the consent of those countries providing virus samples. Supari claimed that this practice was 'obviously unfair and opaque' (Supari, 2007). Indonesian fears appeared vindicated in 2009–10 when, during the 'swine flu' (H1N1) pandemic, high-income countries received privileged access to the relevant vaccine, regardless of who was most at risk from the virus or which governments had provided

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virus samples to manufacture the vaccine (WHO, 2007a; Fidler, 2010a; Knox, 2011; Sinha, 2011).

Although the Indonesian virus sharing crisis was eventually resolved in 2011, what the crisis appeared to confirm was that the traditional view of international health cooperation had been transformed. Historically seen as a largely technical arena focused on such tasks as developing guidelines for 'best practice', agreeing common nomenclature and supporting capacity building in healthcare delivery, it was now characterised by a greater diversity and, on many issues more divergent, range of interests and perspectives. International health cooperation is now known as global health governance (GHG), a term suggesting a qualitative shift from intergovernmental relations to a more complex global assemblage. Crucially, this sense of transformative change in governance, widely constructed as a consequence of globalisation (for example: Cockerham and Cockerham, 2010; Harman, 2012), was not limited to health, but was sensed more widely within the international system.

This first chapter sets out the concerns of this book and its underpinning approach. It begins by discussing global governance, allowing us to begin to interrogate the relationship with GHG. It then discusses the emergence of GHG as a distinct subject of study and practice. This allows us to locate our work within this developing subject area, before outlining the framework of analysis adopted (what we term the 'three transformations' in GHG). The book then proceeds to apply this macro-level framework to four case studies, each focusing on a particular issue widely constructed as central in and to the narrative of global health. These four issues balance the traditional focus in GHG on infectious and communicable disease, with more recent concerns over non-communicable disease and distributive justice issues, and the appropriate and necessary governance responses to each.

The theoretical basis of this book is social constructivism. As Onuf (1989) argues, the social world does not exist independent of observation but is one of our own making, and that the ideas we use in observing and understanding the social world also shape that world. This does not mean that the material world is of no concern, but rather that the material and ideational interact with each other:

> Constructivists hold the view that the building blocks of ... reality are ideational as well as material; that ideational factors have normative as well as instrumental dimensions; that they express not only individual but collective

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> intentionality; and that the meaning and significance of ideational factors are not independent of time and place. (Ruggie, 1998, p. 33)

Therefore, we do not deny the importance of material factors in shaping GHG. Rather, we add to this the manner in which health and health issues are socially constructed (by language and other means), within a specific context of time and place, and *through this construction* possess meaning.

The transformation of global governance

The origins of the transformation in global governance are often identified as lying in the emergence of neoliberalism and free market capitalism as the dominant economic ideology in the 1980s and 1990s. Although not all forms of global governance are manifestations of neoliberalism, these ideas formed a powerful engine for subsequent changes. In particular, boosted by the end of the Cold War, these ideas established a global rationality legitimising a series of policies and empowering certain institutions such as the World Bank. Recognition in time of the failings of neoliberal policies such as structural adjustment, however, led 'not [to] a rejection of neoliberalism, but a recognition of the need for a greater institutional embedding of neoliberal rationalities, in particular by paying greater attention to the mechanisms of governance and securing the social conditions by which free markets could better operate' (Joseph, 2012, pp. 95–6). Thus, neoliberalism provides an economic structure and rationalisation for a set of global norms, policies and institutions, which establish particular forms of global governance. For Cammack (2004) and others, this variant of neoliberalism is deeper than its earliest manifestation, as it involves the reconfiguration of states, institutions and social policies, as well as private actors' forms of authority, by means of the transmission of ever wider sets of policy prescriptions and templates from the global level downwards.

This book argues that the transformation in global governance should therefore not be seen solely in economic terms, important though these are. Rather a series of simultaneous, and sometimes linked, developments contributed to a wider sense of change in the 1990s. The ending of the Cold War affirmed not only the dominance of neoliberal economics, but also opened up new possibilities for a diverse range of actors to play a more effective role in international relations based upon a shift

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in authority from states to global institutions with common and often ostensibly progressive norms (for example: Annan, 2000; Wheeler, 2001; Bellamy, 2009). For commentators such as Rosenau, however, this shift in the basis of authority was more complex and multi-faceted, involving multiple levels: from the subnational, through the state, to the transnational and global. Moreover, both Rosenau and Clark identified the concurrent phenomena of globalisation and fragmentation. Global change therefore appeared to them, not as a unidirectional progressive transformation in international relations, characterised by top-down developments, but as a series of changes pulling in sometimes very different directions. Using the term 'global life', Rosenau suggests that global governance is better understood as a change in an individual's political horizons to incorporate the global (Clark, 1997; Rosenau, 1992, 1995, 1997).

Related to the above was a growing sense of the development of global civil society – social movements with transnational perspectives and interests, often seen as progressive forces promoting humanitarianism, rights and democratisation, or as key social mechanisms for giving voice to individual's political interests in a globalised polity (see for example: Lipschutz, 1992; Falk, 1995; Held, 1996). Improved communications from the 1990s on, also allowed ideas to be more widely shared – constructing what Webster (1995) termed the 'information society' – leading not only to the sharing of norms but also to the greater development of global epistemic communities. If, however, global civil society is conceived as, by and large, 'grassroots' movements impacting on global society and governance, then others identified the importance of global elites, not only in establishing their own epistemic communities, but also as capable of shaping policies and practices outside of traditional governmental structures. Perhaps the most important example is the World Economic Forum held at Davos, Switzerland, but others included philanthropic enterprises such as the Bill and Melinda Gates, Clinton and Rockefeller Foundations. Avant, Finnemore and Sell (2010) also identify the emergence of 'global governors [who] are authorities who exercise power across borders for purposes of affecting policy. Governors thus create issues, set agendas, establish and implement rules and programs, and evaluate and/or adjust outcomes' (p. 2). For Avant et al., they are not only important as *agents* of global governance, but the *character* of their interactions is also an important feature of the international system.

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The sense of transformative change has therefore emerged from multiple directions, and with different stresses being given to the lines of force and agency at play in global governance. But what is also apparent is that the result, in terms of what global governance *is*, lacks focus and meaning. Although the loosening of the grip of states on international relations is common to all of the transformations identified earlier (see also Scholte, 2000), what replaces it is less clear. Most fundamentally, 'it is not clear whether [global governance] really does refer to the governance *of* the world on a global scale, or of whatever governance there is taking place *in* the world' (Joseph, 2012, p. 90). Although clearly more than a 'worldwide tilt from states to markets' (Hewson and Sinclair, 1999, p. 5), there is no consensus about what this diverse set of changes to actors, norms and procedures actually means. Held and McGrew (2003) argue that it represents a shift from states to regimes; Avant et al. suggest a change in agenda setting, rule-making, implementation and monitoring (2010, p. 14); Rosenau (2006) suggests the emergence of a multi-centric globalised space, where political agendas are set and different rule systems collide; whereas others points to the emergence of new transnational networks (for example: Risse-Kappen, 1996; Keck and Sikkink, 1998).

The importance of the above for this book is four-fold. First, it demonstrates the contested nature of global governance – there is no set agreement on what it is and who it is for. Second, the sense of transformative change is clear and rooted in the narrative of globalisation. Third, this transformation in global governance is far more than increases in the speed and intensity of inter-state exchanges. These form a part of the transformational narrative, what may be described as a horizontal axis linking states. For example, bilateral aid programmes, such as the US President's Emergency Plan for AIDS Relief (PEPFAR), form an important element of the patchwork of GHG. However, this is only part of the story. A vertical axis embracing actors 'above' the state (for example, international organisations) and 'below' (for example, civil society organisations) is also part of this new narrative. Finally, the transformation of global governance opens up implications for its relationship with global health, and specifically with global *health* governance, and the governance of specific *health issues* such as HIV/AIDS or pandemic influenza. In particular it suggests a multi-level governance framework involving governance of specific issues, of health and of other policy sectors, within an overall context of transformed global governance.

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Health and global governance

Few analyses to date have either identified or discussed this multi-level nature, most implicitly assuming a nested relationship similar to Figure 1.1. In this relationship, the governance of specific health issues forms part of GHG, which in turn is part of broader global governance. The picture is one of a coherent relationship between multiple levels (for example: Fidler, 2010b; Frenk and Moon, 2013). However, this simplifies the often multi-sectoral nature of the policy world and narratives surrounding it. Thus health issues can affect macro-economic performance and vice versa; environmental issues can affect health; trade policies can affect both health and the environment. This suggests that the governance of these issues is similarly multi-sectoral. Rather than a nested approach, a Venn diagram may be a more appropriate representation of the interaction across various sectoral governances within an overall narrative of global governance (see Figure 1.2). This may also be repeated at the level of individual health issues. Thus, for example, the governance of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) may find areas

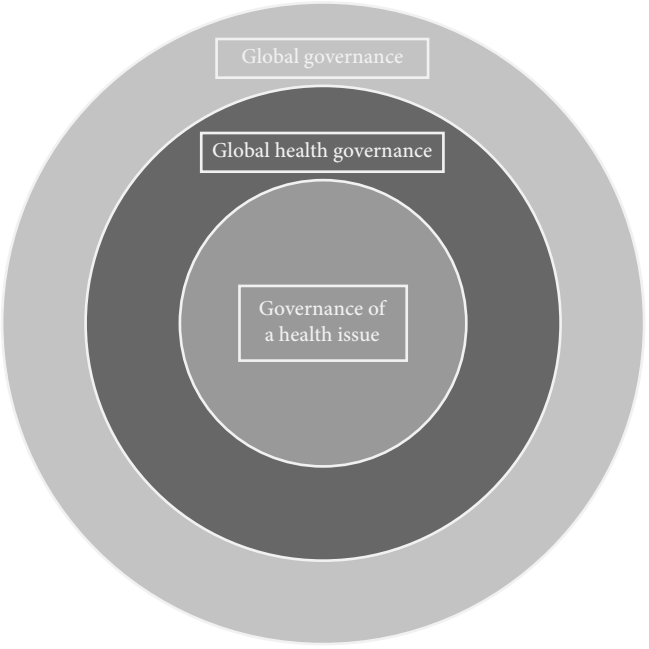

FIGURE 1.1 Nested global governance

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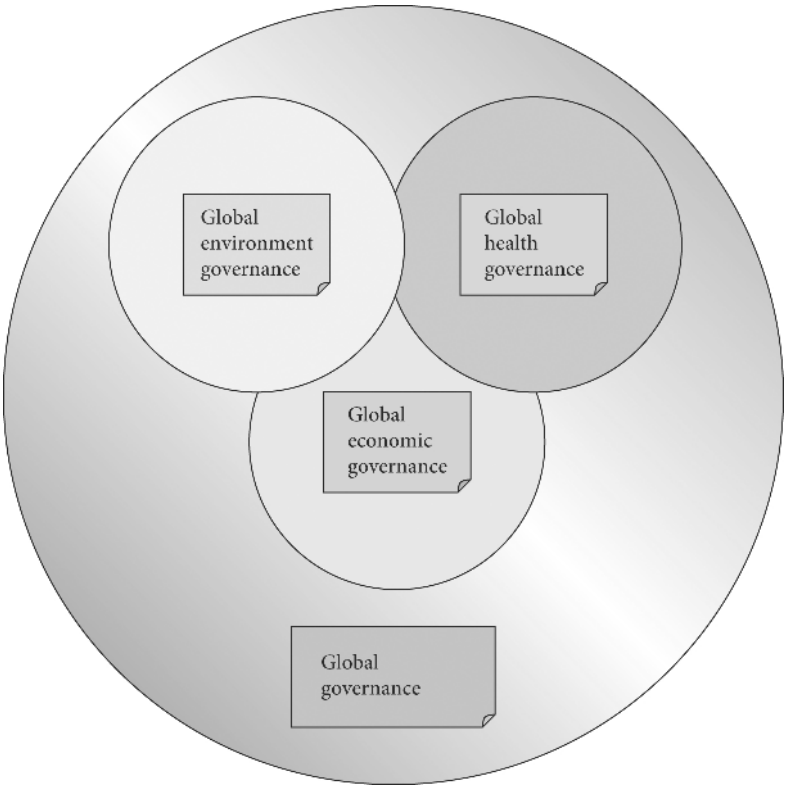

FIGURE 1.2 Global governance as overlapping interests

of overlap with access to medicines. The overlapping nature of this model adds complexity, but continues to suggest a mutuality of interests through the overlapping nature of these relationships reflected in the governance of sectors and issues. Following on from previous work (McInnes and Lee, 2012a), however, we see these relationships as characterised as much by conflict as by cooperation, with different sectors pursuing their own agendas which may or may not align with others, and which may change over time. Moreover this conflict is not only between, but *within* sectors. Thus, within GHG, there may be conflict over the allocation of resources or priority given to specific health issues, as seen for example in the debate over 'AIDS exceptionalism' (Smith and Whiteside, 2010). It is tempting therefore to replace Figure 1.2 with a 'bumper car' model where, at both the sectoral and issue levels, different governances 'bump' into each other (see Figure 1.3). But this suggests that governance is marked by

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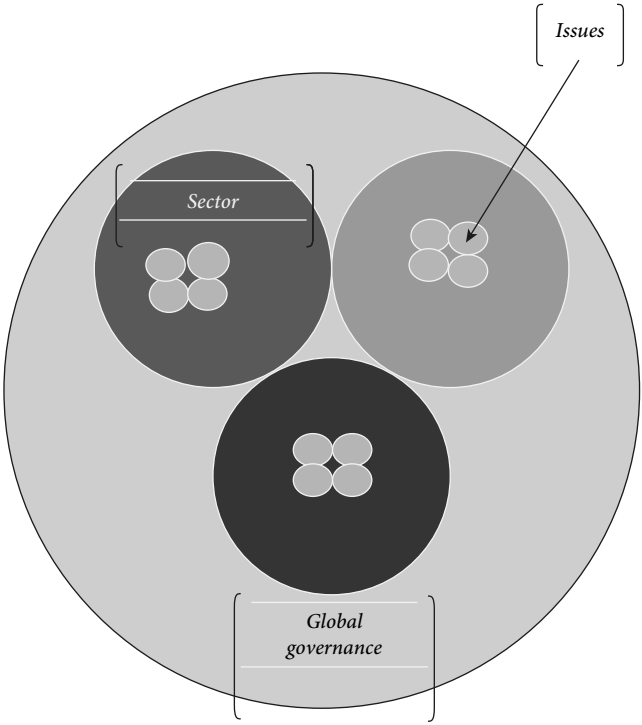

FIGURE 1.3 The bumper car model

an ongoing series of conflicts over issues and agendas, which ignores the potential of cooperation. Moreover the model poorly reflects the manner in which interests may change over time. Our approach, therefore, is one which resembles a kaleidoscope of continually changing patterns where some issues and sectors occasionally overlap, for mutual benefit, and on other occasions may bump into each other. The key analytical question therefore becomes one of understanding when, within this kaleidoscope of cooperation and contestation, do interests, ideas and institutions offer the potential for effective GHG? What circumscribes the prospects for GHG, and what drives its potentialities?

The emergence of global health governance

GHG shares the sense of transformative change and uncertainty over meaning described earlier for global governance more generally. Like

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the broader field of global governance, GHG began to garner scholarly interest with the end of the Cold War (for example: Lee, 1992). Part of this was due to the removal of the constraints imposed by the Cold War's narrow agenda, allowing new issues to emerge (McInnes and Lee, 2012b); and part was due to increased fears of emerging and re-emerging infectious diseases which, for the first time in generations, appeared to place high-income countries, as well as low to middle-income countries, at increasing risk (Garrett, 1996; Price-Smith, 2001, 2002). A key development in the literature has been to broaden the idea of GHG away from a focus on the technical competencies of international institutions, and their ability (or lack of) to deal with emerging global issues, and towards a more politicised view of the relationship between the growing number of actors involved. GHG therefore became more than simply what the WHO and other global health institutions could and should do, to a more complex question of how these institutions related to other actors in responding to the globalisation of health (Dodgson et al., 2002; Harman, 2011a; Kay and Williams, 2009).

The literature on GHG therefore does not solely portray it in terms of a rational response to the development of a new global risk. Rather it reflects on many of the transformations identified earlier in global governance, albeit in a sector specific manner. Thus there is a strong sense that the locus of authority had shifted with the emergence of new and changed institutions. No longer were states the only relevant actors, and no longer was the inter-state or multilateral forum of the World Health Assembly – the governing body of the WHO – the unchallenged lead institution in global health (Lee, 1998). The influence of neoliberal economics and the free market could be seen in health sector reforms and especially the development of global public–private partnerships such as the Global Alliance for Vaccines and Immunisation (GAVI) Alliance, as it had been in the health sector liberalisation programmes precipitated in the neoliberal policies of the 1980s (Buse and Walt, 2000a, 2000b; Rushton and Williams, 2011). Civil society organisations began to emerge with a global focus, most obviously in the area of HIV/AIDS activism (McCoy and Hilson, 2009; Youde, 2012, pp. 99–114). New global elites could be identified, the most prominent of which were the five board members of the Bill and Melinda Gates Foundation. Global epistemic communities could be identified, not only in the biomedical sciences, but also in terms of development and health security. And like the wider field of global governance, there is uncertainty over its

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meaning or composition: whether for example it is a shift in the role of international organisations (Youde, 2012); the emergence of a new and dominant organising form determined by neoliberal economic principles (Williams and Rushton, 2011); the increased significance of international regimes (Fidler, 1999); or, as Youde comments, that there is, perhaps, 'no single global health governance hierarchy and no single solution for global health concerns' (Youde, 2012, p. 3).

Within this literature on GHG, therefore, a number of themes can be detected: (a) GHG is a response to, and a reflection of, an increasingly globalised world, including health determinants and outcomes; (b) it is characterised by existing institutions acquiring new meanings and mandates, and the proliferation of new institutional arrangements; and (c) an increased awareness that the global governance of health is not simply a technical or administrative matter, but a political realm of cooperation and contestation. Although these three themes provide a structure for our analysis of key transformations below, it is via the lens of cooperation versus contestation that this book departs from most analyses of GHG. Building on previous work (McInnes and Lee, 2012a), we argue that the politically contested nature of GHG has as much to do with competing frames of who and what health is for, as it has with competition among global actors. Using social constructivism, we start from the basis that GHG is socially shaped, creating a 'reality' which defines problems and solutions. This does not mean it is divorced from material events, rather it exists in a mutually constitutive relationship with them: constructed explanations embody material events, and these explanations in turn give meaning and significance to the material world.

Globalisation and fragmentation in global health governance

This book starts from the basis that GHG has been successfully constructed as a *fact*, even if doubts persist over its extent, meaning and nature. What it focuses on, however, is the neglect to date of how the macro-level narrative of GHG has been translated into (and reflects) mezzo-level narratives on specific issue areas such as HIV/AIDS and tobacco control. Previous analyses have tended to focus on either the 'big picture' of GHG (for example: Youde, 2012), or on specific issue areas

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(for example: Harman and Lisk, 2013). This book probes the relationship between the general and specific, how these have been constructed, and with what implications. It is not concerned with the micro-level of analysis – how health care is actually financed and delivered. Rather, it focuses on how the transformation in GHG manifests differently across different issue areas comprising global health, and how this in turn is shaped by and contributes to the higher-level perspective of GHG. To do this, we pick four health issues as balancing both the original focus of GHG on infectious disease (in this book, the chapters on HIV/AIDS and pandemic influenza), as well as non-communicable disease (tobacco, especially attempts to create global regulation on the sale of tobacco) and distributive issues (access to medicines and the international patent rights regime). Our suspicion, based on our previous work (McInnes and Lee, 2012a), was that each case study would reveal a different form of GHG: that the global governance of HIV/AIDS would be characterised by diverse interactions among international organisations, global civil society and states within the health sector and beyond; that pandemic influenza would demonstrate the continuing power of the state in the face of a potential global pandemic; tobacco would illustrate the clash of material interests and ideas between transnational tobacco companies (TTCs) and global health organisations; and that access to medicines would reveal how governance in other sectors, in this case intellectual property rights, can spill over into public health. The importance of such findings, across the governance of different issue areas, would be that macro-level narratives of GHG need to be far more nuanced, recognising that different forms of global governance co-exist; and that aspirations for a single, coherent form of GHG may be overly optimistic. Indeed, in a parallel to the work of Clark and Rosenau on the twin forces of globalisation and fragmentation, we wish to explore whether GHG is *both* part of a wider global governance movement, influenced by trends and change outside of health, *and* that simultaneously it consists of multiple different governance structures, fracturing a supposed coherence.

For heuristic purposes, and based on the themes in the literature identified earlier, we identify three broad transformations as constituting the macro-level narrative of GHG. These then provide the analytical structure for the next four chapters, which focus on the individual health issues identified earlier. This common structure allows us to explore the relationship between health governance at the macro-level, and the global governance of individual issues (the mezzo-level). The

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first of these transformations is that health is constructed as a global problem requiring global responses. The second transformation is the emergence of multiple, sometimes competing, ideas surrounding who and what health is for. It concerns the ideas which identify the nature of the problem and shape the nature of the response. The final transformation concerns the changed institutional architecture and actors in global health. If the first transformation concerns the construction of the field, and the second the nature of the problem and the possible responses, then this third transformation concerns who is constructed as a legitimate actor in making these responses. It is important, however, to re-emphasise that this divide is for heuristic purposes. Overlaps and links may exist among the three transformations. Thus, certain actors are likely to be linked structurally to certain ideas. For example, the World Bank's framing of global health has derived from the belief in its macro-economic effects, with health and economic development forming a mutually constitutive relationship. Therefore, actors may not only be given legitimacy by the construction of the field but may also, in turn, shape how the field, problems and responses are constructed.

The methodology in this book generally follows Alexander George's 'structured focused' approach for case studies (George, 1979). Our empirical work used available primary and secondary literature, and key informant interviews. Literature was identified using systematic keyword searches on online databases (including Google Scholar, ISI Web of Knowledge, JSTOR, LexisNexis, OCLC ArticleFirst and PubMed), with further sources cascading from these. Over 300 interviews were conducted in locations including Atlanta, Bangkok, Brussels, Canberra, Geneva, London, Manila, Nairobi, New York, Singapore and Washington DC, with policy-makers, government officials, civil servants (including staff at international organisations), civil society and academia. Interviews were semi-structured using a common data bank of questions. All interviews were conducted on a confidential basis and, where recorded, transcribed to inform analyses. We have omitted direct reference to them where prior permission has not been given.

Transformation 1: 'health is global'[1]

The first transformation is the globalisation of health, narratively constructed as the shift from 'international' to 'global' health, implying

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a qualitative shift in the nature of health interactions across borders (for an early and influential example of this, see Institutes of Medicine, 1997). This narrative is underpinned by reference to events in the material world. In particular, the 2003 outbreak of the novel severe acute respiratory syndrome (SARS) coronavirus, fears in the middle of the last decade over the spread of a human transmittable variant of H5N1 ('bird flu'), and the 2010 influenza pandemic appeared to vindicate the 1999 claim of the then WHO Director-General, Gro Harlem Brundtland, that today 'there are no health sanctuaries' (Brundtland, 1999). Instead health, like other sectors, could be constructed as being profoundly affected by the process of globalisation. Although globalisation is a contested subject, with disagreements over its nature and meaning, a number of 'starting assumptions' can nevertheless be made, which suggest a change in the range and intensity of social actions. Most understandings of globalisation include notions of space–time compression, leading to a qualitative shift in the degree and nature of interconnectedness. This is facilitated by new technologies, allowing increased movement and exchange of people, goods, finance and ideas. Crucially, this results in social action no longer being bounded by territory, including the state. As Joseph points out however, globalisation is less a theory than a rationality which arises from a new set of social practices. The result is that globalisation is often presented as an unarguable fact to which there is no alternative (Joseph, 2012, p. 86). This is important because the manner in which globalisation has been presented as an uncontestable fact has allowed the mantra that 'health is global' (UK Department of Health, 2008) to become one of the dominant narratives in contemporary health policy. Health cooperation is no longer described as 'international' but 'global' in the face of globalisation.

Although the most commonly cited impact of globalisation concerned the speed and scale with which acute and severe infectious diseases might spread (for example, Garrett, 1994), a wide range of other effects were also identified. These include increased drug resistance, changing epidemiological patterns of health and disease, innovations in global information and communication technologies that influence health, changing patterns of health-related human behaviour, the global restructuring of health-related industries, the mobility of health professionals, and innovations in institutional mechanisms for collective action on health (Lee et al., 2002). At the same time, however, the creation and use of the term 'global health' has given a multiplicity of trends a shared meaning, which

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encourages us to see the world differently. Statements such as 'health is global', therefore, are not simply a reflection of an external reality, but a rallying call to reinterpret how we understand health and its determinants, and to draw attention to health issues. Health as global, in this sense, is normative in its framing or social construction of the subject: it is for someone and for some purpose, a progressive force to change the world for the better, not simply a reflection of an exogenous reality.

What has been far from universal, however, is how global health is defined and understood. A key reason for this is that multiple meanings and usages of the term arise from different, and often contested, normative frames. From this perspective, which informs our understanding in this book, global health is not an unproblematic, rational reflection of developments in the material world. Instead, it is a contested field where different social constructions, expressed through normative frames, lead to different interpretations of what the field is, the goals to be achieved and the policy pathways that should be pursued to achieve them (see McInnes and Lee, 2012b).

Transformation 2: competing visions of global health governance

If GHG is cast as a response to globalising forces then, in our previous work, we identified that there is no single idea behind GHG, but rather a series of ideas that are sometimes in conflict or cooperation with each other (McInnes and Lee, 2012a). The second transformation we identify, therefore, is the emergence of competing visions of GHG. Specifically we use the idea of 'framing' to allow us to understand how these competing visions are operationalised (see also Gitlin, 1980). Framing occurs when an issue is presented in such a way as to tie it into a socially constructed reality, and through this, an issue can gain influence and policy purchase. Frames are deployed and promoted by a range of stakeholders, including governments, corporate actors, transnational advocacy groups, international organisations and epistemic communities. As Haas describes, these are the 'cognitive baggage handlers of constructivist analyses' (Haas, cited in Youde 2005, p. 423). In global public health, competing 'baggage handlers' frame health issues in particular ways (for example as a biomedical, human rights, security or economic issue), in an attempt to generate or legitimise specific pathways of response on health issues.

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When they are successful, the chosen frame 'resonates with public understandings, and is adopted as a new way of talking about and understanding issues'. Actors are likely to modify their behaviour accordingly (Finnemore and Sikkink, 1998, p. 897). For example, pandemic influenza has been framed by some global health actors as a security issue (or 'threat') to increase support for emergency preparedness and response planning (Kamradt-Scott and McInnes, 2012), while a network of public health advocates framed tobacco control as a human rights issue in an attempt to tie it into wider legislation on human rights (Reubi, 2012). But framing can also be constitutive of meaning; that is, frames may move beyond being merely a presentational artifice to promote certain actions, and become a means of shaping the way in which a health issue is understood. Frames achieve this by presenting an issue area in terms that have meaning for a worldview and, therefore, are associative with that worldview. Thus, framing pandemic influenza as a security threat has contributed, not only to certain actions being undertaken, but also to shaping understandings of the disease as a global health issue (namely as a transboundary threat). What may therefore begin as a political tactic to gain attention and resources for a health issue may become central to the construction of its very meaning.

The key advantage in using the concept of framing to expand our understanding and explanation of GHG is its recognition of the importance of ideational factors. In short, the manner in which an issue is framed opens up specific acceptable pathways of governance response, based upon shared understandings (or what we term 'visions') of desired global health outcomes. How issues are framed can tap into powerful ideational forces that may prove as significant as institutional competencies, interests and agendas (the subject of much of the existing GHG literature) in shaping GHG, including facilitating or hindering effective GHG. In this book we use five key frames: evidence-based medicine, security, development, economics and human rights (see Box 1.1). A close reading of policy debates on global health over the past two decades suggests these to be dominant frames used in the emerging realm of global health (for a fuller discussion, see McInnes and Lee, 2012a). Most of these frames are, of course, internally contested, with competing theories, methodologies and approaches leading to different policy prescriptions (McInnes and Roemer-Mahler, forthcoming). However it is possible to identify a higher-level commonality in worldview that defines the frame as coherent despite internal contestations (see McInnes et al., 2012, S83–94).

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Transformation 3: the changing institutional landscape of global health governance

The third major transformation concerns the powerful narrative of an unprecedented increase in the range and number of institutions involved in governing global health since the mid-1990s. As WHO Director-General Margaret Chan (2011) observed, there have been 'truly stunning increases in the number of actors, agencies, and initiatives funding or implementing programmes for health development. The landscape of public health is crowded'. The institutional players include established intergovernmental organisations concerned with health cooperation and those with wider mandates beyond health (such as the G8, World Bank and UN Security Council), as well as non-state actors (for profit and not for profit). Although some states continued to play an important agenda setting role, not least through bilateral and multilateral aid programmes such as PEPFAR, civil society organisations (such as the International AIDS Society, International Women's Health Coalition and Framework Convention Alliance) have also gained prominence, not least in agenda setting and norm entrepreneurship (Keck and Sikkink, 1998; Mamudu and Glantz, 2009). Most striking however, has been the emergence of a range of 'hybrid' public–private and purely private (if not for profit) institutions, which are now at the very heart of practical responses to global health. These include global health partnerships, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and charitable foundations, most notably the Bill and Melinda Gates Foundation. By the beginning of the 21st century, these new and sometimes institutionally innovative actors had become recognised as central to, and legitimate actors in, GHG. This rise of non-state, private organisations and funding sources (which even if state-based in origin are disbursed by private or civil society organisations), has been accompanied by a shift towards private forms of authority in health governance (Rushton and Williams, 2011). This includes a deliberate diffusion of authority from the state and traditional inter-state multilateral forums. This shift has also involved a conscious strategy of engagement with the private sector, most notably but not exclusively the pharmaceutical industry, in the generation of governance responses to a very narrowly circumscribed, though important, range of diseases (communicable diseases with epidemic potential such as influenza, SARS, tuberculosis, HIV/AIDS). Many of these new global health institutions have assiduously sought to work with market

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actors to further their goals, perhaps most notably in the area of access to medicines. Far fewer have sought to challenge the potential role of markets in perpetuating health inequalities that have arguably created and perpetuated inequities of access. Moreover, these forms of GHG, by adopting resources, techniques, practices and language drawn from the corporate sector (Bishop and Green, 2008), represent a particular model of aid and health governance (Rushton and Williams, 2011).

The growth in the number of institutions involved in GHG has been two dimensional: increased funding attracts new institutional players, while others brought new sources of funding to global health. Although more often than not donated by G8 states, the modality of health decision-making and service delivery has unquestionably changed. Much of the new money earmarked for 'global health', until more recently, has been focused on selected diseases channelled through vertical programmes rather than supporting health systems. Moreover, other health issues (such as non-communicable diseases) posing significant, and even far greater, burdens of morbidity and mortality, as well as the social determinants of health (WHO, 2008a), have failed to attract commensurate policy priority and resources. Crucially, for the purposes of this book, this inequitable distribution of global health resources is directly reflected in the institutions and associated governance mechanisms that comprise GHG. Signs of a wider recognition of the imbalances that characterise GHG has been evidenced in the work of the WHO Commission on the Social Determinants of Health (WHO, 2008a), the increased attention to health systems strengthening (HSS) and the belated but growing priority given to non-communicable diseases (NCDs); GHG, in this sense, continues to evolve. Some institutional arrangements remain narrowly focused, in terms of the issues and interests served, whereas others seek to directly challenge this agenda. The tensions between cooperation and contestation continue to be played out, shaping the ideas, interests and institutions that define global health thinking and practice.

Conclusion

This book explores how the narrative of transformational change in GHG has been reflected in individual health issues. Importantly however, this is done within a context, outlined in this chapter, where policy issues from other sectors of global governance (such as trade, human rights and secu-

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rity) may impact upon health, and where the governance of one health issue may impact upon another within GHG. Our theoretical basis is one of social constructivism. For us, GHG involves the interaction of events in the material world and ideational framings and interpretations. Our exploration proceeds with four chapters, each focusing on a particular health issue, and each structured by the three transformations identified in this chapter. We use a fairly orthodox assumption that globalisation is a key driver in the narrative of transformational change, and that globalisation is more than 'bilateralism on steroids' but rather a qualitative change in the nature of global relations. Nevertheless, we accept that bilateralism is an important feature of this new global landscape – but it is not the only and arguably not the most important feature.

Given our theoretical underpinnings, it is perhaps unsurprising that we do not attempt to measure the degree of transformation in GHG. Rather, we accept it as a socially constructed 'fact', and are interested in how the macro-level narrative of change in GHG is mirrored in that of individual health issues. Nor are we especially interested in determining the effectiveness of GHG, though our research does lead us to suspect that one of the problems in seeing GHG as a 'failure' is that it is seen in terms of an end point – an effective mechanism, or system, for meeting global health needs and mitigating global health risks. Our empirical work – reflected in the subsequent chapters – leads us to consider it instead, simultaneously, as a *process* of change and adaptation and as an *arena* where actors, institutions and ideas interact. One of the defining features of this process is contestation – between actors and institutions, and between ideas. It would be tempting to suggest that this contestation is a 'problem' in preventing the coherence of GHG and the harmonisation of policies, leading to sub-optimal results. But instead we see this as also possessing healthy attributes, not least in encouraging pluralism and democracy in GHG. It also enables progress through the interaction of different ideas and perspectives on health issues. As a result, we suspect that a settled, shared vision of GHG is unlikely and possibly undesirable.

BOX 1.1 Five visions for framing global health

This box identifies, in broad terms, five 'visions' which underpin framings of global health – that is, they provide an idea which framings can resonate with in order to legitimise or generate support for a particular response. These visions are presented here in terms of

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high-level commonalities and inter-subjective understandings, but they also consist of internal debates and contestations.

EVIDENCE-BASED MEDICINE (EBM)

By the late 1990s EBM had become fully embedded within the majority of medical (clinical) training programmes internationally. At its core, it encourages and reinforces positivist, rationalist ways of reasoning – namely, that a world exists independent of observation that can be analysed using epidemiological and biostatistical tools to provide data that will inform health-related policy decisions (see Davidoff et al., 1995; Rosenberg and Donald, 1995; Sackett et al., 1995; Sackett et al., 1996). Use of this frame is often identifiable by reference to 'evidence' to support decision-making and the deployment of particular techniques such as 'systematic reviews' to inform policy development. In this regard, language is strategic in that the adoption and use of terms such as 'evidence based' and 'systematic' reifies and reinforces rationalist thinking while simultaneously categorising and condemning other forms of reasoning as inferior (that is, who wouldn't want to use evidence to support their decision-making? Who wouldn't wish to be systematic?).

HUMAN RIGHTS

Over the past 20 years, there has been a marked resurgence in public health and human rights (Reubi, 2012). Perhaps the two most significant issues in this resurgence were HIV/AIDS and, later, access to medicines (Olesen, 2006; Biehl et al., 2009; Rushton, 2012). However, other global health issues have also been framed as human rights problems, from maternal and child health to tobacco control (Shiffman and Smith, 2007; Reubi, 2012), whereas from the late 1980s/early 1990s, the gradual shift from population to reproductive health also contributed significantly to the prioritisation of human rights in global health. Although the relationship between the moral–legal rhetoric of human rights and global health is highly contested, it is still possible to identify two particularly influential understandings. The first is that human rights are moral values that should guide public health experts and ensure that their policies and practices are not discriminatory, coercive or undemocratic (see Mann et al., 1994; Mann et al., 1999). The second is that the relationship between human

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rights and health is primarily about the right to health: the right to receive appropriate and affordable health care (see UNCESCR, 2000; Hunt, 2004; Hunt and Backman, 2008). Unlike the first definition, this conception of human rights and health emphasised the importance of international legal norms, judicial enforcement mechanisms and human rights lawyers (Reubi, 2012).

ECONOMICS

This is a particularly diverse and internally contested vision. Market-based theories (that supply is best determined by demand, and price is best set by a 'free' market) compete with public-goods theories (that public provision of health is rational because of the innate qualities of health and its contribution to economic growth). Each theory, however, infers a rational basis of how to use and distribute scarce resources and it is this which underpins economic framings of health. The basic underlying logic that unites all variants of economics in the context of health is that demand for health is inelastic (if you are ill then your demand for treatment does not vary with your income or the price of the treatment), and that the resources that can be devoted to health are scarce. The economic frame is therefore manifested when arguments about efficiency, choice and competitiveness are used to justify the distribution of these scarce resources in particular ways. Thus, health economics is about the rational basis for making choices regarding how to deploy and distribute scarce resources to optimally meet health needs (see Mills, 1997) and generally employs the methodology of classical liberal economics (for example, cost-benefit analysis).

SECURITY

Like economics, security is highly contested. Traditionally, security has been narrowly understood in terms of a clear and present danger to the state, but over the past two decades this has broadened to include other referent objects and a wider range of risks, some of which may be more tangible than others (Buzan, 2001; Booth, 2007). This led Buzan to suggest that security is 'essentially contested' (see Booth, 2007, p. 99) – that is, a concept which generates unsolvable debates about its meaning and application. These contestations have allowed a variety of different terms to become used in the framing

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of health security, each implying different referent objects (in other words, whose security should be protected). These include human security, national security, international security and global health security. The underlying logic that is common to all forms of security, however, is that of threat and defence (see Gray, 2009), though sometimes alternative terms such as 'risk' and 'protection' might be used (see Williams, 2009). Thus, health becomes a security issue when it is perceived and presented in the following ways: (1) as a threat to someone or something, and (2) as something which defensive measures (either in the form of prevention or response) must be taken against. This is the hallmark of the security frame in global health: x is a threat/risk to a referent object in respect to which we must put defensive/protective measures y in place.

DEVELOPMENT

Although there is no single, universally applicable narrative of development, most proponents share an enthusiasm to improve conditions and establish progress in the Third World, where the First World becomes something of a benchmark for measurement (for a critical perspective on this, see Escobar 1995, 2004). The ultimate goal of improving health in the Third World is presented as unarguable and a universal given; rather, the means to achieve it form the point of disagreement for advocates, with a plethora of theories such as modernisation, dependency and trickle-down economics going in and out of fashion (recent examples of this include Farmer, 2003; Sachs, 2005; Collier, 2007). Development narratives are characterised by a series of hierarchical binaries (developed/underdeveloped, donor/recipient, rich/poor, healthy/unhealthy, active/passive, hegemonic/subordinate, strong/weak, for example) which places the idea of 'lack' vis-à-vis the developed world at the heart of this frame (Escobar 1995, 2004).

Note

1 This is the title of the UK's cross-departmental White Paper on global health, published in 2008 (Department of Health, 2008).

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