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Frames, Paradigms and Power: Global Health Policy-Making under Neoliberalism

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Introduction

The study of global health governance has developed rapidly over recent years. The case that health is closely linked to globalization has been successfully made, with authors pointing to spatial compression, increasing trade flows and new patterns of consumption amongst other things as contributing to health crises on a new level and scale.¹ In turn, a widespread perception has emerged that there is such a thing as 'global health' and that it is (and needs to be) globally 'governed'. Scholars have increasingly begun to pay attention to the ways in which health problems are addressed by (and in some cases created by) global policies, processes and institutions. What they have found is a vibrant and innovative policy arena which has recently undergone huge changes. New institutions have been created and many existing ones, including bodies such as the G8 and the

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World Bank, have added health to their agendas and carved out major new roles for themselves in global health governance. Novel forms of public-private partnership (such as GAVI and the Global Fund) have emerged, and a range of other non-state actors (from the Gates Foundation to NGOs) have been incorporated into the 'system' of global health governance. This reshaping of the governance architecture has coincided with an unprecedented 'resource boom' in global healthⁱⁱ and the emergence of health as a matter of 'high politics'.ⁱⁱⁱ These developments might have been expected to improve responses to global health problems. Yet it is widely accepted that the failure to generate adequate responses to manifest health needs, particularly the needs of the poor, persists.

The existing literature has identified a range of factors which help explain this 'failure' of global health governance, but it has not to date generated a conceptually and theoretically-grounded understanding of the global public policy processes which perpetuate it. In this paper we set out a new framework for analyzing global health policy-making. Our intention is to offer a guide which will allow scholars to trace back the links in the causal chain which result in the selection of some global health policies over others. In the first section we make the case that there is such a thing as 'global health policy', however ad hoc and informal elements of it may be, and that the existing global health governance literature (in particular constructivist-influenced work on framing)^{iv} can help shed valuable light on some parts of the global health policy-making process.

We then move on in the second section to set out our framework for understanding the factors which determine the production of global health policy. This framework draws upon public policy scholarship, especially work by John L. Campbell, Peter A. Hall, Yves Surel and Paul A. Sabatier. We argue that global health policy is the product of various material and ideational drivers. Power is

important, but so are ideas. In relation to ideas, we put forward a case that the way in which proposed policies are 'framed' is central to explaining how consensus is built around certain policy choices. Yet there is a need to understand why, and in what circumstances, particular frames are persuasive. In framing an issue in a particular way, an actor (or 'policy entrepreneur')^v connects it with a set of deeper paradigms which form the ideational underpinnings of global health governance. These paradigms influence (often unconsciously) the ways in which actors think and talk about global health problems. In framing an issue actors are drawing on these deeper paradigms to identify a problem and propose a concrete policy solution. In response, we often find other actors engaged in a policy debate forwarding alternative framings, and a process of contestation ensues.

However, the 'playing field' on which these policy debates are played out is not even. The power (or authority) of a policy entrepreneur clearly makes a difference. But as well as material power, policy debates in global health are also structured by deeply-embedded ideas dominant in the contemporary global political environment, in particular the powerful logic of neoliberalism. For us neoliberalism constitutes a 'deep core'^{vi} of the global polity because it operates across almost all areas of global governance, and 'colonizes' and influences all the major paradigms of global health. In section three we outline three ways in which neoliberalism structures debates and shrinks 'policy space' in global health policy, imposing constraints and limiting what is 'sayable', 'doable' - and even what is 'thinkable' - in global health governance.

Global Health Policy and Global Health Policy-Making

Before examining global health policy making, it is necessary to explain what we mean by the term 'global health policy'. Indeed, some may doubt that such a thing can exist within the diverse and often uncoordinated 'architecture' of global health governance, an architecture which many identify as one of the key shortcomings of the existing global health governance 'system'.^{vii} But, we argue here, a lack of coordination does not entail an absence of policy: global health policy-making is clearly occurring and is affecting health outcomes in every region of the world.

Although it is seldom, if ever, defined, the term 'global health policy' (or sometimes 'international health policy') is regularly invoked in the literature, although in a variety of ways, often with little precision, and often in a manner synonymous with other concepts such as global health governance. One of the ways in which the term has most often been used is in relation to the transmission of health-related policies from International Organizations to national health systems. Schiller, Hensen and Kuhnle, for example, examine the policies which actors such as the WHO, UNICEF, the World Bank and the WTO are generating for national health systems.^{viii} Thus, for them, global health policy is viewed primarily as being transmitted 'downwards', from the global to the national health policy-making space. Others have viewed global health policy more widely, and have included 'bottom-up' responses within their definitions. Lee, Fustukian and Buse define it as

the ways in which globalization may be impacting on health policy, and alternatively what health policies are needed to respond to the challenges raised by globalising processes.^{ix}

For them, global health policy-making occurs at a variety of levels: local, national regional and international. We see global health policy as being both 'top down' and 'bottom up'. National governments *are* being forced to respond to global health problems. At the same time there *are*

examples of policies and regimes which are global in their origin and in their effects. Our definition also encompasses both formal instruments (such as laws, rules, standards, regulatory frameworks) and more informal outputs (such as principles, norms and guidance). Our understanding of global health policy is therefore a maximalist one, incorporating a range of actions and outputs that can be divided between formal and informal, and between 'global-level policies for health' and 'policies for global health', including such things as:

- Formal national policies addressing global health problems (e.g. PEPFAR – a national policy instrument addressing the global HIV/AIDS pandemic).
- Formal international laws, rules and standards either directly addressing global health issues (e.g. the International Health Regulations), or indirectly impacting upon global health (e.g. structural adjustment).
- Informal national principles and norms addressing global health (often these are culturally-specific, an example being the US culture of large-scale philanthropy which has had huge effects on contemporary global health governance).
- Informal international principles and norms (e.g. the expectation that wealthy countries provide development assistance for health to poorer countries).

Obviously, the more formal elements of global health policy are more easily detectable, but that is not to suggest that less formal principles and norms are any less significant. And whilst 'global health policy' definitely exists, we would not go so far as to say that there is any single agreed set of such policies. For example, there is no single global policy for malaria. What exists is a range of overlapping and sometimes competing policies from various sources.

Global Health Policy Cycles: Insights from the Existing Literature

However, our interest here is not only in the policy outputs themselves but also in how they come about. Within the public policy literature the concept of the 'policy cycle' has been highly influential.^x The policy cycle is typically presented as a four-stage heuristic model which follows the process from problem definition and agenda setting, through formal decision-making, to implementation and finally monitoring and evaluation.^{xi} Whilst the policy cycle has been the subject of various critiques,^{xii} it nevertheless provides a useful basis for analyzing the policy process. Our primary interest here is in the first two stages of the cycle (agenda setting and decision-making), although the model could be extended to apply to any or all of the stages.

More recently the 'domestic' policy cycle framework has been 'conceptually stretched' to cover 'global public policy' processes.^{xiii} In contrast to the more clearly definable and spatially constrained domestic policy space, global public policy processes are much more messy. Stone has sought to encapsulate this multi-level and dynamic policy space via the metaphor of the 'global agora' which she describes as a "growing global public space of fluid, dynamic and intermeshed relations of politics, markets, culture and society." What is characteristic of the global agora is that it is a "domain of relative disorder and uncertainty where institutions are underdeveloped and political authority unclear, and dispersed through multiplying institutions and networks."^{xiv} These features of the global agora are immediately evident in global health governance, where individual institutions (e.g. the World Health Assembly) may have clear mandates and procedures with regard to health policy-making but there is no settled hierarchy between the myriad institutions and agents. In fact, one of the defining features of global health governance is the sheer diversity of actors with the

ability to produce policy, including: national governments; formal International Organizations (from the WHO to the World Bank); public-private partnerships; civil society organisations and epistemic communities; the private sector; and “global policy networks” encompassing some or all of these actors.^{xv}

Given the importance of global health policy, it is perhaps surprising that the global health governance literature has not to date produced a coherent framework for analysing its production. What the literature does provide, however, is an excellent basis for beginning to build such a framework. Indeed the global health governance literature has become increasingly sophisticated and nuanced over time and, drawing on a range of theoretical approaches. Various, it has catalogued the substantial recent changes global health governance has undergone, attempted to describe the bewildering complexity of the existing ‘system’, and made a powerful case that the global health governance is ‘failing to deliver’. Whilst clearly no single explanation for this failure suffices, scholars have supplied a persuasive list of economic and political factors which militate against effective global health governance. These include resource scarcity, which both exacerbates health problems and undermines governance responses;^{xvi} the failure to properly utilise those resources which are available;^{xvii} a lack of coordination between different global health actors and a ‘confusion of mandates’;^{xviii} the ‘vertical’ orientation of many global health programmes and policy initiatives which can create “islands of excellence in seas of under provision”;^{xix} market failure;^{xx} and the simple absence of political will.^{xxi} Whilst we agree with the broad thrust of these diagnoses, what the literature has not generally done is to interrogate the reasons why these failures continue to be reproduced through an examination of policy processes, and it is in this area that this paper seeks to make a contribution. The literature frequently tends to jump from describing the institutional architecture to the ‘end product’ of a policy process without really addressing what structures and determines the policy process.

There have been two notable exceptions to this, both of which have offered real value in informing our framework. The first include a number of detailed studies which have been carried out on the creation of particular policies or regimes, for example the negotiation of the revised International Health Regulations^{xxii} and the Framework Convention on Tobacco Control.^{xxiii} The second are constructivist -inspired attempts to understand the process through which certain health issues come to be prioritised whilst others are not (for example the work of Shiffman^{xxiv} and Shiffman and Smith^{xxv} on agenda setting in global health). The ‘agenda-setting phase’ is crucial to the formation global health policy, and indeed is the first stage of the traditional ‘policy cycle’. Whilst Shiffman and Smith’s work has focussed largely on this initial phase, a number of the features which they have identified as important in explaining prioritization are similarly central to understanding other stages of the policy process. Labonté and Gagnon have used a similar conception of competing frames to analyze the ways in which states construct health as a foreign policy issue.^{xxvi} In particular, they analyze the ways in health has been framed in terms of security, development global public goods, trade, human rights and ethical/moral considerations in national policy debates.

A Framework for Analyzing Global Health Policy-Making

Given the complexity of global health governance, there are certain constraints on any attempt to develop a single framework to guide the analysis of global health policy. The framework itself must be sufficiently flexible as to be applicable across different institutional settings, health issue areas,

and different spaces and times of governance. The necessary generality of this framework is, of course, a potential weakness. Our aim, however, is to provide an indication of the questions which should be asked in analyzing global health policy-making rather than a rigid formulaic analytical guide.

Our framework focuses on a number of explanatory levels and lines of force. At the most immediate level, framing plays a crucial part in debates over global health policies. The ways in which particular problems and solutions are framed by actors engaged in policy debates is one of the key means of apprehending why certain policy choices are made over others. Our model, however, takes framing only as a first step and looks behind these surface debates to link those frames to deeper ideational paradigms and to the distribution of power in the international system. Debates over appropriate responses are characterized by competition between actors advancing alternative frames and, in doing so, they are attempting to connect a proposed response to established paradigms which lie in the background of global health discourse. Whilst (like much of the constructivist literature) we highlight the ideational factors which contribute to the selection of global health policies, we also see various forms of power as playing an important role in the process.

At an even deeper level, we argue that global health policy-making is structured by the logic of neoliberalism. We view neoliberalism as the 'deep core' of the contemporary global political economy,^{xxvii} representing a set of shared beliefs that structures many areas of global public policy. This is not to say that neoliberalism is uncontroversial, nor to dismiss the importance of counter-hegemonic discourses, nor to ignore the fact that there are cases in which global public policy runs contrary to its logic. In general, however, neoliberalism profoundly affects the configuration of power and authority in global health governance, embodies a range of policy preferences which can

be applied directly to health, and combines in powerful ways with the dominant paradigms of global health. Thus in our model we see neoliberalism as playing an overarching role, setting “constraints on the range of solutions which actors perceive and deem useful for solving problems”.^{xxviii}

Here we present our model in diagrammatic form and the article then sets out the key issues at each level, beginning with framing and the construction of global health policy and then moving on to ‘trace back’ the deeper influences on the policy process.

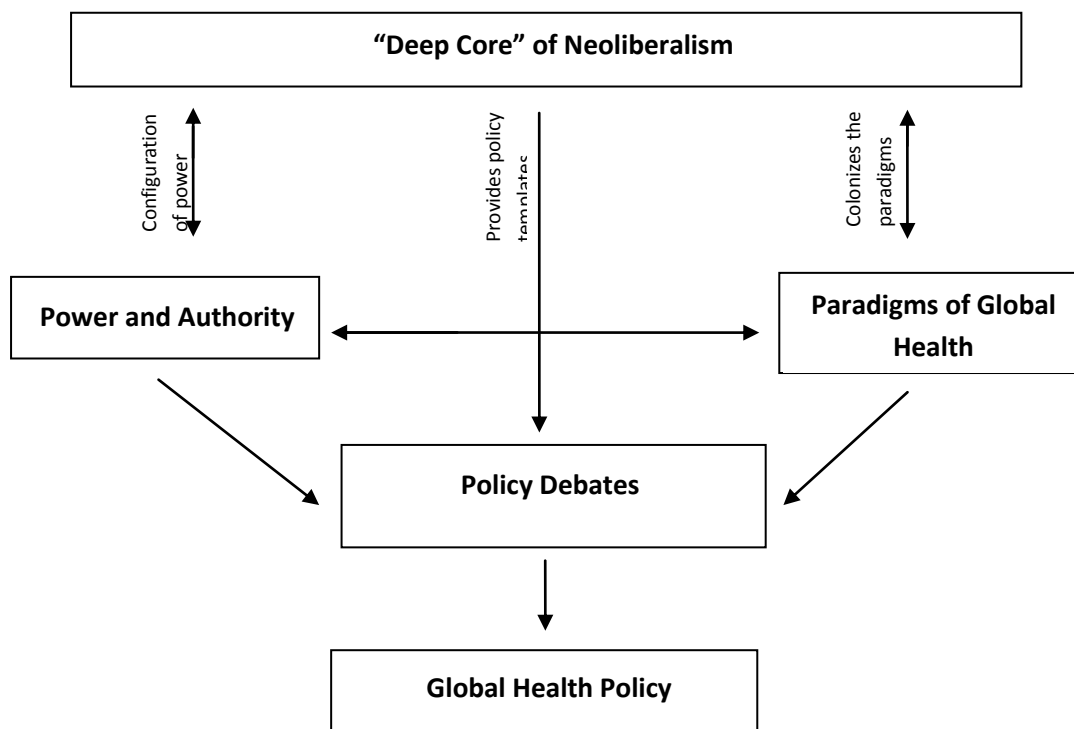


Figure 1: Framework for analysing global health policy-making

Frames and Paradigms

Policy debates are characterized by contestation between competing framings of global health issues. Frames draw – either implicitly or explicitly - on broad ideational paradigms of health. The success or failure of an attempted framing is a consequence of both the extent to which the frame ‘resonates’ with these broader paradigms, and also the ‘power’ of the framer.

Frames

Frames are linguistic, cognitive and symbolic devices used to identify, label, describe and interpret problems and to suggest particular ways of responding to them.^{xxix} Global health governance actors deliberately (and in many cases strategically) forward particular frames “to help fix meanings, organize experience, alert others that their interests and possibly their identities are at stake, and propose solutions to ongoing problems.”^{xxx} When they are successful in doing so, the chosen frame “resonates with public understandings [here, with deeper paradigms] and are adopted as new ways of talking about and understanding issues.”^{xxxi} Framing influenza as an international security threat, to take one example, clearly identifies it as a certain type of global problem which requires particular forms of global response. As a result, frames fundamentally affect the ways in which global health policy is crafted and lead to one policy outcome being selected over others.

There are a number of elements of framing which are directly relevant for the model which we put forward here and which have clear links with various phases in the policy cycle. The first is ‘issue construction’ which can determine whether or not an issue makes it onto the global health

governance agenda at all. Like Shiffman, we see ideas as playing an important role in this process, and in doing so join him in rejecting a positivist account in which “a condition or risk is a problem when it becomes serious; a problem becomes a priority if it grows in scope and gravity”, in favour of a constructivist one in which, “there may be disagreement over what qualifies as a problem” and framing plays an important part in persuading an audience to prioritize a particular issue.^{xxxii}

Actors also use framing techniques in the next stage of the policy cycle (in which formal policy decisions are made) to demonstrate that their proposed policy response is the right one. Policy entrepreneurs can have various motives for selecting particular frames. Often they will frame health issues and their proposed responses in order to build consensus around what they genuinely believe to be the best solution.^{xxxiii} Contestation in such cases is indicative of deep-rooted differences in the ways in which actors see, interpret and respond to the world around them. However, framing can also be used instrumentally by actors in an attempt to justify (or even to mask the true motives for) prior policy choices. This manipulation of frames – often called ‘frame distortion’ – is well-recognised in the literature,^{xxxiv} and can make it difficult to determine the sincerity of a given instance of framing.

Whatever their motive, actors engaged in framing at any stage of the policy cycle are pursuing a strategy of persuasion, aiming to use the strength of a particular frame to influence other actors’ perceptions of their own interests and convince them of the legitimacy/appropriateness of the framer’s preferred policy response. The likelihood of a particular frame successfully persuading an audience rests upon a number of variables.^{xxxv} As we discuss below, the identity of the policy entrepreneur matters: powerful actors are more likely to be successful in persuading an audience. Yet power does not offer a full explanation. The likelihood of successfully persuading other actors

also depends to a large extent on the degree to which the chosen frame resonates with shared commitments to the deeper paradigms which preoccupy the next section of this paper, and as to the perceived applicability of that paradigm to the issue in hand. It is certainly not the case that any issue could be successfully framed in any way – the empirical facts and inherent characteristics of a health problem place certain limits on what frames could credibly be deployed. Nevertheless, successfully applying a new frame to an old problem can have a dramatic impact on the global response.

Which frame(s) come to dominate the global governance of a particular issue is not a given. Frequently there will be contestation between different frames, with different actors promoting their own ways of understanding (and in turn their own preferred ways of addressing) a particular issue. Most global health issues can be framed in more than one way, and consensus is not always achieved. At any one time, different governance agents may be pursuing divergent policy approaches in relation to the same global health issue, a problem which is only partly captured by the global health governance literature's identification of a lack of coordination in the system. Nevertheless, there are often policy trends evident which are the product of the ascendancy of a particular frame. The growing prevalence of the concept of 'Global Health Security' in the policy discourse, for example, is a product of the framing of particular health problems (mainly infectious disease pathogens) as security threats.^{xxxvi}

Paradigms

For public policy scholars such as Peter A. Hall, John L. Campbell and Fred Block, paradigms lie in the 'cognitive background' of policy processes. Paradigms are "[u]nderlying theoretical and ontological

assumptions about how the world works” and “[p]aradigmatic effects are profound because they define the terrain of policy discourse”.^{xxxvii} Thus paradigms structure how actors view and understand the world, embody taken for granted ideas and assumptions about how the world works, and as a consequence “limit the range of alternatives policy makers are likely to perceive as useful”.^{xxxviii} Other scholars have used alternative terminologies (such as Sabatier’s ‘policy core’^{xxxix}) to denote much the same thing.^{xl} When proposed policy choices are framed in a way which fits (or resonates) with these paradigms, “they appear natural and familiar and, as a result, are more likely to appeal to policymakers than alternatives that do not.”^{xli}

Frames and paradigms are therefore closely linked. Whilst frames lie in the ‘cognitive foreground’ of policy processes, paradigms lie in the ‘cognitive background’.^{xlii} In framing an issue, actors are putting forward a particular interpretation of one or more paradigms, thus automatically limiting the terrain of the policy discourse and, likewise, inferring particular types of policy response (which Campbell calls ‘programmatic ideas’).^{xliii}

Given the centrality of health to human and social life, the range of interests at stake, and health’s cross-cutting policy dimensions, it is no surprise that there are a number of powerful paradigms in the ‘cognitive background’ of global health. These paradigms are often historically and structurally embedded and widely diffused. They embody various cognitive assumptions about the nature of ‘health’, the roles of governance actors, and about the broader social world. Within contemporary global health there are a huge range of powerful paradigms, each of which embodies particular assumptions, norms, values and understandings. Whilst it is impossible to devise a comprehensive list of such paradigms (or to formulate universally-agreed labels to describe them), there are a number which are particularly influential in global health policy-making. Here we offer four:

Biomedicine is drawn from the Western medical tradition but has in many ways become the globally dominant paradigm, at least amongst medical professionals (although even here other streams of thought, such as social medicine, are evident). It focuses on understanding the structure and mechanisms of the human body and diseases. Biomedicine revolves around positivistic scientific research and prevention and intervention at the level of the individual patient, for example through the development and use of pharmaceuticals. Biomedicine is often presented as being a value-neutral techno-scientific knowledge system and thus as not 'normative' in any real sense.

Human Rights is another well-established paradigm which has, over recent decades, become important in global health through the assertion of a 'human right to health' by a variety of actors, including the WHO and various civil society organizations. Its normative stance towards health is based on the universality of individual and/or community rights, and the consequential obligations on others to protect those rights. In practice, however, there are often tensions between the human right to health and other rights, particularly notions of individual liberty and the right of individuals to make choices about their own body.

Security has been described as an 'essentially contested' concept,^{xiv} but despite this its various forms all rest cognitively on a threat-defence logic.^{xiv} In global health terms, this has most commonly been applied to addressing the threats posed by the trans-border spread of infectious diseases. In more recent years the security paradigm has changed as the range of referent objects have been broadened, opening the way for a range of new securities, from 'human security' to 'global health security'. Part of the normative power of security is its concentration on existential threats, tying it closely to the ultimate health issue: life and death.

The *economic* paradigm rests on a set of assumptions, the most powerful of which is that health, like any other commodity, is a scarce resource.^{xlvi} Whilst supply is always limited by available resources, the demand for health is inelastic (people's demand for a life-saving treatment does not decrease with price). The dominant contemporary normative position is that the market is the most efficient (or indeed the only) means of balancing the supply-demand equation.

This paper could proceed with a similar rehearsal of other influential paradigms in global health policy, including international development, moral/religious (or 'civilizational') views, and communitarian ideas, but the point is clear. We simply seek here to indicate the nature and range of paradigms that appear most commonly (and 'fit naturally') in the global health discourse. These paradigms as presented here are heuristic devices for looking at the ideational underpinnings of global health governance. In reality these paradigms are themselves internally contested, overlap, and change over time. The hierarchy between them is also subject to change. Although the public policy literature that has examined 'paradigm shifts' has generally examined cases of one paradigm giving way to another.^{xlvii} In global health there is almost never only one paradigm at work. Finally, it is of course the case that many international actors would subscribe to many or all of these paradigms, at least in the abstract. At the level of particular responses to particular problems, however, they often come into conflict.

Relationship between frames and paradigms

In our framework, framing provides the linkage between paradigms which reside in the cognitive background of global health and the foreground of policy debates. In framing an issue, actors are (either consciously or unconsciously) labelling it in a way which connects it with these ‘cognitive background’ ideas which, given their broad nature, do not offer precise, uncontroversial or operable principles which could guide a governance response.

Frames are thus inextricably linked to paradigms, but paradigms themselves are so broad that they do not directly infer particular policy outcomes: actors can frame an issue in relation to the same paradigm but in support of very different – even opposite - policy preferences. The case of tobacco control provides a classic example of this. Anti-tobacco campaigners have often suggested framing the implications of (passive) smoking as a human rights issue.^{xlviii} Their success in doing so can be seen in the Framework Convention on Tobacco Control which, in its preamble, refers to a whole series of rights, including “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”^{xlix} Yet the opposing arguments have also been framed in relation to the human rights paradigm. The tobacco industry has often couched its arguments in terms of individual rights, arguing for the existence of a right to smoke (as freedom of choice) and portraying tobacco control policies as discriminatory.¹

It is clear from this discussion that we see ideas as having a key part to play in the policy cycle. In terms of operationalizing this framework, there are a number of questions which could be applied to any policy cycle, including:

- What language is used in discussions of a global health issue (i.e. how is it framed)?
- What competing frames are brought to bear? How well do they resonate with the major paradigms of global health?

- Who voices particular framings and within what institutional contexts (e.g. particular communities of experts, organisations, the media)?
- What authorities, texts etc are cited in support of a particular framing?
- How do the audience react to particular framings (do they gain support or are they opposed? Are they repeated in other contexts? etc)?
- Are ideational links drawn between different policy fields/issue areas (e.g. are examples of successes/failures in other areas deployed)?
- How do framings differ at different stages of the policy cycle: are they consistent or do they change?

Power and Authority

Ultimately, framing is a question of agency, and in global governance this inevitably brings in power relations. Although, as mentioned above, the extent to which a frame resonates is an important variable in the success or failure of framing, clearly the process of contestation between competing frames is profoundly affected by power. Global health governance is not a Habermasian ‘ideal speech’ situation in which the best argument wins out. Power matters, and outcomes are determined not only by the persuasiveness of a particular frame, but also by who is advancing that frame. This would not be news to most constructivist scholars: it is well-recognised that powerful actors use frames strategically in order to advance (or secure) their interests.^{li} Yet work on argumentation in international politics points to the fact that sometimes the better argument *does* win out, even when forwarded by (materially) non-powerful actors (whether that be small states or

non-state actors).^{lii} It is possible for less powerful actors to successfully advance particular framings of an issue and to persuade other actors to adopt that frame.

Even so, we would not want to argue that material power does not play a central role in the production of global health policy: it clearly does. In the most extreme cases, material power (and even coercion), exercised either publicly or behind the scenes, can determine policy outcomes. The TRIPS agreement, for example, was included in the WTO Uruguay Round largely at the insistence of the US, whose framework for the eventual agreement was itself developed by US Pharma and other knowledge-producing corporations.^{liii} It was foisted on developing countries by a process of ‘trade weight’ and carrot-and-stick measures, in a sense the exercise of ‘hard power’. In practice, however, even materially powerful actors usually see it as necessary to frame their proposed governance responses in such a way as to be broadly acceptable to other, and it is rare for coercion alone to explain outcomes in global health governance. Rather, the process of contestation is characterised by a combination of relational power and the persuasiveness of the ideas themselves.

There are also different kinds of power to consider. Material power (in the form of economic resources, for example) is not the only kind of power that matters in global health governance. We can posit a number of other forms of power (‘authority’ might be a better word) which enable certain actors to be unusually effective in forwarding their chosen framings of global health issues.

One example is the various forms of authority which accrue to actors in certain influential positions. The bureaucracies of International Organizations which, as Barnett and Finnemore have argued, are able to “use discursive and institutional resources to induce others to defer to their judgement”, are one example.^{liv} This authority is partly a product of expertise, but also rests upon their roles in

classifying the world, fixing meanings, diffusing norms, and creating and following institutional rules and procedures. It should not be a surprise that the institutional cultures of IOs impact profoundly upon the kinds of governance response which they are likely to pursue, and the types of frames they deploy. Epistemic communities are influential in global health, and also find themselves in a privileged position to advance particular framings within certain institutional settings. The global biomedical community, for example, wields enormous 'soft power' in terms of its ability to persuade, argue for, and justify particular approaches and solutions. Cortell and Peterson have identified an influential institutional culture of biomedicalism at the WHO,^{lv} and framings of health policies in biomedical terms have an enormously powerful appeal both to other policy communities and the general public. The appeal to expertise, scientific method and neutrality all confer upon it the power to influence other governance actors.

Power of various forms can also influence the extent to which actors are able to engage in a policy process in the first place, and beyond this can confer a special status or legitimacy upon certain actors. This type of power, then, is essentially a product of an actor's position within the structures of global health governance (although that in itself cannot be divorced from other forms of power).

Power, frames and policy context

A combination of power and ideas determines the institutional contexts within which policy cycles take place, and the different mix of actors involved. Ideas legitimize the use (or creation) of certain institutions, and thus are constitutive of the very architecture of global health governance. It was through a particular set of ideas about health and economic development, for example, that the World Bank gradually became an important institution in global health. The phenomenon of 'regime

shifting', "whereby states and nonstate actors relocate rulemaking processes to international venues whose mandates and priorities favor their concerns and interests" has also been apparent.^{lvi} Helfer, for example, has described the way in which the United States and the European Community deliberately shifted negotiations over the intellectual property regime from WIPO to the WTO, and have continued to deploy this strategy with regard to global IPRs.^{lvii} Framing can also be used deliberately by less materially powerful actors in order to draw new institutions and actors into the debate.

Given the complex mix of power and ideas at work in global health governance, there is a clear methodological problem in demonstrating the claim that frames and paradigms (rather than material power) are really doing the work in shaping the nature of global health responses. Providing evidence of this causality is a difficult process, and one for which there is no perfect solution. This is not a problem confined to the framework presented here, but rather one which is characteristic of the broader constructivist project. Shiffman, for example, provides a list of 11 factors which shape prioritisation, including factors related to both actor power and ideas, but faces the same problem as us in weighing the relative importance of those factors. Perhaps the heart of the problem is that general frameworks only take on meaning when applied to specific issues (in our case to specific policy cycles). There is no standard weighting between power and ideas: the factors play out differently in different cases.

We can, however, suggest methodological strategies which have been put forward in the literature which we believe can help us to show the policy impact of particular ways of framing a given global health issue, and help us to identify whether frames or power are really doing the explanatory work. Of course, we would not argue that researchers are value-neutral or able to operate outside of these

debates. Nevertheless, Campbell outlines a number of promising approaches which all involve careful tracing of policy processes.^{lviii} Interviewing policy-makers in order to map their policy preferences and also their interpretation of particular policy-relevant events is one method. Detailed historical tracing of policy processes – including analyzing policy documents and other texts – can also help to link particular framings of issues with a governance response. Others have suggested more formal methodological approaches, including a variety of quantitative and qualitative coding procedures used to identify frame-relevant patterns in the documentary evidence.^{lix} Our contention is that it is through a mixture of such methods, applied in a careful and detailed way to individual policy cycles, the causal links between ideas and governance responses can be shown. Similar methodologies can be used to identify the operation of power in policy processes, and again much rests on the facts of the individual case. Deployment of resources (as is increasingly the case with the Gates Foundation’s funding of global health programmes) brings both a seat at the table of global health governance and the ability to directly affect policy outcomes. Institutional representation (e.g. board membership) is also an indicator of instrumental power. Thus mapping the actors and resource flows in a policy field can tell us much about the effects (and the distribution) of power.

In the light of this discussion we can add to the questions which we identified above.

- What actors, communities and institutions have a visible stake in the outcomes a policy process?
- Who is involved in determining policy outcomes? Which institutions/individuals provide leadership, and who is excluded from the policy process?
- Is the policy process/outcome seen as legitimate or not?

- What communities of experts are referenced and deployed in policy debates?
- Who provides the resources to implement policy and what conditionalities are attached, if any?
- Is contestation apparent in the policy cycle, and how is such contestation mediated or settled?
- In what ways is procedural power evident (e.g. through standard operating procedures, policy templates, institutional structures and hierarchies etc)?
- Is there evidence that actors without traditional material power have influence on policy outcomes?

The 'Deep Core' of Neoliberalism

Part of the problem with many of the constructivist approaches to global health governance (and indeed to global governance more broadly) is the over-emphasis on agency and ideas to the neglect of deeper structural determinants. The 'playing field' on which global policy debates are played out is not level, but is skewed by historically specific and deeply embedded ideas and configurations of power. Constructivists, of course, would argue that agents and structure are mutually constituted.^{lx} Equally, neo-Gramscians would see nothing particularly radical in viewing particular 'world orders' as the product of a dialectical relationship between power, politics, economics (and production) and ideas.^{lxi} For our purposes this agent-structure debate can be bracketed off. What matters for our framework is not how or why the 'deep core' of neoliberalism came to be dominant, but that it is, and that it impacts on global policy processes in a number of ways.

The public policy literature has employed various terminologies to denote what we call here the 'deep core'. Whatever terminology is chosen, the point is that:

“At the highest/broadest level, the deep core of the shared belief system includes basic ontological and normative beliefs ... which operate across virtually all policy domains.”^{lxii}

The deep core provides an overarching logic and a background set of assumptions and values that has influence across policy areas and social spaces. As such we would expect the deep core to operate across institutions and policy areas, from global economic governance to global environmental governance, and to permeate down through societies, from the global to the level of the self-regulation of individuals. Thus, whilst the paradigms of global health which we identified above operate across global health governance, the deep core operates across many, if not all, areas of global governance. Clearly, the deep core is always historically specific and is intertwined in a reciprocal relationship with other structurally-embedded 'ways of doing things' (such as transnational finance and production), forms of social organization, political subjectivities, and gender relations.

Neoliberalism has been seen to be operating in this way in a variety of policy fields,^{lxiii} and we see this as holding true in global health. Clearly neoliberalism has not always occupied this position – indeed the neoliberal economic model has only come to replace Keynesianism over the last 30 years or so.^{lxiv} Neither is the neoliberal ideology uncontroversially accepted by all actors in the international system. We view the position of neoliberalism with regard to our paradigms and framings of global health policy in a similar fashion to Cerny's articulation of a globally 'hegemonic paradigm'. Cerny makes a case for viewing neoliberalism as a broader, deeper and more dominant

force in global life than is more circumscribed antecedent that characterised a critical phase in national economic policy making in the 1980s:

Neoliberalism has increasingly come to frame intellectual and political debates in recent years as economic doctrine, public policy agenda, descriptive framework, analytical paradigm and social discourse. It has become deeply embedded in 21st century institutional behavior, political processes and understandings of socio economic “realities.” In this way it has superseded “embedded liberalism”... as the common sense and key “shared mental model”... of the evolving “art of governmentality” in a globalizing world.... Embedded neoliberalism has become the common sense of the 21st century.^{lxv}

Following this broadened understanding of neoliberalism, we see three particular ways in which it has evolved to shape global health policy;

First, neoliberalism has affected the configuration of power and authority through the rolling back of state (and international public) authority over health, whilst also diffusing authority across a wider range of both public and private actors.^{lxvi} Thomas and Weber have shown how the transition from a broadly social democratic system to one defined by neoliberalism has affected the institutional configuration of global health governance.^{lxvii} In particular, they argue that global financial institutions such as the World Bank, IMF and WTO took on a pre-eminent role after this change, usurping the agencies of the United Nations System, and bringing with them a very different set of policy preferences. Similarly, Rick Rowden has shown how neoliberalism has provided the ideological blueprint for the IMF’s role in GHG, a role which, according to Rowden, has entailed the systematic undermining of many public health systems.^{lxviii} The increasing importance of the private sector as

'partners' in global health governance has also been widely noted, as has the appeal to markets as the most efficient mechanism for allocating scarce health resources. By a gradual ceding of authority to institutions who promote neoliberalism in health, neoliberalism's dominance has become concretized and self-fulfilling.

The second way in which neoliberalism structures global health governance is by embodying a series of policy preferences (many of which have been applied in other areas of global governance) that are now being widely applied to global health issues. These preferences explain some of the contemporary 'policy trends'. The most commonly noted of these is the promotion of liberalized and privatized healthcare systems, a trend which is having significant global effects on the ability of people to access health services. Furthermore, the same trends in other areas of public service provision also have important health implications. The privatization of water and sanitation services, for example, has often been made a precondition for World Bank and IMF loans, and has clear health consequences if it excludes some people from access to clean water.^{lxi} These policy trends are often manifest in the approaches taken by powerful global health governance actors, most notably the international financial institutions, who have developed a range of policy templates which they apply to countries through the use of various mechanisms such as World Bank Country Health Portfolios and Poverty Reduction Strategy Papers.^{lxii}

Third, neoliberalism colonizes many of the paradigms of global health which we highlighted above. To take one example, biomedicine and neoliberalism have made natural bedfellows, sharing as they do an emphasis on individuals as being autonomous and rational consumers ultimately responsible for their own risk behaviours and their own well-being. Colleen O'Manique has argued in the case of HIV/AIDS that:

Intrinsic to both neoliberalism and biomedicine is an individualistic view of humans, a view that is reflected in the policy response to AIDS in Sub-Saharan Africa. The largely biomedical policy response fits nicely into the neoliberal agenda, to the extent that factors that fuel the spread of HIV are not considered proper targets for intervention.^{lxxi}

Neoliberalism and biomedicine also come together in what has been termed 'biopower', wherein risk, behaviour (including sexual behaviour) and choice are individualized and made subject to governance (via measurement, monitoring etc). We witness this relationship, for example, in the growth of global markets for processed and fast food, whereby demand is often structured by aggressive marketing and franchising, where decisions about health risks are devolved to the consumer, and where regulation (health policy) is largely absent. At the same time, a range of governance actors are exploring ways of harnessing the market to modify individual behaviour. It is apparent in these moves that neoliberalism has deep-going effects vis a vis health governance, not least in the reconstitution of individuals and patients as rational economic actors (as is also present in QALY and DALY methodologies). In this way, not only are the macro-level economic, political and social determinants of health left to a great extent unaddressed, they are actually concealed. A similar colonization can be seen in relation to human rights and health.^{lxxii} In short, the hegemony of the neoliberal orthodoxy results in a situation where all of the paradigms of global health exist and develop in a context defined by neoliberal ideas.

In all of these ways neoliberalism has the effect of limiting what is sayable, doable and even thinkable in global health governance. The range of arguments which can be legitimately advanced are circumscribed, and beyond this neoliberalism's embedded nature means that there is seldom

any need for its ideological strictures to be enforced: the 'orthodoxy' is just that and is well on the way to having a 'taken for granted' quality which global governance actors rarely seek (or even think) to challenge. This does not, however, entirely exclude resistance. There remains the possibility of forwarding counter-hegemonic critical discourses and, as a result, there remains the possibility of change in global health governance.

The deep core of neoliberalism, therefore, has both direct and indirect effects upon global public policy. It both privileges particular policy preferences and also structures the terrain on which policy debates take place. The challenge for the researcher, however, lies in identifying how the deep core permeates and manifests itself. We propose the following questions which aim to reveal its structuring power, focusing on the three lines of force detailed above (namely, the privileging of certain actors and voices; evidence of distinctive policy templates, and the manner in which it colonizes the paradigms of global health). Whilst none of these questions in and of themselves provide conclusive proof of the role of neoliberalism, taken together they may provide persuasive evidence of its overarching structuring impact: Whilst this claim is clearly normative and the power and presence of neoliberalism continues to be a divisive and contentious referent in global political life, for us it is persistent and powerful enough to characterise the overarching meta-framework under which global health policy is at least presently conducted.

Actors

- What is the role of global economic actors and private interests in specific global health policy cycles?
- Are particular states or groupings of states (e.g. G8) associated with particular policies, do they promote them, or mediate their facilitation?

- How does their role relate to that of other global health governance actors? Are they dominant or just another voice?
- How seriously are actors who critically engage with neoliberal policies taken?

Policy Templates

- What particular role is ascribed to states and other international public policy actors in the policy cycle? What roles are assigned to markets and private actors?
- How are competing interests, for example between economic development and individual health status, balanced or reconciled? Does one set of objectives or interests predominate?
- Have policy templates from other regimes or areas of policy been imported into global health policy, and are such templates associated with or indicative of neoliberalism?
- To what extent are private actors and market mechanisms seen as legitimate or useful in securing policy outcomes?

Paradigmatic effects

- Are successful arguments framed in economic logics (e.g. efficiency, cost-saving) or do they employ economic evidence or methodologies?
- Do certain policy debates/discourses include framings which combine paradigms of health with neoliberal ideas?
- Are arguments put forward which bring together paradigms which may appear to be diametrically opposed (e.g. are policy debates ostensibly about development or public goods for health couched in discourses of market efficiency, consumer power and choice or the failure/inefficiency of public initiatives and interventions)?

- Are policy debates characterised by framings which stress the individual nature of risk, responsibility and (un)healthy behaviour?
- Are regulatory powers or policy interventions challenged on the basis that they infringe on private/individual/market rights?

Conclusion

We have argued here that the determinants of global health policy are more profound and more deep-rooted than much of the current literature suggests. Here we have set out a framework for analysing global health policy cycles that attempts to capture the mixture of power, ideas, agency and structure, which informs each stage of the policy cycle and produces global health policy. We have set out a series of questions which, we believe, can help researchers to unpick these issues in relation to particular policy cycles. Much work remains to be done in tracing empirical examples of these processes. The contribution which this article is intended to make, however, goes beyond this. Through integrating insights from a range of literatures we have sought to enrich the conceptual basis of current work in the rapidly developing field of global health governance. In broader terms, the model could be of utility in any field of global public policy, and indeed there is scope for interesting comparisons to be made between global health and other sectors and regimes.

Finally, in the light of the framework we set out here, we conclude with three deliberately normative contentions as to why global health governance is presently failing to adequately address manifest health needs.

Firstly, global health problems are often framed in unhelpful ways. This may be deliberate – actors seeking to justify certain policies in pursuit of an ulterior motive – or it may be the product of genuine beliefs. Either way, successfully framing a problem in a particular way determines the linguistic and cognitive terrain (and can therefore exclude other terrains), leading to consensus being built around the ‘wrong’ responses. This is obviously more likely to happen when the framer is a powerful actor, and it is for this reason that the framings put forward by powerful actors should be submitted to particular scrutiny.

Secondly, the relationship between paradigms of health changes over time, and it may well be that in the contemporary system of global health governance the paradigms which dominate (we would identify in particular economics and biomedicine) militate against a broad social understanding of the determinants of health. Thus the cards are stacked against policy approaches which attempt to address these issues.

Thirdly, and most fundamental for us, is the structuring logic of neoliberalism which exacerbates economic and health inequalities and limits the range of likely responses to global health problems. Many of the most innovative recent global health initiatives have been an attempt to smooth some of the rougher edges created by neoliberal global governance. They have not, however, fundamentally challenged it. So for now the crisis of global health seems likely to persist, and global health governance will likely continue to fail.

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ⁱⁱ See Laurie Garrett, “The Challenge of Global Health”, *Foreign Affairs*, Vol. 86, No. 1 (2007), pp.14-38; David McCoy, Sudeep Chand and Devi Sridhar, “Global health funding: how much, where it comes from and where it goes”, *Health Policy & Planning*, Vol. 24, No. 6 (2009), pp.407-17.

ⁱⁱⁱ David P. Fidler, “After the Revolution: Global Health Politics in a Time of Economic Crisis and Threatening Future Trends”, *Global Health Governance*, Vol. 2, No. 2 (2008/9), pp. 2-21.

^{iv} See especially: Ronald Labonté and Michelle Gagnon, “Framing health and foreign policy: lessons for global health diplomacy”, *Globalization and Health*, Vol. 6, No. 14 (2010), pp.1-19; Jeremy Shiffman, “A social explanation for the rise and fall of global health issues”, *Bulletin of the World Health Organization*, Vol. 87 (2009), pp.608-613; Jeremy Shiffman and Stephanie Smith, “Generation of political priority for global health initiatives: a framework and case study of maternal mortality”, *The Lancet*, Vol. 370 (2007), pp.1370-79.

^v Judith Goldstein, *Ideas, Interests and American Trade Policy* (Ithaca, NY: Cornell University Press, 1993); Judith Goldstein and Robert Keohane (eds.), *Ideas and Foreign Policy: Beliefs, Institutions and Political Change* (Ithaca, NY: Cornell University Press, 1993).

^{vi} Paul Sabatier, "The Advocacy Coalition Framework: Revisions and Relevance for Europe", *Journal of European Public Policy*, Vol. 5, No. 1 (1998), pp.98-130.

^{vii} Garrett, *op cit.*; Allyn L. Taylor, "Governing the Globalization of Public Health", *Journal of Law, Medicine & Ethics*, Vol. 32, No. 3 (2004), pp.500-508.

^{viii} Christof Schiller, Henni Hensen and Stein Kuhnle, "Global health policy: What role for international governmental organizations?" in Rune Ervik, Nanna Kildal and Even Nilssen (eds.), *The Role of International Organizations in Social Policy: Ideas, Actors and Impact* (Cheltenham: Edward Elgar, 2009).

^{ix} Kelley Lee, Suzanne Fustukian and Kent Buse, "An Introduction to global health policy" in Kelley Lee, Suzanne Fustukian And Kent Buse (eds.), *Health Policy in a Globalising World* (Cambridge: Cambridge University Press, 2002), p.10.

^x Harold D. Lasswell, *The Decision Process: Seven Categories of Functional Analysis* (College Park: Bureau of Governmental Research, College of Business and Public Administration, University of Maryland, 1956).

^{xi} Other variants of the policy cycle concept have identified more than four stages. See Jack Barkenbus, "Expertise and the Policy Cycle", (1998), available: <http://www.gdrc.org/decision/policy-cycle.pdf> (accessed 9 February 2011), pp.1-2.

^{xii} e.g. Douglas Torgerson, "Contextual orientation in policy analysis: The contribution of Harold D. Lasswell", *Policy Sciences*, Vol. 18, No. 3 (1985), pp.241-261.

^{xiii} Diane Stone, "Global Public Policy, Transnational Policy Communities, and their Networks", *Policy Studies Journal*, Vol. 36, No. 1 (2008), pp.19-38.

^{xiv} *Ibid.*, p.21

^{xv} Charlotte Streck, "Global Public Policy Networks as Coalitions for Change" in Daniel C. Esty and Maria Ivanova (eds.), *Global Environmental Governance: Options & Opportunities* (New Haven, CT: Yale School of Forestry & Environmental Studies, 2002).

^{xvi} e.g. Dodgson, Lee and Drager, *op. cit.*, p.23.

^{xvii} e.g. Garrett, *op. cit.*

^{xviii} Kelley Lee, Sue Collinson, Gill Walt and Lucy Gilson, “Who should be doing what in international health: a confusion of mandates in the United Nations?”, *BMJ*, Vol. 312 (1996), pp. 302-307.

^{xix} Kent Buse and Amalia Waxman., “Public-Private health partnerships: a Strategy for WHO”, *Bulletin of the World Health Organization*, Vol. 79, No. 8 (2001), p.750.

^{xx} Patrice Troullier, Piero Olliaro, Els Torreele, James Orbinski, Richard Laing and Nathan Ford, “Drug development for neglected diseases: a deficient market and a public-health policy failure”, *The Lancet*, Vol. 359(9324) (2002), pp.2188-2194.

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^{xxii} David P. Fidler, “From International Sanitary Conventions to Global Health Security: The New International Health Regulations”, *Chinese Journal of International Law*, Vol. 4, No. 2 (2005), pp. 1-68.

^{xxiii} Jeff Collin, Kelley Lee and Karen Bissell, “The Framework Convention on Tobacco Control: the politics of global health governance”, *Third World Quarterly*, Vol. 23, No. 2 (2002), pp.265-282.

^{xxiv} Shiffman, *op. cit.*

^{xxv} Shiffman and Smith, *op. cit.*

^{xxvi} Labonté and Gagnon, *op. cit.*

^{xxvii} Sabatier, *op. cit.*; Yves Surel, "The role of cognitive and normative frames in policy-making", *Journal of European Public Policy*, Vol. 7, No. 4 (2000), pp.495-512.

^{xxviii} John L Campbell, "Institutional analysis and the role of ideas in political economy", *Theory and Society*, Vol. 27 (1998), p.399.

^{xxix} Adapted from Mayer N. Zald, "Culture, Ideology and Strategic Framing" in Doug McAdam, John D. McCarthy and Mayer N. Zald (eds.), *Comparative Perspectives on Social Movements: Political Opportunities, Mobilizing Structures, and Cultural Framings* (Cambridge: Cambridge University Press, 1996). For a discussion of the use of framing in constructivist International Relations see Audie Klotz and Cecelia Lynch, *Strategies for Research in Constructivist International Relations* (New York: M.E. Sharp, 2007), pp.51-7.

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^{xxxi} Martha Finnemore and Kathryn Sikkink, "International Norm Dynamics and Political Change", *International Organization*, Vol. 52, No. 2 (1998), p.897.

^{xxxii} Shiffman, *op. cit.*, p.609.

^{xxxiii} Thomas Risse, "Global Governance and Communicative Action", *Government and Opposition*, Vol. 39, No. 2 (2004), pp.288-313.

^{xxxiv} e.g. Rodger A. Payne, "Persuasion, Frames and Norm Construction", *European Journal of International Relations*, Vol. 7, No. 1 (2001), pp.37-61.

^{xxxv} Shiffman and Smith, *op. cit.*

^{xxxvi} e.g. Global Health Security Initiative, "Ministerial Statement", Ottawa, November 2001, available: <http://www.ghsi.ca/english/statementottawanov2001.asp> (accessed 9 February 2011); WHO, *The World Health Report 2007. A Safer Future: Global Public Health Security in the 21st Century*. Geneva: WHO, 2007.

^{xxxvii} Campbell, "Institutional analysis", *op. cit.*, p.389.

^{xxxviii} John L. Campbell, "Ideas, Politics, and Public Policy", *Annual Review of Sociology*, Vol. 28 (2002), p.22.

^{xxxix} Sabatier, *op. cit.*

^{xl} Surel, *op. cit.*

^{xli} Campbell, “Institutional analysis”, *op. cit.*, pp.389-390; Peter A. Hall, “Policy Paradigms, Social Learning and the State: The Case of Economic Policy-making in Britain”, *Comparative Politics*, Vol. 25, No. 3 (1993), pp.275-296.

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ⁱⁱⁱ e.g. Thomas Risse, “‘Let’s Argue!’: Communicative Action in World Politics”, *International Organization*, Vol. 54, No. 1 (2000), pp. 1-39.

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^{lvii} *Ibid.*

^{lviii} Campbell, “Ideas, Politics, and Public Policy”, *op. cit.*

^{lix} Klotz and Lynch, *op. cit.*, p.53.

^{lx} Alexander Wendt, “The agent-structure problem in international relations theory”, *International Organization*, Vol. 41, No. 3 (1987), pp.335-370.

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^{lxxi} Colleen O'manique, "Global Neoliberalism and AIDS Policy: International Responses to Sub-Saharan Africa's Pandemic", *Studies in Political Economy*, Vol. 73 (2004), p. 66.

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