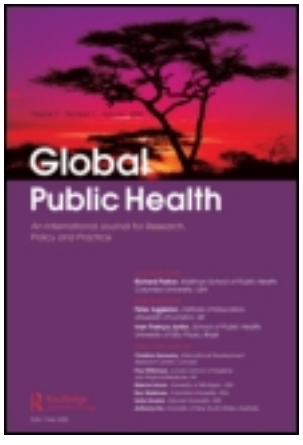

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Framing global health: The governance challenge

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INTRODUCTION

Framing global health: The governance challenge

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With the emergence of global health comes governance challenges which are equally global in nature. This article identifies some of the initial limitations in analyses of global health governance (GHG) before discussing the focus of this special supplement: the framing of global health issues and the manner in which this impacts upon GHG. Whilst not denying the importance of material factors (such as resources and institutional competencies), the article identifies how issues can be framed in different ways, thereby creating particular pathways of response which in turn affect the potential for and nature of GHG. It also identifies and discusses the key frames operating in global health: evidence-based medicine, human rights, security, economics and development.

Keywords: global health; global health governance; frames and framing

Globalisation is widely seen as influencing patterns of health and disease worldwide (Dodgson *et al.* 2002, Cockerham and Cockerham 2010, McInnes and Lee, 2012). It is also understood as both causing and requiring changes to how decisions on health policy are made and organised. It has caused change, not least through the emergence of new bodies with global reach. It requires change because if 'health is global' (DoH 2008), then collective solutions are required for shared health problems. Thus the emergence of 'global heath governance' (GHG) is widely seen in two ways. First, it is seen in terms of institutional developments – the emergence of new global actors such as the GAVI Alliance; the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and the Bill and Melinda Gates Foundation (Ollila 2005, Buse *et al.* 2009, Williams and Rushton 2011), or the adoption of new roles and responsibilities by the existing actors such as the WHO or the World Bank (Dodgson *et al.* 2002, Ruger 2005, Cockerham and Cockerham 2010). Second, the emergence of GHG is also seen in an ostensibly rationalist light as a reasoned

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response to an exogenous development, namely the globalisation of health determinants and outcomes (Collin *et al.* 2002, Fidler 2004).

Both the nature of emerging global health problems and the necessary mechanisms of GHG to deal with them, however, have historically been narrowly defined in both the policy and academic worlds (although more recently movement to broaden this focus has been apparent[1]). In particular, four limitations can be identified through much of the available policy and academic literature:

- The existing analysis has emphasised the institutional and technical features of GHG actors and policies, and has failed to adequately grasp more fundamental reasons for the disjuncture between global health needs and governance responses (see Kay and Williams 2009).
- Research so far has with some success analysed individual global health institutions or mechanisms, but there has been little comparative analysis to draw wider lessons for strengthening GHG (see Youde 2012).
- Analysis to date has focused heavily on infectious diseases and SARS, HIV/AIDS and pandemic influenza in particular (Fidler 2004, 2010, Davies 2008). Although vitally important, limited attention has been given to the governance challenges posed by the wider range of global health issues faced.
- Attention has focused on material factors such as disease outbreaks, funding mechanisms and preparedness plans. Only comparatively recently have ideational factors – the ideas that shape our understanding of issues, thereby creating acceptable pathways of response – begun to be examined (see Shiffman 2009).

These limitations led to the establishment in January 2009 of a four-year project examining competing visions of GHG, funded by the European Research Council, involving a multidisciplinary team co-located at the Centre for Health and International Relations at Aberystwyth University (CHAIR) as well as the Centre on Global Change and Health in the Department of Global Health and Development at the London School of Hygiene and Tropical Medicine (LSHTM). The project's aim has been to look beyond institutional (in)competencies and technical responses; to broaden the focus to understand a broad range of global health challenges; to examine the ways in which responses to global health crises are shaped by a contested space of competing ideas and worldviews of health; and to offer a comparative analysis across a range of health issues.

This special supplement of *Global Public Health* considers the way in which GHG has been influenced by the world of ideas. To facilitate this, the supplement adopts a constructivist theoretical approach, which allows an examination of the ideational as well as material basis behind contemporary debates and controversies. As Onuf (1989) argues, the social world is one of our own making where the ideas we use shape our understanding of 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 intentionality; and that the meaning

> and significance of ideational factors are not independent of time and place' (Ruggie 1998, p. 33).

Therefore, in this collection we do not deny the importance of material factors in shaping GHG, but add to this the manner in which health and health issues are socially constructed (by language and other means) and *through this construction* possess meaning. Specifically, we use ideas of 'framing', whereby an issue is presented in such a way as to tie it into a broader set of ideas about the world, or 'socially constructed reality', and through this gain influence and policy purchase. Frames are defined by Gitlin as 'persistent patterns of cognition, interpretation and presentation, of selection, emphasis and exclusion, by which symbol-handlers routinely organise discourse' (1980, p. 7). Framing has been used extensively in the public policy literature (see Entman 1993, Fischer 2003, Jerit 2008), though perhaps less so in public health (see Dorfman and Woodruff 2005) and only recently in a very limited number of studies pertaining to GHG (Shiffman 2009, Labonté and Gagnon 2010). In policy debates, actors often deliberately (and in many cases strategically) use frames as a tool of persuasion, deploying them to call attention to an issue, influence other actors' perceptions of their own interests and convince them of the legitimacy/appropriateness of the advocate's preferred policy response. When they are successful in doing so, the chosen frame 'resonates with public understandings, and are adopted as new ways of talking about and understanding issues', and actors will be likely to modify their behaviour accordingly (Finnemore and Sikkink 1998, p. 897).

Frames are deployed and promoted by various stakeholders, including transnational advocacy groups, international organisations and epistemic communities. These are the 'cognitive baggage handlers of constructivist analyses' (Haas 1992 cited in Youde 2005, p. 423). In global public health, competing 'baggage handlers' frame health issues in particular ways (as a biomedical, human rights, security or economic issue), in an attempt to generate or legitimise specific pathways of response on health issues. For example, in this collection, Kamradt-Scott and McInnes (2012) point out how pandemic influenza has been framed as a security issue (or 'threat') to generate support for emergency plans and preparation, while Reubi identifies how a network of activists successfully framed tobacco control as a human rights issue in order to tie it into the existing legislation on human rights. Not all of these 'baggage handlers' are equal, but they have differential power, including intangible factors such as social capital, which can lead to one group being more successful than another. But framings can also be constitutive of meaning – that is, they may move beyond being merely a presentational artifice to become a means of shaping the way in which a health issue is understood. They achieve this by presenting an issue in terms that have meaning for a worldview and therefore are associative with that worldview. Thus, to follow the earlier example, framing pandemic influenza as a security issue has led not only to action being undertaken on the issue, but also to the very nature of the disease being understood in terms of posing a '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 meaning. Therefore, in this collection we use the fruits of an ongoing four-year multidisciplinary research programme to examine the manner in which health issues are framed, for what purposes and with what effects.

It should be noted from the outset that global *governance* is defined here as conceptually distinct from global *government*. The focus of global governance is not

on the creation of a supranational authority with the legitimacy to impose globally binding laws and regulations over states' wishes. Nor is it solely concerned with formal agreements or arrangements such as treaties, convention regulations or international institutions, though in much of the literature on GHG, these remain the general focus of attention. Instead, it covers a range of formal and informal agreements, principles and understandings that inform acceptable behaviour. Governance may indeed be formal, and may involve relinquishing sovereignty in particular circumstances, but it may also be seen in tacit agreements, informal understandings and the positional power of organisations and institutions (see Rosenau and Czempiel 1992, Rosenau 1995, Hewson and Sinclair 1999). It therefore covers a wide spectrum of possibilities and accepts that those involved may include not only traditional actors such as states and international institutions, but also global civil society and charitable foundations. Nor is it necessarily the case that formal agreements such as treaties and conventions, which are ostensibly binding in terms of international law, are necessarily more important to GHG than tacit agreements or shared understandings: a treaty with no monitoring or enforcement mechanisms may not be honoured, while a widely accepted understanding of what should be done under certain circumstances may prove much more significant in governing behaviour.

The key advantage in using framing to understand and explain GHG, then, is its introduction of an ideational element: how the manner in which a health issue is framed opens up specific acceptable pathways of governance response based upon shared understandings (or what is sometimes referred to as 'worldviews'). How issues are framed can tap into powerful ideational forces that may prove as significant as institutional competencies, interests and agendas in shaping GHG, including creating difficulties for effective GHG.

Project background

The core challenge for GHG is how collective action on an increasingly broad range of shared global health concerns can be more effectively achieved. We have already detailed some of our concerns over the generally narrow focus of much of the literature. The attempt to embed a broadened conception of what GHG encompasses is therefore a key component of this project. But the project is also underpinned by an understanding that the challenge of GHG is not simply technical – of devising appropriate institutional configurations and competencies and treatment regimes – but a political one. By this we mean that the sort of problems encountered in GHG are not amenable to rational, value-neutral analysis leading to an optimal solution, but exist in an arena where different values, interests and knowledge create competition and contestation. GHG is inherently political because it raises fundamental questions regarding where power and authority does and should lie in governing to protect and promote human health, and whose interests should be served or not served by the distribution of costs and benefits arising from such authority. For example, access to antiviral drugs during an influenza pandemic raises the question of how to balance national interests and those of the global commons. This is an inherently political question, but so is that of who has the authority to make a decision on this and similar global health issues. This is one of the reasons why GHG has developed into a highly contested space. But the space is also

contested because there is no single underlying logic behind calls for action. Rather, there are a variety of presentational artifices that have been used to gain attention to different (and sometimes the same) health issues, each of which may suggest a particular pathway of policy response underpinned by a particular governance framework. Thus, and rather simplistically, framing pandemic influenza as a security threat is likely to privilege national over collective regional or global interests, to suggest a territorially focused policy of 'at the border' controls and to promote disease surveillance as a core GHG response. In contrast, framing influenza as a development issue is informed by the idea of a shared humanity where rights and responsibilities are couched more widely; it may suggest policies that focus on upstream causes of disease, including levels of poverty, and would involve the provision of aid for capacity building in the GHG responses. The project's framing approach, therefore, helps us to understand how GHG is shaped by different, and at times competing, perspectives and worldviews of the nature and causes of global health problems and the appropriate solutions to them. The articles in this special supplement demonstrate how the framing of global health issues and their associated governance responses to date have led to the creation of particular pathways of response. Moreover, like Shiffman (2009) we are interested not only in advancing our understanding of how certain framings may prove more persuasive and expedient than others in generating action on global health issues, but also how action may be constrained by competing framings that may cross institutional boundaries.

Research design and methods

An initial scoping study supported our hypothesis that there was little by way of comparative analysis in GHG, and that much of the literature focused on the problem of infectious disease. From the start, therefore, the project has been designed around four comparative case studies that form the empirical basis of the articles that follow. These include not only infectious diseases as key generators of discussion on GHG (for this project we use HIV/AIDS and pandemic influenza as case studies), but also non-communicable disease (tobacco control) and distributive issues (access to medicines). To facilitate comparison across case studies, we adopted a standard 'structured focused' methodology (George 1979). The temporal focus starting in the 1990s was chosen because it marked major changes in both the international system and in Development Assistance for Health (DAH). It is also the period when health began to be constructed as being global (Brown *et al.* 2006). A second scoping study identified five key frames to be examined across the case studies: biomedicine, security, development, economics and human rights. These frames were not unique to the case studies examined by this project, but appeared to be dominant framings across the emerging realm of global health. However, subsequent work led us to modify this approach in two important respects. First, biomedicine proved an unwieldy frame to operationalise and research, and a narrower but related frame of 'evidence-based medicine' (EBM) was focused upon given the impact of this movement on biomedical research and policy over the past 20 years. Second, we had an initial concern that most of the frames were internally contested, with competing theories, methodologies and approaches leading to different policy prescriptions, making their value as frames uncertain. In this respect, EBM perhaps suffered the least, but each of the others appeared to a greater or lesser extent to be potentially

problematic. We needed to identify a higher-level commonality in worldview that defined the frame as coherent although internal contestations could still be acknowledged. This is reflected in the brief introductions to the frames used later in this paper and in several of the papers in this collection, including those by Reubi (2012), by Williams (2012) and by Woodling *et al.* (2012). A crucial move was to accept that the identification of specific frames as coherent was to some extent heuristic in that it simplified reality for analytical purposes, but in a nonetheless useful manner. Further empirical research has subsequently supported our scoping study in that, although other frames might exist, these five have been dominant in global health and, in particular, GHG.

The research used available primary and secondary literature and key informant interviews. Literature was identified using keyword searches on online databases (including Google Scholar, ISI Web of Knowledge, JSTOR, LexisNexis, OCLC ArticleFirst and PubMed), with further sources cascading from these. Texts included scholarly works, 'grey' literature and policy papers. Following a review of the literature, we were able to produce a 'spotter's guide' of key features for each of the frames under analysis prior to the first phase of interviewing. For each frame we identified the following: knowledge, arguments and language used; the communities of experts involved; and techniques (or what some might term 'technologies') of governance. These were not intended to be binding and inflexible tools, but rather to provide a common understanding across the case studies, enabling us to identify the operation and influence of frames. The 'spotter's guides' were consequently amenable to review as further data were received. During 2010 and 2011, 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 data bank of questions common across the case studies. The interviews were digitally recorded, transcribed and shared through a secure SharePoint site. As approved by the Research Ethics Committees of both the LSHTM and Aberystwyth University, all interviews were conducted on a confidential basis unless the key informant agreed otherwise. The interviews have been used extensively to support the following papers, but for these reasons of confidentiality we have omitted reference to them (unless the interview subjects gave prior permission) and used published sources wherever possible.

Frames

This section briefly introduces the five frames used by the project and reflected in this collection. As already noted, these are heuristic devices that we use as analytical tools while simultaneously recognising the presence of internal contestations in many of these frames and their potential.

EBM initially gained prominence in the mid-1990s, but by 1998 the movement had spread rapidly internationally to become fully embedded within the majority of medical (clinical) training programmes. At its core, EBM 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, 1996). As a direct result of its integration into contemporary training programmes, successive generations of medical/clinical practitioners have been trained in EBM methods and ways of thinking. As a result, EBM has become the primary mode of scientific, rational enquiry for contemporary biomedicine and clinical practice and the key frame for the health policy community (Tonelli 1998, Kristiansen and Mooney 2004). 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' reify and reinforce rationalist thinking while simultaneously categorising and condemning other forms of reasoning as inferior (i.e., who would not want to use evidence to support their decision-making? Who would not wish to be systematic?).

Over the past 20 years, there has been a marked resurgence in framing global public health issues in terms of *human rights* (see 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), while 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. Unsurprisingly, the relationship between the moral-legal rhetoric of human rights and global health is highly contested. Indeed, even within a same organisation there can be competing understandings of how human rights and health relate. One can, however, still identify understandings that have been particularly influential over the last two decades. One of these is that developed initially in the 1990s by Jonathan Mann (the former Director of the World Health Organization's Global Programme on AIDS) and subsequently developed by other AIDS advocates (Fee and Parry 2008). For them, 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, 1999). Another influential understanding of human rights and health is that which developed during the twenty-first century by both the UN Committee on Economic, Social and Cultural Rights (UNCESCR) and the UN Special Rapporteur on the Right to Health, Paul Hunt. For them, the relationship between human 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 Mann's definition, this conception of human rights and health emphasised the importance of international legal norms like article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (IESCR), judicial enforcement mechanisms and human rights lawyers (Reubi 2012).

Economics is a particularly diverse and internally contested frame (Amariglio 1990). Health economics, by extension, is no exception. For example, 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 (e.g., cost–benefit analysis).

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 of health security, each implying different referent objects (i.e., 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.

As with the previous two frames, *development* is contested, with multiple meanings. 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, etc.), which place the idea of 'lack' vis-à-vis the developed world at the heart of this frame (Escobar 1995, 2004). But development is a problematic frame: it seems that health in the Third World must *always* be a matter for development, although other frames/paradigms will most probably also play a part.

Conclusion

The following articles are therefore based upon a coherent research programme examining the contested realm of GHG. This collection focuses on the ideational realm – the ideas that shape the field in both policy and academic terms. Specifically,

these articles examine the manner in which health issues are framed, for what purpose and with what effects. Each of the following articles uses one of the five frames previously identified in this paper as being dominant in GHG, to examine one of the four case studies used by the project. Comparison is possible for two of the case studies (HIV/AIDS and pandemic influenza), with both being examined by different frames, and two different frames (security and development) being used to examine the same issue. Kamradt-Scott explores the influence of EBM on pandemic influenza preparedness, and how vaccines and antiviral medicines are promoted as indicators of pandemic preparedness. In particular, he notes how EBM has further reinforced the advocacy of drug-based solutions, placing vaccines and then antivirals centre stage while downplaying alternative preparedness measures. Reubi addresses the recent proliferation of human rights approaches in public health by focusing on the issue of tobacco control. Crucially, he shows how framing can be used not simply to generate attention for an issue but how, by reframing tobacco control as a human rights issue, the existing legislation on human rights could then be brought to bear on tobacco control. Reubi also demonstrates how a small but influential network can succeed in reframing an issue. Williams identifies how the patent system has been framed in economic terms as necessary or even benign in establishing a system that allows new drugs to be developed and traded; he finds that this has created a range of difficulties for access to medicines and ultimately a dysfunctional global drug market. Despite the emergence of a range of new actors intent on broadening access by intervening on drug price and innovation, Williams remains sceptical of their impact, given the strength of the economic framing of the patent/trade regime. The security frame is considered in two articles. Rushton examines the debate over limitations imposed on HIV-positive travellers in light of the US decision in 2010 to repeal its legislation. Restrictions had been imposed using a security frame, while opponents of the legislation attempted to undermine this framing by challenging the empirical evidence or by counter-framing it as a human rights issue. Rushton concludes that the counter-framing proved insufficient in itself to change US policy and that other factors, including changing political context and network building strategies by opponents to the legislation, were necessary factors. In the second article using the security frame, Kamradt-Scott and McInnes use the Copenhagen School's securitisation theory to examine how pandemic influenza has been framed as a security issue. They conclude that the act of framing was insufficient on its own, and that material factors (especially disease outbreaks such as SARS and H1N1) were necessary for a successful securitisation. But once securitisation had occurred, it then proved effective in driving policy change. Finally, Woodling, Williams and Rushton argue that although HIV/AIDS has been framed in a number of different ways, thereby allowing a multisectoral approach to emerge, development has proved a particularly powerful and resilient frame. This has been seen recently when, with other health issues beginning to claim attention away from HIV/AIDS, the development frame was used in an attempt to re-establish AIDS' special status.

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Note

1. Not least in the policy world, where maternal health care featured prominently in both the 2010 UN summit on the Millennium Development Goals (MDGs) and the G8 meeting of the same year. In 2011 the UN held a summit on non-communicable diseases (NCDs).

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