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Global Health Governance as a contested space: competing discourses, interests and actors

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Abstract:

The literature on Global Health Governance has developed rapidly over recent years with a large number of scholars from a variety of disciplinary backgrounds entering the field. Much of this work has been focussed either around the governance roles of specific institutions (IOs, GHPs, foundations etc) or the governance of particular health problems (most commonly infectious disease). Now seems to be a suitable point at which to take a step back and ask some more conceptual questions about how Global Health Governance works and what drives contemporary global responses to health problems.

This paper argues that Global Health Governance can best be understood as a process of contestation between a variety of different discourses, each of which takes a particular approach to health as a global issue, and each of which generates certain policy responses. It argues that the key contemporary discourses influencing Global Health Governance are biomedicine, human rights, economism and security, but that other (currently recessive) discourses also have an influence. These discourses are promoted by different global health actors and each has gained salience in particular issue areas. The paper argues that it is in the interplay of these discourses – a process in which both power and ideas play a role – that contemporary Global Health Governance is shaped.

Introduction

Global Health Governance (GHG) as a field of study has developed rapidly over recent years. Scholars from Public Health and International Relations as well as other disciplines have increasingly begun to pay attention to the ways in which health outcomes are affected by global policies, processes and actors. Factors such as spatial compression, trade flows and new patterns of consumption have all generated a perception that there is such a thing as 'global health' and that there is a need for more effective governance in this area.

This paper argues that the academic literature examining GHG that has coevolved with the globalization of health has reached a watershed moment. The case that health is linked to globalization has been successfully made, and by-and-large it is accepted that health is 'governed' on a global scale. The first-generation of GHG literature has largely cast the problems facing global health in terms of an insufficiency of resources, lack of political will, lack of inter-agency coordination and so on (e.g. Commission on Macroeconomics and Health, 2001). The normative assumption underpinning much of this literature is twofold: that what is needed is *more* (and more efficient) governance to respond to manifest health needs; and, second, that such governance will lead to better health outcomes. In contrast, we view the contemporary 'architecture' of GHG as far wider and more far-reaching than much of the existing literature would suggest, and we argue that GHG already encompasses a plethora of new and powerful agencies and actors who are determining health policies at both the global and national levels (the Bretton Woods organizations and new Global Health Partnerships being prime examples). Furthermore, it is not a given that more governance will lead to better governance, nor is reforming existing institutions likely to be sufficient - especially when one considers that the current modality of GHG has failed to perform adequately. Now seems to be a suitable point at which to take a step back and problematize current approaches to the study of GHG, asking some more critical questions about how GHG works in practice, and what really drives contemporary global responses to health problems.

In this paper we argue that GHG can best be understood via a process of contestation and cross-pollination between a number of competing discourses of health. In doing

so we draw on a research framework for GHG developed in a recent successful bid to the European Research Council.[2] This framework has already generated other early outputs which treat GHG in such a way (Lee, 2009). We seek to further elaborate and refine the model and to show its utility over two illustrative examples of contemporary issues in global health. GHG is not a monolithic edifice but rather is comprised of a bewildering range of actors, initiatives, processes and policies (Kickbusch, 2005). What this model contributes is an overarching framework for understanding the context within which global health policies are made and the manner in which governance responses vary across different spheres of health, and over time. As such, this represents a new research agenda for GHG and is part of what the authors see as a new second generation of scholarship in this area.

We begin by setting out this conceptual framework and explaining the centrality of the key contemporary discourses of GHG and, crucially, the contestation within and between them. Our discourses, drawn from the research framework discussed above, include security, biomedicine, human rights and economism. However, we depart slightly from the programme's joint framework, viewing these as the discourses as the ones which currently dominate, but not as the only ones which matter. In this respect, we contend that both civilisational and structural discourses are necessary for a comprehensive account of what does the work in GHG, and – perhaps more importantly – that we need to be sensitive to the overarching role of neoliberalism in structuring the process of contestation. Finally, we examine two global health issues in which the contestation process is seen to be played out: the development of global responses to HIV/AIDS, and the renegotiation of the International Health Regulations. Overall, we will show that the different discourses of GHG have concrete policy and material manifestations, that they shape and determine responses, and that they reflect the fact that there are real interests and power at play in GHG.

The state of the art in the study of GHG

The very existence of a GHG literature is symptomatic of the major gains which have been made in recent decades in understanding the transnational and global dimensions

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[2] 230489-GHG. For further details see:
http://www.aber.ac.uk/interpol/en/research/chair/GHG%20Synopsis.pdf

of health. Moreover, the literature has substantially contributed to moving the focus of attention away from discrete national health systems and their comparative political economy to understanding how these systems are influenced and shaped by policies emanating from supranational organizations (Deacon, 1997; Zacher & Keefe, 2008). International Public Health has become a mainstream field of study and it is now widely accepted that explanations of individual or population health status cannot be divorced from broader structures and processes (e.g. Farmer, 2005; Lee et al, 2007). The state of scholarship in this area has substantially improved our understanding of the relationship between health and 'the global' in recent decades. The literature which specifically addresses questions of GHG has crystallised many of these important gains.

However, there are a number of limitations with the existing GHG literature. Firstly, existing analyses have tended to emphasise the institutional and technical features of GHG actors and policies in a narrow way, excluding the broader global context (Fidler, 2004). As a result it has often failed to adequately grasp the more fundamental reasons as to why there is such a marked disjuncture between global health needs and governance responses. As Kay and Williams argue (2009), whilst the contemporary zeitgeist of GHG is one in which there is a widespread perception of its inchoateness and failure, there is little understanding as to why this persists. Examining the institutional landscape of GHG in isolation assumes that it is a discrete area of global life driven primarily by health-sector actors and health concerns. So a great deal of emphasis has been placed on the World Health Organization (WHO) and other dedicated health-sector agencies, but only scant attention has been devoted to powerful global economic governance actors as they relate to health. The policies that these institutions generate, their effects on global health, and their increasingly central role in GHG help explain why there is systemic failure. Yet such actors are frequently viewed as exogenous interlopers by much of the existing literature when in reality they are part of the very fabric of GHG (Kay and Williams, 2009). GHG is a much broader, deeper and more disjointed system of governance than the current literature often suggests. However, there is now a nascent body of literature of literature that is starting to stress the real health governance powers of these very agents (Labonte; Buse & Walt; Lee). As we will discuss below, GHG cannot be separated from global governance in general, and in particular from the neoliberal project which presently

dominates that system. By the same token, the key contemporary discourses of GHG which we identify are not in general unique to global health: they are inextricably linked to and emanate from other areas of global governance and political economy.

The second limitation of the existing literature is to a great extent the product of the first. GHG literature to date has largely been focused upon the operation and reform of existing governance mechanisms, and with the challenges of institutional deficiency and resource scarcity (Koivusalo & Ollila, 1997). For Lee, by contrast, "inefficiency and ineffectiveness in the form of poor coordination and duplication of effort, neglect of certain issues or populations, .. mismatch of resources with health needs … problems of transparency, accountability, leadership" and so on "are symptomatic of deeper contestations within GHG among competing perspectives." (Lee 2009: 10) Like Lee, we question whether existing scholarship is getting to the heart of the problem with GHG. Undoubtedly research in the field has provided a wealth of insights into the politics within the WHO, for example, or the ability of certain powerful member states to determine health outcomes in particular cases (Siddiqi, 1995). What has largely gone unexplored, however, is the question of where those actors get their preferences from – in constructivist terms how their identities and interests are constructed (Wendt, 1999). Here we seek to understand GHG in a way which brings the ideational more fully into view but does not divorce it from the operation of material power. For us, the 'discourses' of health which we set out below are ideal types – heuristic devices – which provide analytical purchase on these ideational motivations.

Thus, we suggest that these discourses – and the process of contestation within and between them - provide a methodological lens for examining particular issues and policy outcomes in GHG. By largely ignoring the ideational and material origins of actors' motivations, much of the GHG literature is failing to grasp why the disjuncture between health needs and governance responses persists. More often than not, measures and policies which are designed to promote better global health (such as the Framework Convention on Tobacco Control) are incontestably in the (health) interests of humankind yet they confront competing worldviews and socio-economic paradigms which dictate alternative actions and reflect alternative interests (Global Health Watch, 2008). Where regulatory or health intervention measures fail, it is

simplistic to assume that they do so purely from a lack of political will or a lack of resources. Often they fail because, in cases where different priorities are in conflict, health will not always prevail. Furthermore, such conflict is subject to the exercise of real power, whether that be ideational, material or (perhaps most commonly) a combination thereof.

This raises problems for well-intentioned reformist approaches to GHG because it suggests that improving the quality (and quantity) of health governance is not just about institutional reform or increasing cooperation, although these may in themselves be good things. Rather, it is about reconciling health with a plethora of competing priorities and political and economic goals. This is a far more complex task. The mood of failure in GHG is a reflection of the fact that, even when on the agenda, and even in the most pressing areas of global health (such as managing and responding to pandemics), the mediation of these interests does not always result in the prioritisation of health goals. In fact in many instances, - when health confronts free trade and neoliberal economic globalization, for example, - the need for better health (and health governance) tends to come a poor second. Sadly, health does not always trump other interests (Rushton, Labonte 2009).

The third limitation we see in the current literature is that, despite piecemeal and usually institutional-specific effort by scholars, GHG has thus far failed to generate anything more than simplistic accounts of the international political economy of health (Kay & Williams 2009). The recent publication of the Commission on the Social Determinants of Health report (2008) was a major breakthrough in this regard, not least in acknowledging that health status was directly linked to inequalities generated by a single all-encompassing global capitalist system. Work by Paul Farmer has also linked questions of poverty, postcolonial legacies and power in the international system to health outcomes for the poor (Farmer, 2005). However, to date, very little work has fully captured how the neoliberal project is colonising and cross-pollinating with GHG, and how it is shaping health outcomes at all levels.

An approach which takes the construction of identities and interests seriously (such as the one we suggest here) must take account of the hegemony of neoliberal ideology. Neoliberalism is a powerful structuring ideology which sets the parameters within

which actors form their identities and interests. And beyond this it is embodies a range of policy templates which can be readily applied to the health sector. By examining the competing discourses it will become apparent that this does not exclude debate over appropriate policies and approaches. Yet neoliberalism in some sense overarches the divergent discourses: it colonises all of them, and at various stages, and over a huge number of health issues, it has successfully co-opted a diverse range of actors.

Contemporary discourses of global health

The project from which this paper emerges focuses upon four key contemporary discourses of global health: biomedicine, economism, human rights and security. These discourses have been best summarised by Lee (2009). We briefly rehearse their key elements for the sake of clarity..

Biomedicine is based upon medical and techno-scientific responses to health problems. It focuses on clinical and epidemiological characteristics of disease and modes of transmission, using observation, scientific research, and pharmacological treatments as its main responses. In contrast to Public Health approaches which have historically stressed social and economic determinants of health, the biomedical discourse stresses individual biology and risk behaviours (Foladori 2005). Some authors, whilst seeing obvious merits in the biomedical approach, have also identified the limitations that it brings, most specifically that it generates an atomised and individually-focussed approach to health that stresses treatment at the doctor-patient level, alongside the scientific search for 'magic bullets' at the macro-level, rather than interventions at the level of the community/society and economy (Schneider, 2006: 6-8). This stress on individual responsibility for health status finds a deep resonance with the equally atomised nature of consumer behaviour in markets, and with the wider emphases of neoliberalism on factors such as individual choice and responsibility, and with the shift of health from the public (and state-based) to the private market. According to Lee (1999: 5), the biomedical model has had a profound historical impact on GHG and has been reinvigorated through a series of new initiatives from the mid-1990s onwards. She identifies actors such as the Global Fund and the Gates Foundation as pursuing a largely biomedical approach to global health

problems, stressing the development of vaccines and drugs, and focussing upon single-disease campaigns.

Economism is often seen as sitting alongside, or as a natural counterpart to, the biomedical model (Frankford, 1994; Sparke 2009). Its increased importance as a discourse of global health can be traced to the entry of the World Bank into GHG from the 1980s onwards (Buse, 1994; Koivusalo & Ollila: 25).. As its baseline, economism assumes that resources are finite and that the challenge for GHG – and for governments – is how to most efficiently allocate those resources - effectively an exercise in rationing. The market, at least for the World Bank, has been championed as the most effective mechanism for achieving efficiency. In policy terms this leads to an emphasis on quantitative measures of the impact and relative benefit of various policy options. As Lee states (2009: 6), the Global Burden of Disease Programme at Harvard University, which attempts to quantify the burden of disease in terms of Disability-Adjusted Life Years (DALYs), is a prime example of this kind of policy tool. Proponents of this worldview stress the importance of basing policy on scientific evidence and of achieving maximum possible benefit for a given expenditure (Edejer et al, 2003; Murray & Lopez, 1996). Furthermore, economism has at least axiomatically led to a wider neoliberal project in global health and, although not an inevitable conclusion of its assumptions regarding efficiency and rationing, has been deployed to bolster suggestions that health and health systems should be liberalized, marketized and commodified.

Human rights discourses have found resonance in both the international public health and social medicine canons (Mann et al, 1999). In broad terms, human rights approaches start from the assumption that there is a human right to health, viewing the inability of individuals to access healthcare services, for example, as impinging on those rights. It thus foregrounds equality of access to healthcare, but also embodies an understanding of what constitutes 'good health' that is broader than the predominant biomedical view. The foremost institutional expression of this approach is the Alma Ata Declaration which defines health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" and goes onto assert that health is "a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization

requires the action of many other social and economic sectors in addition to the health sector." (WHO 1978) Human rights approaches to health have become strongly associated with civil society engagements, and also in social mobilization around issues such as access to medicines and patenting (Galvão, 2005; Thomas, 2002). Given the tenor of this approach, it is not surprising that it is also often linked with critiques of global health inequalities and with a recognition of the structural factors that systematically deny human rights. It has a strong correlation, therefore, not only with Public Health approaches, but also with structural discourses of health which we examine below. Proponents of the human rights discourse seek to push the international community and states to deliver upon their commitments to the right to health and, in some instances, to assist foreign citizens whose own states have failed to respond adequately (Hunt, 2006).

Security-based discourses of health have come to the fore in the post-Cold War era as a response to some of the more pressing threats currently facing states through health crises such as pandemic outbreaks, and via purported linkages between HIV/AIDS and state fragility. As such, it is inextricably linked with the broader process of globalization which has led to increased international traffic and trade, bringing with it the prospect of far more rapid transmission than was previously the case. In its most powerful expression, infectious disease has been presented as a challenge to the security of nation states (e.g. UN Security Council, 2000; National Intelligence Council, 2000). Almost inevitably, what such a worldview leads to is a narrowing of the global health agenda and the prioritisation of those issues (most notably infectious diseases) which are viewed as a source of threat. Whilst this may in some instances lead to interstate cooperation in the pursuit of collective security, it also has the troubling potential to distort health investments and aid priorities (Elbe, 2006). Some have argued that this latter tendency can be seen in some concrete cases, for example the engagement of the US PEPFAR programme with Nigeria (Ingram, 2007). Framing an issue in security terms is often seen as a means of lifting it above 'run of the mill' political issues and increasing its importance on high-level political agendas (e.g. Buzan, Waever & de Wilde, 1997). This may be so, but it is apparent that in practice the security discourse is sufficiently malleable to be combined with other discourses in new and powerful ways. Thus, despite its ostensibly state-centric focus, it has not been immune to the broader neoliberal agenda. To return to the example of

PEPFAR - the single biggest state-based investment in the fight against HIV/AIDS - it has sought to combine US foreign policy and geostrategic interests with an attempt to enshrine the patent rights of US-based pharmaceutical corporations, via an insistence on the use of US proprietary drugs (Buse & Walt, 2002). Although the security discourse is a powerful one, the discursive framing of health issues in terms of security does not obviate the need to take account of competing interests. This can be seen in the way in which attempts to achieve collective health security (for example via the International Health Regulations, examined below) must be reconciled with the global trade and intellectual property regimes.

Whilst we concur with Lee (2009) that these four discourses dominate the contemporary global governance of health, and that GHG is characterised by the process of competition between them, we seek here to build upon her argument in three distinct ways. Firstly, we argue that a more *longue durée* view of global health can lead to the identification of further discourses which have been highly prominent in other historical periods, leading to the conclusion that the range of discourses in play changes over time. Beyond this, we argue that certain discourses which might be seen as having 'died out' are in fact only recessive or have changed in emphasis, and that in some areas they continue to have an influence over the shape of GHG. Secondly, we see the discourses themselves as having their own internal faultlines, and not as monolithic paradigms of global health and governance. It is the contestation within as well as between discourses which drives global health policies. Thirdly, as we have indicated already, we see neoliberalism as overarching these discourses at the present historical juncture, setting the context within which contestation is carried out.

To begin with the first of these points of departure, we argue for the addition of at least two additional discourses to the framework, both of which are to some extent currently recessive, but each of which, we argue, continues to provide a motivation for certain actors with regards to health.

Civilizing discourses have commonly exhibited religious, moral and, cultural approaches to health. Such discourses are deep and persistent in relation to both Public Health in general and infectious diseases in particular. Historically concerns

with health, moral well-being and religiosity have been closely entwined, inspiring both national public health systems and also colonial and Western-led international health actions (e.g. Porter, 1999; Stern, 2006). Indeed, civilising discourses of health were strongly represented in the arguments that sought to legitimise colonialization (e.g. Manderson, 1987, 1996). They also led to developments such as the foundation of metropolitan schools of 'tropical medicine' and public health (Anderson, 1996). Curing the 'other' has often been driven by ideas about the superiority of Western civilisation and culture, and the implications of such an understanding continue to this day (Aginam, 2003). Although currently relatively recessive in its most extreme form, this type of thinking continues to be evident, for example, in the arguments put forward by religious conservatives in the US which have had a dramatic effect upon US HIV/AIDS prevention policies (Burkhalter, 2004; Epstein, 2005). Despite the often moral and missionary tone of the civilizing discourse, it has nonetheless exhibited strong links with the globalization of Western biomedicine and developed-world models of healthcare infrastructure, with implicit notions of their superiority over indigenous approaches and structures.

Structural (most commonly Marxian) discourses of global health have strong historical antecedents (not least in the genesis of the Alma Ata Declaration described above) and continue to supply activists and scholars with a basis for critiquing contemporary GHG and the dominant discourses of global health (most notably, but not only, economism). Proponents of such a discourse argue that there is a pressing need to consider the broader political, economic and social determinants of health. These types of accounts of global health are apparent in a range of interventions, reports and commissions, and often in the activities of civil society organisations.(e.g. Commission on the Social Determinants of Health, 2008). This discourse shares a great deal of commonality with human rights-based approaches and has more often than not championed social medicine and public health. In terms of its contemporary salience, this discourse is often deployed as a means of problematizing the ways in which contemporary neo-liberalism, inequalities across the global economy and market-driven responses actively precipitate continued crises in health systems and GHG.(Thomas & Weber, 2004). So even this discourse has become inextricably linked to neoliberalism, to which it is a reaction, and even at its most radical such an approach has to engage with GHG and health in terms of the dominant neoliberal

ideologies, policies and paradigms. The implications of the discourse are that health challenges can only be tackled by radical changes to the way in which GHG and financial and economic regimes are currently geared. It is no surprise, then, that it currently has a limited degree of influence within the major institutions of GHG.

To conclude, in methodological terms we see these discourses as a window onto the worldviews which motivate action. We therefore see language, and more broadly 'texts', as fundamental to understanding GHG – it is through examining discourses that we can get analytical purchase on the clash of ideas present in institutional settings and health policies.

GHG as a contest between discourses of global health

In the cases which follow we examine how the processes of contestation within and between discourses play out in particular issue areas. First, however, we offer some thoughts on how in general terms we can theorise discursive contestation in GHG. There is a great deal at stake in this process. The potential effect on health outcomes for individuals is clear. There is also much at stake economically: health is the single largest economic sector worldwide that remains largely unprivatized (Kay & Williams, 2009), and the estimated value of global healthcare products and services annually is $5 trillion. Given these two facts is should be no surprise that a wide range of motivations – from pure humanitarianism to narrow economic self-interest – are apparent.

Contestation between discourses

Whilst we have drawn attention to the overarching logic of the neoliberal paradigm, there is nothing pre-ordained about which discourse(s) will come to determine governance of a particular health issue. As we will see in the cases we examine below, this is contingent on a range of factors, some of which are specific to the issue at hand (such as the strength of the biomedical case for treating patients with anti-retrovirals); in other cases the governance response is determined less by the innate characteristics of the issue, or the particular compelling logic of an appropriate response, and more by competing interests and the operation of power. Although we

treat actors' identities and interests as socially, materially and historically constructed – and are thus open to the possibility that they can change over time – we do not see them as infinitely malleable and we can therefore treat interests as relatively fixed and stable (Wendt, 1999: Chapter 3). As noted previously, the various discourses of GHG are indicative of deep-rooted differences in the ways in which actors see, interpret and respond to the world around them. The worldviews of health reflected by them do not merely determine how actors respond to particular questions, they also form an ontological starting point from which actors operate, influencing both their' diagnosis of the problem at hand, and their preferred approach to dealing with it. Debates over appropriate health governance responses are not merely about petty political point-scoring or self-interested horse-trading (although both are common enough) but rather are the product of far more fundamental ideational commitments that interplay with power and material interests.

Since actors in health have different capacities and different (material) power resources at their disposal, it is not surprising that very often the most powerful actors get what they want. But they do not always, for reasons as diverse as their susceptibility to unified opposition; their sensitivity to moral shaming and reputational damage; argumentative self-entrapment; or indeed changes in their perception of their own interests which lead them to regret previous policy approaches. In the longer-term, of course, there can be changes in who holds the power. In addition, as was arguably the case with the FCTC, in some cases the strength of a good argument can defeat economic interests and state power even outside a Habermasian ideal speech situation (Habermas, 1980). Thus, whilst change is more difficult than mere institutional reform, there remains the possibility of change in GHG (and, speaking normatively, there remains the possibility of change for the better).

For the purposes of developing this research framework, how then do we describe the process of contestation: how does it manifest itself? Contestation takes two forms: the obvious and the tacit. The more 'obvious' forms revolve around relational power processes, which have both material and ideological dimensions. The less obvious, or tacit, forms of contestation are the result of structural power and, in some instances, resistance to it.

At the most extreme end of the spectrum, material power and even coercion – exercised either publicly or behind the scenes - can determine outcomes in GHG. 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 BigPharma (and other knowledge-producing corporations) (Sell, 2003). It was foisted on developing countries by a process of 'trade weight' and carrot-and-stick measures. Similarly, the interests of the US and international food processing corporations have largely stymied attempts to implement the WHO anti-obesity strategy, and have done so by blocking regulatory efforts to this end in the Codex Alimentarius and other regimes (Dyer, 2004). What matters here in terms of health and health policy outcomes is not so much who holds the power, but which particular worldview informs those actors' perceived interests.

It is clear, however, that there is more than one type of power at play in GHG. Non-material forms of power can determine outcomes too, and whilst material and ideational power are often exercised together, even relatively 'weak' actors (in material terms) can have a degree of influence which belies their supposed status. The global biomedical epistemic community, for example, wields enormous soft power in terms of its ability to persuade, argue and justify particular approaches and solutions. Its appeal to expertise, scientific method and neutrality all confer upon it the power to persuade in certain circumstances. To state that this community is not powerful is therefore a mistake. In health terms, Vincente Navarro (1977), drawing on Weber, has claimed that bureaucracies and professionalization of medicine and health also grant power to certain agencies and actors. In the case of bureaucracies, as Barnett and Finnemore (2004: 29) have argued, they are able to "use discursive and institutional resources to induce others to defer to their judgement." This 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. When one considers what may be described as the World Bank's 'culture of economism' and how it pervades and drives that bureaucracy's massive influence over global health policies and programmes, the real effects of this become clear. Similarly, the fact that the WHO bureaucracy is staffed largely by medical professionals has a real impact upon its organizational preferences (Cortell & Peterson, 2006).

What these different forms of relational power in GHG entail is that a wide range of different types of agents (and different discourses) have the potential to shape GHG. Part of the strength of GHG literature has been the moving of the focus of governance on from traditional actors (primarily states and international organisations) to encompass a plethora of other types of agents, although it has not always delved into where these other actors get their power from. Despite this, scholarship has pointed to how loose alliances of civil society organizations, health and sex workers, church groups and rights activists have coalesced around HIV/AIDS and employed almost the entire range of discourses of health and a variety of strategic techniques to operationalize the power they wield, just as so-called 'transnational advocacy networks' have in other spheres of governance (Keck & Sikkink, 1998).

Two more subtle forma of power also determine the shape of GHG, and set the context in which the contest between worldviews of health is played out. The first is the structural power conferred on certain actors (states or firms, for example) that they by their position (both material, ideological, and often geographical) in the global political economy. Often 'the way things are done' in global structures of production, credit and security, for example, largely determine the manner in which things continue to be done. Alternative approaches can in this way be squeezed out. This can be seen in the fact that the vast majority of pharmaceuticals are produced by an oligopoly of large corporations. This is self-perpetuating, but beyond this it also structurally limits the range of options open to the development of alternative structures of innovation and supply, and ultimately the ability of the world's poor to access medicines. Secondly, the fact that the global capitalist system and the policies that govern it operate from what are principally neoliberal templates, means that ideational and policy spaces open to actors are further constrained. At a practical level, these structures can limit the range of things which are 'sayable', and even the range of options which are conceivable, whilst tacitly legitimising particular worldviews of health. Thus, this type of structural power has the ability to co-opt actors into a particular programme or means of dealing with health, often without them realising it. Neoliberalism in particular has demonstrated its ability to co-opt the other major discourses. This is exactly why we identify neoliberalism as a form of meta-narrative or super-structure which the discourses discussed above are largely subjected to and colonized by. Yet, crucially, contestation is not excluded entirely.

There remains the possibility of forwarding counter-hegemonic discourses and, as a result, there remains the possibility of change in GHG.

Contestation within discourses

Thus far we have presented these discourses largely as monolithic, ideationally uniform and self-contained. This is clearly a simplification, and in fact faultlines and contestation exist within as well as between discourses. This is important for understanding that the process of formulating GHG is more nuanced than would at first be apparent, but also for explaining how different worldviews of health mutate and are themselves subject to power and agency. It is not surprising that juggernaut ideologies of the social world are often subject to internal divisions and competing perspectives. Without wishing to labour the point, we will here illustrate some of the division within the key discourses we have identified. Further reflections on these will come out of the cases we examine below.

It has been widely noted within the Security Studies literature that the very term "security" is essentially contested (e.g. Buzan, 1991). Different actors use the term to talk about very different referent objects, and about different types of threats to those referent objects. One of the clearest examples of this – and one which has been particularly influential in the field of health – has been the emergence of the concept of human security in opposition to more narrow traditional state-centric notions of security (Axworthy, 2001; Sen & Ogata, 2003). So in the case HIV/AIDS, human security approaches stress the threat dimensions of the pandemic in terms of individuals and communities (as the referent objects) and in terms of the overspill effects on other areas such as food security (de Waal & Whiteside, 2003; de Waal & Tumushabe, 2003). In contrast, national security-based approaches have pursued a far narrower definition of HIV as a security threat, looking at its effects on state stability, regional security and the effectiveness of security forces and peacekeeping operations (Campbell, 2008; Singer, 2002). Of course, the fact remains that both of these viewpoints are essentially about 'security' in some shape or form, and thus contribute to the legitimizing of viewing health as a security issue. Many have questioned the consequences of this 'securitization' of health (Elbe, 2006; McInnes, 2006).

Economism is not merely a worldview: it is a set of positivistic and economistic methods for calculating the most efficient deployment of limited resources. It is thus not surprising that in relation to the cost and benefits of private health systems over publicly-funded ones, that the exact same methods are used to justify each side of the debate (Tapay & Colombo, 2004). Although economism and economics often presents itself as a neutral, scientific instrument, it is, of course, nothing of the sort.

Biomedicine has also long been divided, and at times bitterly polarised. During the latter half of the 20th Century, for example, the fortunes of social medicine have waxed and waned. Lee describes this history as a contest between 'magic bullets' and social medicine: in some periods (the late 1960s-early 1980s) social medicine was in the ascendancy before the pendulum swung back towards a greater emphasis on technical and biomedical solutions (Lee 2009: 4-5). Likewise, in the developing world, the fortunes of the 'barefoot doctor' have come full circle in countries such as China and India (Zhang and Unschuld, 2008; Mudur, 2007). In the West, when one considers the evolving sociology of doctor-patient relations, there has been a growing sense that the doctor is no longer the figure of unquestioned authority that they once were (Shorter: 1985). At the global level, different types of biomedical models are apparent, and which is dominant at a particular time and in a particular issue area can lead to very different types of global health policies, aid programmes and health interventions. Currently, biomedicine has well resourced and vociferous champions in global health, not least by a range of Global Health Partnerships (GHPs) and foundations, the majority of which work from the 'magic bullets' end of the biomedical spectrum (Birn, 2005).

The human rights-based discourse is not simply legally-driven but also has strong normative elements. It is not surprising, therefore, that deep divisions are apparent in view on how human rights relate to health (in itself an equally contestable concept). Whilst human rights discourses share a common starting point that there is a human right to health – and that such a right is universal and inalienable a major faultline is apparent between largely 'liberal' (in the classical sense) conceptions and more radical traditions (Mann et al., 1999). The liberal conception views individual rights as legally and institutionally guaranteed (by either the state or the international community) and identifies a series of rights for individuals and obligations for

providers of access to healthcare and treatment. These types of rights and obligations have close links with the human security canon and is present in the Alma Ata Declaration (WHO, 1978). In contrast, more radical conceptions of the human right to health see a failure in liberal approaches to address the structural factors that systematically erode these rights in the first place. The liberal conception has dominated the international legal approach, and has thus far gained the most ground in attaining institutional legitimacy. More radical critiques are often expressed in opposition to the perceived failure of such institutions and actors to attribute blame. The People's Charter for Health is a prime example of the radical approach, stating in its preamble that

> "Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed." (People's Health Movement, 2000)

The civilizational discourse, as noted above, has deep historical roots in missionary and imperialistic traditions as they relate to health. On the one hand this discourse encompasses moral, biomedical and colonial elements and has been strongly associated with the extension of Western biomedical and Public Health models to less developed countries (Aginam, 2003). Whilst the civilizing discourse has largely lost the more hard-edged associations with Victorian morality and colonialization, a similar logic is nevertheless arguably present in the manner in which Smallpox eradication was carried out (Bhattacharya, 2006), in abstinence-based programmes for HIV/AIDS and other STIs, and even in some approaches to the treatment of alcoholism (e.g. the 12-step programme). Thus, it can be argued, the tradition continues over a range of currently globalized health initiatives, is present in PEPFAR, in the activities of the Catholic Church, and the health and aid programmes of Christian fundamentalist organisations across the globe., Although the civilizational discourse is often criticised, the bald fact is that in many instances the extension of Western models of biomedicine and Public Health undeniably brought benefits to recipient populations. Arguably civilizing tendencies form the basis of the

activities of a range of organizations that are still seen as conducting work which is valuable and laudable (and this includes actors such as Oxfam, CAFOD, and even the Bill & Melinda Gates Foundation), and is often cast as humanitarian work. These organizations see certain categories of health issues as 'of the other', but see their responsibility as good international citizens to help out. In practice these organizations work on the basis of radically different normative standpoints: thus the civilizing logic which can be seen to underpin their work does not necessarily lead to commonly agreed policies and activities.

It will be no surprise to any reader that leftist and structural accounts of global health are deeply divided. For example, on the one hand accounts of deep divisions within global health status resulting from somewhat crude and mechanistic Marxian readings of the global political economy would view capitalism as the sole obstacle to global health (Navarro, 1977). More nuanced accounts, however, stand apart from such approaches and focus on the material and the economic and their neglect of ideational, institutional and technical determinants of global health (Kickbusch, 2002). They stress the interdependency of states, markets and knowledge-systems in providing the deeper structural explanations for the disparity in health between the global poor and rich. It is the latter category which has become ascendant in debates over a range of health issues (principally emanating from academia and civil society) since the end of the Cold War.

Despite these divisions within the discourses of global health we nevertheless argue that they represent a valuable analytical tool for the study of GHG. Viewing each discourse as coherent is justified as each is characterised by particular forms of language and logic with regard to health. The different components of the security discourse, for example, all treat health in terms of a threat-defence logic – and a threat-defence language. Whilst they differ over the identification of the referent object, they represent different expressions of a common worldview. The reason as to why they are coherent is also found in the fact that opposite parties within these discourses are forced to operate and contest each other in the same language game, or policy terrain. Economism in the social sciences of health is possibly the most powerful expression of this: contending parties over specific health issues have to draw on statistics, cost-benefit analyses and calculations of efficiency to fight their

corner. Understanding the power of language here is, after all, vitally important. When we consider the motivations of different actors in health, and the manner in which health policies are made, these can best be accessed through an examination of the language in which arguments are couched (Milliken, 1999)..

Contestation in practice

For illustrative purposes we here analyse two cases – one of a single disease and one of a global regime – to demonstrate the utility of the conceptual framework which we have elaborated above.

1. HIV/AIDS

The scale and severity of the HIV/AIDS pandemic, most notably in sub-Saharan Africa, but increasingly in other parts of the world, is well-known and there is scarcely any need to reiterate it here. Suffice to say, AIDS contributed to more than 2.1 million deaths in 2007 alone (UNAIDS/WHO, 2007, p.1). There are currently around 33 million people worldwide living with HIV. Two thirds of those are in Africa. Global inequalities in the prevalence of HIV and AIDS are scarcely coincidental, and the strong links between HIV and poverty have become well-recognised in more recent years. Indeed, HIV/AIDS has grown as a global health problem alongside the globalization with which it is associated.

The development of global approaches to combat the HIV/AIDS pandemic is a classic case of contestation within GHG and the adoption and promotion of certain discourses by various agents has reflected power and social mobilization. Since AIDS was first linked to the HIV virus in 1984 (Gallo, 1984) there have been many significant breakthroughs made. In purely biomedical terms, although a vaccine has not yet been developed, there have been huge advances in antiretroviral therapies (ARVs) which can dramatically extend the expected lifespan of people living with HIV/AIDS. There have also been many lessons learned on the most effective prevention and education strategies. There are also a huge array of institutions which have been put in place at every level (the global to local) to deal specifically with the pandemic, and unprecedented levels of funding have been committed. However, these gains have

been limited by problems associated with resource scarcity and rationing, and with persistent structural poverty in the regions affected. There is a widespread perception that current attempts to turn back the tide of HIV/AIDS are failing (Lee, 2009). Such a perception is not misplaced. We would argue that the underlying reason for such a level of confusion in the global governance of HIV/AIDS is not merely a lack of coordination between the various agencies (although clearly that does not help), but because of a real and ongoing contest of worldviews and material interests.

Although it is to some degree a simplification, it is possible to see the development of governance in this field over the last 20 years as having proceeded in three stages. At each of those stages particular discourses have risen and fallen in importance, and in some cases have directly driven change. In the first phase, during the 1980s, official policy towards HIV (at least in the West) was predominantly a domestic health problem, with the response driven largely by biomedical approaches and public health-based prevention strategies (Shilts, 2007). Understandably, biomedical research into the nature, causes and pharmacological solutions to the virus were given a high priority. Alongside these (and in no small part due to the failure to find a vaccine or a cure) were education measures aimed at promoting safe sex and safe intravenous drug use. Yet these were certainly not the only discourses in play during this phase. Civilizational discourses also played a significant role, largely due to the social profile of those initially most affected by the virus (in particular men who have sex with men and drug users). Terms such as "gay plague" became a common feature of public debate (e.g. Daily Telegraph, 1983). The US commentator Patrick Buchanan, previously a speechwriter for Richard Nixon, wrote in his newspaper column that "The sexual revolution has begun to devour its children. And among the revolutionary vanguard, the Gay Rights activists, the mortality rate is highest and climbing." (Buchanan, 1983: 311). If less stridently expressed, such an approach was also common in official circles. It was not until 1987 that Ronald Reagan first used the word 'Aids' in public (Gill, 2006: 10). It can be argued that these moral and religious ideas inhibited effective action to combat the threat of HIV/AIDS in the early years. In response there was the emergence of an early rights-based discourse, pioneered by bodies such as the Terrence Higgins Trust, in which civil society groups attempted to destigmatize people living with HIV/AIDS.

During the 1990s, the governance of HIV/AIDS gave way to a second phase in which the international dimensions of the looming crisis came to the fore. A further set of discourses entered the fray as the issue became globalized. As the scale of the pandemic in sub-Saharan Africa grew – and as the links with poverty became more well-established – the pandemic began to be viewed as an international development issue. Of key importance in this second phase was a global social mobilization by a loose alliance of actors who couched arguments for a more robust governance response to the pandemic in terms of an array of different discourses (Seckinelgin, 2008). These alliances, including medical professionals, gay rights activists, sex workers, development activists and even economists, converged around the issue of patents. As ARV treatments began to be developed and improved there was increasingly a debate between economistic and human right-based discourses focussed around the issue of access to medicines and in particular the global supply of patented ARV treatments at prices beyond the poor and particular national markets where the disease is most acute (Thomas, 2002). Economistic arguments, meshing neatly with the neoliberal intellectual property regime under TRIPS, were deployed in support of the need to maintain incentives for the pharmaceutical industry to continue its R&D effort (Attaran & Gillespie-White, 2001). Civil society groups in particular – but also some governments in the global South – contested this with rights based arguments, asserting that individuals were being denied their human right to health (Khor, 2007). Perhaps more interestingly in conceptual terms, economistic discourses can be used in support of increasing access to medicine, by highlighting the economic consequences arising from lost productive capacity, food security, and the transfer of savings into health care, and the flight of capital. Interestingly, bodies such as WHO and development activists saw no alternative than to forwarding interventions in the market, and thus tweaking the rules of the existing global production structure for drugs, and were thus forced to either talk to the corporations, as was the case with WHO under Brundtland (Kapp, 2001), or seek government or philanthropic to supply sources of funding. This debate serves as an excellent illustration of the ways in which divisions within discourses can come to the fore, and how particular forms of language can be used instrumentally in support of particular policy positions, and of how neoliberalism reduces the space available to proponents of alternative approaches in GHG.

An arguably even clearer instance of contestation has been seen in the third phase of engagement with HIV/AIDS, roughly from 2000 onwards, in which there have been deliberate attempts by some actors to reframe the pandemic in terms of security. Whilst the debate between the other discourses has continued, security has entered the equation bringing with it new actors into the global governance of HIV/AIDS. The UN Security Council Resolution 1308, passed in 2000, is most commonly cited as the pre-eminent example of the 'securitization' of the disease McInnes, 2006: p.326). The origins of this resolution lay in concerted attempts by the US, in particular in the person of Ambassador to the UN Richard Holbrooke, but wholeheartedly supported by Vice-President Al Gore, to raise the profile of the pandemic and move it up the international agenda (Prins, 2004). Drawing attention to the potential effects of high prevalence rates on uniformed services, peacekeeping operations and, in the worst case analysis, the stability of entire states and regions has succeeded in achieving in increasing the political profile of HIV. Yet some commentators have expressed concerns about the potential costs of the securitization of HIV/AIDS, and in particular the dangers inherent in harnessing health issues to foreign and security policy (Elbe, 2006). Alongside this shift towards security, however, scholars such as Ingram (2009) have identified a more subtle shifting in the attitude of the Christian conservative right in the US, who increasingly demanded a more active US engagement with the pandemic in the developing world (Epstein, 2005). The role of churches' missionary activities in this sea-change in US foreign and aid policies is important. The point is even those powerful actors which have been at the forefront of securitization have not acted solely according to a security based logic, and can be influenced by other discourses and interests.

Overarching all of these changes, we argue, is the hegemony of neoliberalism which has in many instances set the agenda and the parameters of the debate. A number of examples of this structuring logic can be teased out. First, whilst PEPFAR was clearly in part a recognition that HIV/AIDS could be mobilized as a tool of US foreign and security policy it was also put in place to protect the commercial interests of BigPharma, and enshrine these corporations' place in the global supply chain for the rolling-out of HIV/AIDS treatment (Ingram, 2009). PEPFAR was in also a response to the unprecedented social and governmental mobilization at the top level of GHG (a mobilization that was concretely expressed at WTO Ministerials such as Doha, the

Millennium Development Goals, and in the South African government's legal challenge to the TRIPS agreement). But whilst this international pressure brought about a major US policy response, that response was one based upon a perception that US commercial and patent interests were under threat (Ingram, 2009). Those who had challenged the status quo had precipitated a response from the most powerful actor in the international system, but perhaps not the response that they wanted. Thus, because neoliberalism is polymorphous it is not surprising that the single biggest aid programme in this field, although ostensibly humanitarian, was in part about protecting commercial interests.

Second, in the latter two phases of HIV/AIDS governance both activists and specialized agencies have been co-opted into the language of biomedicine and economism. In a Foucauldian sense GHG in this area has largely become a technical exercise in monitoring, statistics and the efficient delivery of biomedical solutions (Elbe, 2005). Whilst these types of activities have become institutionalized in bodies such as UNAIDS and WHO, and are clearly important, the fact remains that they have circumscribed the range of what is permissible and sayable in terms of global health policies, and orientates discourse towards the reinforcement of market-based and biomedical solutions. Fundamental problems associated with the pandemic - such as structural disparities and wealth and income and market fundamentals - remain largely unchallenged.

In sum, it is possible to read the history of global (and national) responses to HIV through the lens of the various discourses which characterise the global governance of this issue area. As has been shown, the fortunes of those discourses rise and fall over time, with particular discourses dominating in certain periods. It can be seen from this illustration that the causes of this variation can be many and varied. In some instances they can be due to the changing nature of the health issue itself (as, for example, when the snowballing of the pandemic in the developing world transformed HIV/AIDS into a global issue linked with poverty and development, rather than homosexuality and drug use). However, it is also clear that these discourses can and did overlap and cross-pollinate, and were utilised by a diverse range of agencies as sources of power at different times. Their use by actors is therefore contingent and not always mutually exclusive, and can be explained by real power and real material interests. In other

cases, changes in the range of available responses alters the terms of the debate (so, obviously, access to medicines only becomes an issue once those medicines have been developed). In still other cases actors can use material power and persuasion to forward a particular worldview by using and legitimising the use of certain types of speech (as has been the case with the security discourse).

2. The International Health Regulations

Interstate cooperation in the area of disease control is not a novel phenomenon and the first concerted attempt to coordinate international action was as long ago as 1851 (Fidler, 2001). Yet the global governance of infectious disease continues to generate controversy, and in doing so neatly encapsulates some of the tensions inherent in GHG, and the competition between discourses.

The International Health Regulations (IHR) set the framework within which states cooperate and respond to outbreaks of infectious disease WHO (WHO, 2008). In essence, the IHR are a global regime for the global governance of infectious disease and also a collective security regime in that their focus is upon limiting the cross-border spread of pathogens. The immediate ancestry of the IHR lies in the first specifically 'international' framework for health governance, the *International Sanitary* Conference of 1851 (Fidler, 2001). A century later the International Sanitary Regulations were adopted by the fourth World Health Assembly in 1951 (WHO, 1956). In 1969 the ISR were amended and renamed the IHR (WHO, 1983) and remained more or less unchanged until the major revisions agreed in 2005. The negotiations which ultimately led to that revision stretched out over more than a decade. In 1995 the World Health Assembly passed Resolution WHA48.7 calling on the Director-General to begin preparing a revised version of the regulations. A lengthy consultation ensued (e.g. WHO, 1996; WHO, 1998). The process was given a new impetus following the SARS outbreak of 2003 which underlined the deficiencies of the existing system and the need to introduce a more robust set of regulations..

Even in this important area of international public health, where the goals and benefits of cooperation and regulation would appear to be compelling, GHG continues by characterised by divisions, faultlines and competing interests. The whole process of

negotiating the new IHRs can be understood in terms of the various discourses of GHG. Ostensibly a set of rules put in place to protect public health by limiting the threat of disease through biomedical/public health interventions, employing measures such as monitoring and surveillance, epidemiology and quarantine, the regulations themselves embody a range of elements drawn from the discourses identified above. Not only that, but the argumentation process during the drafting of the new regulations brought into the open the fundamentally different approaches and understandings of a variety of global health actors. In addition to biomedicine, of particular importance, we argue, were security, human rights, and economistic discourses. Furthermore, certain elements of a civilisation approach persist.

At the most fundamental level, the shape of the regulations is informed by the neoliberal agenda, and at the heart of the IHRs there is a fundamental tension between global health, free trade and global markets. This tension is encapsulated in Article 2 which sets out the overall aims of the IHR regime (but also its inherent limitations as a public health measure). It states that the IHR's purpose is "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which *avoid unnecessary interference with international traffic and trade*." (WHO, 2008, p.10, emphasis added). In practice this meant concerted efforts from an early stage in the revision of the IHR to ensure the consistency of the new regulations and the WTO Agreement on the Application of Sanitary and Phytosanitary Measures (SPS),[3] and to minimise the potential for conflicts between the two. Perhaps inevitably, the IHR and the relevant WTO regulations approach the problem of infectious disease from opposite directions. The WTO's primary mission is the negotiation of trade liberalization agreements. International disease outbreaks have historically interrupted the flow of free trade and thus fall within its remit. The key issue for the WTO – and central to the SPS Agreement - is allowing states the right to put in place measures to protect health but at the same time preventing that from being used as a spurious basis for protectionist trade measures. The WHO, by contrast, is charged with promoting health, although in the IHR it recognizes that this

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[3] For a comparison of the provisions of the SPS and the IHR see: WHO, 1999.

should not be allowed to lead to overly restrictive travel and trade measures which have no scientific basis.

The end result of this attempt to reconcile the trade and infectious disease regimes, and the result of the overarching power of the neoliberal paradigm, is found in Article 57(1), which provides that "States Parties recognize that the IHR and other relevant international agreements should be interpreted so as to be compatible. The provisions of the IHR shall not affect the rights and obligations of any State Party deriving from other international agreements." On the face of it this would appear to provide a legal basis for the primacy of the WTO trade regime over the IHR in cases where the two come into conflict. In terms of structuring power of the neoliberal paradigm, it is notable that the creation of IHRs which failed to recognise the primacy of global travel and trade would have been inconceivable. Particularly given the fact that the WTO has a far more advanced dispute settlement system in place than the WHO, it seems highly likely that a member of the WTO which feels that unduly restrictive measures have been put in place in response to a 'public health emergency of international concern' occurring on its territory would take its case to the WTO. In the past in disputes where health and trade collide the WTO has tended to privilege trade law over biomedical and scientific evidence (Labonte, 2009).

Whilst this divide between neoliberal and public health concerns lies at the heart of the IHR, other areas of competition between discourses were readily apparent. The control of infectious disease has a clear security dimension, and also links here to elements of a civilisational programme. The regulations are part of a long tradition of attempts to protect populations of nation states from foreign disease threats. In contemporary discourse this has started to be expressed in terms of 'global health security', a term which has generated opposition from states and other actors (Aldis 2008) Where the security and civilizational logics come together is through their identification of potential threats posed by 'the other', and emphasis upon dealing with them before they become a common global problem. The civilisational discourse is also arguably apparent in the ways in which threats have to be identified and dealt with under the IHR (the domestic infrastructure requirements set out in Annex 1), and the way in which biomedical techniques are transposed via the WHO role in advising

countries on putting in place the necessary infrastructure to meet their obligation (Wilson et al 2008).

In reality states have a far wider range of foreign and security policy concerns than infectious disease, and at certain points these also intruded on the negotiation process. Perhaps predictably, the issue of Taiwan's inclusion in the revision process – and its status vis-à-vis the regulations themselves – was a major problem for China. This was particularly prominent at the time of the negotiations over the IHR as Taiwan had been one of the territories most severely affected by SARS. Despite this, Taiwan's request to participate in the November 2004 and February 2005 meetings of the IHR Intergovernmental Working Group were rejected due to the opposition of the PRC (Chen, 2004). Taiwan is not a signatory of the IHR, and the issue of whether or not the IHR apply to Taiwan is a complex one (although in practice it has pledged to abide by the regulations). The IHR rely on their universality in order to be effective. The obvious irony is that, as Taiwan's closest neighbour, and given the increasing flow of goods and people between the two territories, the PRC is perhaps most at risk from this hole in the global disease surveillance net (Hou, 2007). As such, this is a clear instance of the perceived foreign and security interests of one member state having a negative impact upon the development of effective GHG structures. Discourses of security in health clearly still capture strong elements of sovereignty and national interest, as much as they are driven by interstate conflicts and competing agendas. States have a range of different security interests in play at any one time. 'Health security' interests will not always predominate.

Perhaps less apparent than the security and trade dimensions of the IHR, economism as a discourse was one of the key motivations for the entire revision process. One of the major shortcomings of the previous regulations was that the balance of cost and benefit in terms of compliance was weighted towards non-compliance. Cash and Narasimhan (2000) examined two cases in which developing countries did report cases of the notifiable diseases to the WHO under the 1969 IHR: a 1994 outbreak of plague in Gujurat, India; and a cholera epidemic in Peru in 1991. In both cases the affected countries fulfilled their obligations under the IHR 1969. On both occasions, however, other states far exceeded the permissible responses, taking measures which included stopping food imports, cancelling flights and issuing travel advisories. Cash

& Narasimhan cite estimated economic losses at approximately US$2 billion in the Indian case and US$770 million in trade alone in the Peruvian case (2000, pp.1362-3). The economic disincentives for compliance were obvious. There was a concerted attempt in the revised IHR to give WHO new powers to circumvent this calculation: firstly allowing it to receive reports of outbreaks from non-governmental sources and secondly, in extremis, giving it the power to declare an outbreak a 'public health emergency of international concern'.

Many of the long-standing divisions within the human rights discourse are also laid bare in the IHR. There has traditionally been a tension between 'health at the border' and individual rights. Measures such as quarantine and the compulsory testing of asylum seekers for TB and HIV/AIDS involve a balance of rights between those of the individual and the rights of the wider community to health security. In the case of the IHR, it is made incumbent upon states to apply the regulations "with full respect for the dignity, human rights and fundamental freedoms of persons." (Article 3(1)). Thus, again, in this area there has been an attempt to reconcile health with states' wider normative and legal commitments to other governance structures and regimes.

In sum, this case study illustrates a number of features of discursive contestation. First, discourses not only conflict with each other and lead to tensions in GHG, but also combine (as with security and biomedicine) and inform health policy choices (as with the attempt to circumvent the cost/benefit analysis which previously undermined compliance). Whilst the principal agencies involved in the creation of the IHR were the WHO and its member states, it is clear they were not acting in a vacuum but had to take account of the wider interests of a range of actors. States were as much motivated by protecting free trade, one of the holy cows of economic globalization, as they were of protecting their own security interests. What this shows is that – in contrast with much of the existing GHG literature – treating GHG as a distinct sphere of activity leads us to miss the importance of a wider range of interests. Thus whilst it would be logical for all states to have an interest in securing themselves from external disease threats, they are in some circumstances prepared to trade these security concerns off against their other interests (for example in promoting economic globalization via free trade). What we can also see in this case are the ways in which particular global institutions champion certain discourses, as with the WTO and the

WHO. Even when the modalities of governance on the surface seem somehow separate, they are in fact connected.

Conclusion

Returning to our initial observations on the limitations of the existing GHG literature, we have tried to show here that GHG is a far broader and deeper 'system' of governance than a simply biomedical or public health canon writ large. It is clear that not only are there a wide range of actors present in contemporary health governance, but that they are motivated by – and are often champions of – a range of discourses. GHG is intrinsically linked to the wider landscape of global governance, not least in the manner in which the neoliberal template increasing colonises it over a range of issue areas and health policies. In this sense the WTO is not only a trade-related actor but systematically a health-related actor as well. So whilst there is clearly still utility in GHG as a field of study in of itself, it is an analytical construct, and the study of it can only be viable in the context of a recognition of the interlinkages and lines of force which impact upon it. Furthermore, by engaging in a *longue durée* historical account of key discourses in health and health governance, we understand that certain discourses dominate at particular junctures, and that discourses from other areas of social, economic and political life cross over into the domain of health. So whilst it currently overarches the full range of other discourses, there is nothing inevitable about neoliberalism's continuing hegemony.

We began this paper by noting the widespread perception of failure in GHG. We have argued here that the causes of that failure are more complex than is often recognised. In particular we would draw attention to three causes of governance failure. Firstly, it is clear that health is sometimes subordinated to other priorities and agendas. So what some might see as a 'failure' of GHG could in fact be seen by others as a 'success' in terms of other areas of governance (e.g. a success in global economic governance). Furthermore what constitutes successful GHG is itself contestable and normative. It is clear that agencies such as the World Bank do not believe that introducing economism and privatization policies into developing countries' NHSs are governance failures. The disjuncture between much of the academic GHG literature and the approaches of some of the most significant global health actors is the product of an implicit

normative understanding as to what constitutes 'good health governance', and to what GHG is and is not.

Second, and for this reason, sometimes the 'wrong' discourses win out. It has been shown above that economic and security discourses wield a particular power, for example. The pursuit of those logics may not always lead to the best results in terms of health outcomes. We have also introduced a more complex understanding of how power operates in GHG and the manner in which different agencies can coalesce or oppose each other by drawing on the discourses at hand. In the case of HIV/AIDS, sometimes politically polarised actors coalesce around a particular discourse or speech act, and it is clear, for example, that even actors who oppose the neoliberal project as it relates to health can nevertheless end up being co-opted by it.

Finally, sometimes the very process of contestation between discourses precipitates failure. The dispute between Indonesia and the WHO over the sharing of influenza virus samples showed how such conflicts have the potential to undermine global public health efforts in concrete ways (Fidler, 2008, Holbrooke and Garrett 2008)). In perhaps one of the most bizarre but revealing international disputes of recent years, Indonesia claimed sovereignty over 'its viruses' because it was resistant to the global inequality in 'who benefits' from vaccine development (in this case the US pharmaceutical industry). This brief example shows how the mix of often disparate and contesting discourses present in global health issues often lead to perverse health outcomes.

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