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Understanding change in global health policy: Ideas, discourse and networks

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How is radical change in global health policy possible? Material factors such as economics or human resources are important, but ideational factors such as ideas and discourse play an important role as well. In this paper, I apply a theoretical framework to show how discourse made it possible for public and private actors to fundamentally change their way of working together – to shift from international public and private interactions to global health partnerships (GHPs) – and in the process create a new institutional mechanism for governing global health. Drawing on insights from constructivist analysis, I demonstrate how discourse justified, legitimised, communicated and coordinated ideas about the practice of GHPs through a concentrated network of partnership pioneers. As attention from health policy analysts turns increasingly to ideational explanations for answers to global health problems, this paper contributes to the debate by showing how, precisely, discourse makes change possible.

Keywords: Constructivism; ideas; discourse; networks; change; partnerships

Introduction

In a 2009 speech, Director General of the World Health Organisation (WHO), Margaret Chan stated that to achieve ‘transformational change’ in Africa, ‘the policies must be right, and the money must be used effectively and efficiently’ (Chan 2009). If such radical transformation is possible, how is it possible? To answer this question requires a step beyond important, if superficial, statements about getting the policies right: it requires understanding the ideas and discourse, or ideational factors, which inform those policies, and the networks through which they travel. As a first step in the application of ideational factors to global public health, I demonstrate how a theoretical framework first developed in the political sciences might usefully be employed to shed light on one particular radical shift in policy – the shift from public and private interaction to public–private global health partnerships (GHPs).

The analysis of discourse that follows is informed by an ideas-based approach to society called Constructivism. Constructivism is beginning to attract interest from global health policy analysts, although it remains on the margins of the discipline (Kickbusch 2003, Harmer 2005, Shiffman 2009). It does, however, have a long pedigree in the political sciences (Adler 1997, Wendt 1999, Hay 2009). I distinguish...
ideas-based approaches to global health from power-based and interest-based approaches. Whilst the differences between these approaches are complex and nuanced, the most important distinction is that ideas-based approaches – as the name implies – attach much more significance to the role of ideas and discourse.\(^1\) Power-based analyses see ideas as nothing more than functions of power: put crudely, the ideas that shape global health are the ideas of the most powerful actors. Interest-based theories regard ideas as little more than useful tools for maximising self-interest, where ideas act like signalmen diverting a train from one track to another. Ideas-based approaches such as Constructivism argue that ideas rather than material forces structure our lives and construct our identities and interests (Wendt 1999, p. 1).

When GHPs first attracted the attention of researchers at the beginning of the twenty-first century, early criticism drew on power-based assumptions to highlight the disparity in power relations between public and private actors and the potential for the most powerful partners to further extend their influence over global health by manipulating the partnership process for their own gain (Karlinger and Bruno 2000, Utting 2000, Richter 2003, 2004). Since that early work, interest-based analyses have dominated the literature on partnerships. In these analyses, the emphasis has predominantly focused on identifying areas for reform (Buse and Walt 2000, Buse and Harmer 2007). There has been little attempt to apply ideas-based insights to analysis of GHPs despite their potential to illustrate how ideational factors construct global health policy, or how the identities and interests of public and private actors might be reconstructed through partnership (Buse and Harmer 2004). This paper seeks to fill that gap – using the phenomena of GHPs to show how ideational factors structure global health policy – whilst also flagging potential areas for future research.

Adopting an ideas-based approach to global health provides theoretical space for researchers to ask a different set of questions from either power-based or interest-based approaches. Numerous studies of GHPs ask why questions: why did the change from public and private to public–private global health interventions occur? Answers to that question cite changes in ideology, lost legitimacy in international institutions, the monopolistic position of transnational pharmaceutical industries, the growth of non-government organisations (NGO), new technologies, increased support from private foundations and globalisation as causes (Buse and Walt 2000, Reich 2002, Widdus and White 2004). Ideas-based analysis asks a different, how-possible, question: how was it possible for such a radical institutional innovation as GHP to be adopted and embraced by the international health community, overcoming entrenched interests, institutional obstacles and cultural barriers in the process? Doty (1993, p. 298) explains the difference between the two questions, thus:

> How meanings are produced and attached to various social subjects/objects, thus constituting particular interpretive dispositions that create certain possibilities and preclude others. What is explained is not why a particular outcome obtained, but rather how the subjects, objects, and interpretive dispositions were socially constructed such that certain practices were made possible.

In the following analysis of three GHPs – the Drugs for Neglected Diseases initiative (DNDi), Stop TB Partnership and the TB Alliance – I demonstrate how the practice
of GHP was made possible by the meanings produced and attached to a specific health problem. I argue that it was possible for these GHPs to emerge when they did because the ‘problem’ of tuberculosis and neglected diseases was constructed through the discourse of globalisation, global health governance and global public goods (GPGs). This ‘interpretive disposition’, to use Doty’s phrase, made possible the practice of GHPs.

Before proceeding, it is important to be clear what I am not arguing in this paper. I am not disputing the role of material power: clearly, rich foundations such as the Bill and Melinda Gates Foundation have bankrolled numerous GHPs. Neither am I disputing the existence of strategic self-interests that are no doubt employed by actors when they engage in partnership, though I would argue that partnerships have the potential to re-construct those self-interests. Finally, I do not claim that ideational factors are more important than either power or interests, although I would argue that understanding what ideas and discourse do should precipitate a reconceptualisation of both power and interests — which, sadly, is beyond the scope of this enquiry but warrants further exploration in a public health context.

More modestly, I argue that while power-based and interest-based approaches can, and are, enrolled to explain the historical origins of individual GHPs, only ideational factors provide a satisfactory account of how it was possible for this paradigm shift in public and private relations to take place. The ideas and discourse of GHPs were generated not by the most powerful actors, but by a close network of academics and public health entrepreneurs and advocates; and they had to overcome, not reinforce, institutional self-interest from both public and private spheres hostile to the idea of public–private partnership.

**Methods**

As noted above, the aim of this analysis is to demonstrate the utility of a theoretical framework, first developed in the political sciences, for understanding the role of discourse in global health policy. In her analysis of European capitalism, Schmidt (2002) presented a set of indicators that demonstrated discourse ‘at work’ (Table 1). I conducted a comprehensive review of policy documents, transcripts of speeches and minutes of meetings documented on each of the three GHP’s websites. The objective of the review was to identify and extract from the documents any instance of each of Schmidt’s indicators: technical and scientific arguments, paradigms and frames of reference that defined ‘reality’, appeals to a deeper core of organising principles and norms, clear associations between the practice of GHP and long-established values, a common language and vision of the practice of GHP, and evidence of the practice of GHP translated into accessible language for public consumption. Once extracted, the instances were collated and common features were identified both within and across GHPs.

In an effort to triangulate findings from the literature review, semi-structured interviews were also conducted with 14 respondents using a pre-designed question guide. The respondents were identified using purposive sampling and ‘snowballing’ techniques, and were broadly representative of international health organisations, NGO and the pharmaceutical industry. My interviews were conducted either face-to-face or by telephone; each interview was recorded and transcribed and a
copy of the transcription sent to each respondent. The interviews lasted from 30 minutes to 2 hours. Close reading of each transcript was conducted with the same objective as the literature review: to identify instances of Schmidt’s six indicators of discourse.

The choice of GHPs was determined not only by their shared interest in neglected diseases, but also their distinct institutional characteristics: Stop TB was hosted by a multilateral organisation; DNDi was managed, initially, by the NGO Médecins sans Frontières (MSF); and the TB Alliance was a legal independent partnership. Given these institutional differences, I hypothesised that different discourses would develop through these partnerships. If a similar discourse was evident, then the challenge would be to provide an explanation that went beyond reference to the institutional setting of the partnership.

The discursive construction of global health partnerships: a review of the literature

**Discourse introduced new technical and scientific arguments**

All three of the sample GHPs emerged from, and were justified by, scientific and technical arguments developed by working groups comprised of health practitioners, academics and representatives from key international and transnational institutions and organisations. DNDi produced a series of technical papers illustrating the lack of research and development for neglected diseases (MSF 2001, Trouiller et al. 2001, 2002), the principal thrust of their argument being that both public and private sectors had failed to respond to the problem of neglected diseases, and that a unique public model of partnership was necessary. Both the TB Alliance and Stop TB produced influential reports that presented scientific and technical arguments and data to justify their targets (TB Alliance 2001a, 2001b, WHO 2002). In each example, justification for the move to partnership was grounded in technological and scientific imperatives.
Discourse depicted paradigms and frames of reference that defined reality to justify the idea of global health partnership

It is clear that a policy paradigm for GHP emerged during the late 1990s and early in the twenty-first century in reaction to the neo-liberal, market-oriented economic paradigm of the 1980s (Buse and Walt 2000). The call for a new paradigm echoed through the discourse of GHP during this period, although there were differences of opinion as to the precise character of this paradigm. MSF, for example, had long-argued for a ‘paradigm shift’ in the response to neglected diseases. In 2003, at an international conference organised to consider a global framework for supporting health research and development (R&D) in areas of market and public policy failure, Pecoul (2003) of MSF argued that ‘a paradigm shift is needed: changing global rules to prioritise people’s health needs over profit’. Pecoul (2003) also identified the principal shift necessary to ensure access to essential medicines: ‘withdraw essential drug development from the market logic and build public responsibility to do so’. The DNDi, argued Pecoul, represented a shift away from the market-based development paradigm most strongly associated with neo-liberal economics (Peck and Tickell 2002).

In contrast to DNDi, the TB Alliance and Stop TB did not eschew the market, although they recognised that reliance on the market alone would not achieve their goals. The Alliance provided a cost analysis of the anti-TB drug market in an effort to demonstrate the potential of the market to encourage anti-TB drug R&D and also encouraged the industry to invest in that market through various push and pull strategies. The Stop TB Partnership worked closely with one of the chief institutional architects of neo-liberal economic policy – the World Bank – endorsing a key Bank strategy for addressing global poverty – Poverty Reduction Strategy Papers (PRSPs) (Espinal 2004).

Discourse appealed to a deeper core of organising principles and norms to justify the idea of global health partnership

Discourse justified the practice of GHPs first by situating neglected disease in the context of globalisation, which it presented as a ‘reality’, and second by appealing to a conception of governance (rather than government) as an appropriate organising principle for responding to the crisis in neglected disease. Underpinning the discourse of GHP was also an appeal to an emerging norm that treated neglected disease as a GPG (Table 2).

Globalisation was, and remains, an essentially contested concept (Hirst and Thompson 1999, Lee 2003, Held and McGrew 2008). However, the complexities of the debate were not reflected in speeches communicating the idea of GHP to the global public. Consider, for example, the then Director General of the WHO, G.H. Brundtland’s description of the ‘global health threat’ facing us all: ‘In the modern world, bacteria and viruses travel almost as fast as money...With globalisation, a single microbial sea washes all of humankind. There are no health sanctuaries’ (Brundtland 2001a); or Nils Daulaire’s assertion: ‘I see globalisation as a morally neutral but nonetheless inevitable force that poses both opportunities and threats’
Table 2. How discourse appealed to the ‘reality’ of globalisation, the organising principle of governance and an emerging norm of health as a global public good.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>The ‘reality’ of globalisation</th>
<th>Organising principle: global governance</th>
<th>Emerging norm: health as a global public good</th>
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</thead>
<tbody>
<tr>
<td>Stop TB</td>
<td>‘In the days of globalisation, mass migration and cheap air travel, MDR-TB is just a plane ride away’. (Lee 2002)</td>
<td>‘The development of the global economy has not been matched by a development of the global structures of representative governance’. (Kumaresan et al. 2004)</td>
<td>‘The evidence is clear. A world free of TB is a global public good’. (Kochi 2000)</td>
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<td>‘In the face of rapid globalization, TB, too, is crossing continents’. (Kochi 2000)</td>
<td>‘As it becomes more commonplace to consider health as one of the prerequisites for development and economic growth, along with such basics as…good governance,…I expect we will see a wide variety of new interventions and collaborations’. (Brundtland 2001b)</td>
<td>‘I am proud to be a sponsor and catalyst of the Global Plan to Stop TB. By supporting the development of this model plan, the Open Society Institute advances its vision of promoting equity and global public good’. (Soros 2002)</td>
</tr>
<tr>
<td>TB Alliance</td>
<td>‘Because TB anywhere is TB everywhere, we must do better and invest smarter to stop this comeback disease’. (Freire and Dauliere 2002)</td>
<td>‘There is also an explosion in intellectual thinking on governance. We should be evolving governments. The markets have evolved much quicker – a lot more, a lot faster. And we should take note of that. So that is the big framework, I think’. (Interview with author, 2nd October 2003)</td>
<td>‘The Global Alliance will have an unwavering commitment to global public goods’. (Cape Town Declaration 2000)</td>
</tr>
<tr>
<td></td>
<td>‘Tuberculosis is Ebola with wings… and therefore carries a much broader, global threat’. (Raviglione 2001)</td>
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<tr>
<td>DNDi</td>
<td>‘The past 30 years have witnessed unprecedented transformations in global health…however, the benefits of the “global health revolution” have not been distributed evenly’. (MSF 2001)</td>
<td>‘In the ongoing process of creating a new world order, the global economy must be structured to address the true needs of society’. (Trouiller et al. 2001)</td>
<td>‘Ensuring access to new tubercular drugs means that lifesaving essential medicines cannot be treated like any other commodity, like CDs or cars; they are a global public good’. (Orbinski 2001)</td>
</tr>
</tbody>
</table>
(Hagmann 2001). In these two examples, the discourse presented globalisation as a reality; and thus, a global response – a GHP – was justified.

The practice of neglected disease GHPs was also possible, however, because discourse justified partnership in terms of a global organising principle: global governance. As with globalisation, global governance also remains a contested concept, but by the mid-1990s all of the key international health organisations were talking in global governance terms (World Bank 1994, WHO 1998, United Nations Development Programme [UNDP] 1999). In particular, the search was on for new mechanisms of cooperation that could respond to the challenge of governing globalisation. The discourse of GHPs appealed to international enthusiasm for global governance and was thus accepted more uncritically than it might have been 10 years earlier.

Finally, discourse justified the practice of GHP by appealing to an emerging norm of health as a GPG. The discourse surrounding all three of the sample GHPs makes repeated reference to this global norm. There is a comprehensive academic literature supporting the argument that health is a GPG (Chen et al. 1999, Zacher 1999, Kaul and Faust 2001) and that GHPs provided a governance structure for the provision of health as a GPG (Kaul and Ryu 2001, United Nations Education, Scientific and and Cultural Organisation [UNESCO] 2002).

Discourse associated the practice of global health partnership with long-established values to legitimise that practice

Discourse legitimised the practice of GHP primarily through an appeal to equity. DNDi, for example, described itself as an equitable model of drug development for neglected diseases. Bernard Pecoul, Director of the DNDi, described the Initiative’s ‘vision’ in the following terms: ‘To improve the quality of life and the health of people suffering from neglected diseases by using an alternative model to develop drugs for these diseases and ensuring equitable access to new and field relevant health tools’ (Pecoul 2003). The Initiative argued that lack of access to drugs for neglected diseases was inequitable because of market failure, and it laid responsibility for the crisis at the feet of both the public and private sectors. Thus not only it became necessary to take R&D for neglected diseases away from the market, but also an appropriate response for a needs-based initiative where ‘monetary gain is inconsequential compared to the cost of human lives’ (MSF 2003).

The TB Alliance also presented itself as an equitable response to the crisis in R&D for neglected diseases. A representative from TB Alliance, for example, explained how they first saw the lack of R&D in TB as:

A health equity outrage that somehow we were accepting that in developing countries we could have second-class citizens with second hand drugs that are 50 years old because the disease was not endemic in America or Europe...[the Alliance] came from this field where the patients were not being served, and we actually pointed the finger to the complete health equity gap in what is called R&D. (Interview with author)
The TB Alliance discourse skilfully juxtaposed logics of necessity with logics of appropriateness. This was essential because of the innovative nature of the ‘partnership’ model (Box 1).

Box 1. Examples of discourse juxtaposing logics of necessity with logics of appropriateness.

‘This partnership demonstrates how it is really possible to combine the fruits of aggressive biotech strategy with a social mission’, Maria Freire (TB Alliance 2002).

The Economics of TB Drug Development report ‘shows that it not only makes economic sense, but with substantial social returns there is a “moral imperative” to invest in this long neglected area of research’, Jacob Kumaresan (TB Alliance 2001c).

‘The Alliance is a shining example of public and private sector partnerships to bridge the gap between market opportunities and people’s needs…’ (Brundtland 2001c).

Box 1. Examples of discourse juxtaposing logics of necessity with logics of appropriateness.

Stop TB (2010) explicitly recognised that ‘shared values facilitate achievement of our shared goal’. These values included: urgency, equity, shared responsibility, inclusiveness, consensus, sustainability, and dynamism. They were expressed through the Partnership’s commitment ‘to act now – for all, through collective action – and into the future’ (Stop TB 2010). Partnership provided the most appropriate governance mechanism for realising that commitment. Through membership of the Partnership, members were encouraged to make ‘efficient, effective, and equitable use of the resources available to them’ (Stop TB 2010).

**Discourse coordinated the practice of global health partnership by providing a common language and vision**

There is evidence across each of the sample GHPs of a common language and vision. I noted above the shared reference to the ‘reality’ of globalisation, governance as an organising principle and an emerging norm of GPGs. In addition, however, in each of the GHPs there were references to action that was ‘needs-driven’ and produced ‘win–win’ outcomes. ‘Consensus’ was required on technical priorities such as DOTS. Each of the GHPs emphasised the right to healthcare, equity of access, inclusion of developing countries, market failure, drug-based and biomedical responses to neglected disease, generic drug production, TRIPS-compliant safeguards and support for IP rights. Finally, there was an implicit acknowledgement by each of the GHPs that developing countries had the capacity to help themselves and that they should support ‘capacity-building’ activities; that it was in the interests of both poor and rich to resolve the crisis in R&D; and a shared optimism that the pharmaceutical industry was changing the way it saw its opportunity-cost structure.

That common ideas are shared amongst the GHPs should not be surprising because, as illustrated below in the discussion of the neglected disease GHP network, there were strong links between various key actors involved in all three of the GHPs. The point to make is simply that given the similar work experiences and environments...
of many of the key people responsible for establishing these partnerships, it should not be surprising to find that shared ideas first informed and then evolved the practice of GHP. But it should also be noted that key actors involved in the sample GHPs did not always share precisely the same ideas and beliefs – most notably, there were differences in opinion about the most appropriate model of partnership.

Discourse communicated the practice of global health partnership by translating it into accessible language for public consumption

In her work on discourse, Schmidt argued that ‘the overall outlines of a policy programme are given expression in a “master” discourse by a “master” politician’, and that the overall outlines of the policy programme are most clearly articulated through public communication (Schmidt 2002, p. 235).

As early as 1996, at the Habitat II Conference on Human Settlements, the UN made it clear that GHP was a necessary guiding principle of its future global governance role, as Noel Brown, former Director of the United Nations Environment Programme, made clear: ‘I believe that the future of the United Nations will rest on effective partnering with the private sector – with business and industry’ (Veon 1998).

The ‘necessity’ argument quickly developed into a ‘there-is-no-alternative’ (TINA) mantra (Box 2). GHPs were presented as ‘the only possible’ or ‘only viable means’ of ensuring ‘peace and harmony’. The simple but powerful message was that we are ‘dependent’ on GHPs ‘whether we like it or not’; and as noted above, the TINA argument was supported by explicit assumptions about the ‘global’ character of neglected diseases, the importance of global governance as a coordinating principle and the undisputed value of GPGs. Whilst each of these concepts is contested, the complexities of the debate were never reflected in speeches communicating the idea of GHP to the global public.

Box 2. The TINA mantra of GHPs.
Interviewing the partners: a review of findings

As noted in section ‘Methods’, interviews with individuals working with DNDi, the TB Alliance or Stop TB were conducted to triangulate findings from the literature review. A close reading of the interview transcripts confirmed many of the findings described above as well as providing important insight into the existence of a network of ‘partnership pioneers’ through which the discourse of GHP travelled.

Only two respondents made explicit and unsolicited reference to either ideas or discourse during the interview, and just one provided a sophisticated analysis of the role that ideas played in defining the operational parameters of partnership, noting: ‘the partnership…has to be defined, in very clear operational terms to ensure that the ends that that partner or parent partner seeks can be met’. For this respondent, the utility of ideational factors was in their ability to convey information that would ensure that the partnership achieved its agreed purpose. No other respondents provided unsolicited comment on the role of ideational factors and expressed puzzlement when pressed. To the question ‘Do you think ideas were important during the early days of the GHP’, eight respondents agreed but did not discuss why and four respondents offered cursory answers (‘of course’, ‘ideas are always important’) and moved the discussion to another topic.

Common across each of the interviews was repeated reference to other actors’ competing interests. The WHO was mentioned by 8 of the 14 interviewees, of which two were complimentary about the role it played and six were critical of the organisation, using terms such as ‘inflammatory’ or as suffering from a ‘dichotomy of thinking’ and ‘resistant to change’. There were few references to either the private sector or NGO except from interviewees who were representatives of these sectors.

When asked about the context in which GHPs emerged, 11 interviewees made reference to ‘globalisation’, six to ‘governance’ and four to ‘global governance’. Most made reference to globalisation during their initial description of the development of their respective partnerships. Interestingly, two interviewees working for the WHO, and one independent adviser, argued against the existence of global governance, preferring instead to use the term ‘international’ to describe relations between actors within the GHP.

As noted in Section ‘Introduction’, constructivists recognise that ideational factors are more than tools used to maximise self-interest and more than simply an expression of material power: ideas and discourse have the potential to reconstruct actors’ identities (Wendt 1999). The literature on GHPs is silent on this potential and barely touches on the possibility that it could be mechanisms within which ideas and discourse reconstruct partners’ perceptions of their self-interest (Buse and Harmer 2009). Rather than see GHPs as sites in which social learning can take place, and in which actors’ interests are reconstructed through exposure to new ideas and norms, the dominant argument is that actors enter GHPs with predetermined interests, and that these interests do not change. There was no indication from any of the interviewees that they believed that actors’ perceptions of their self-interest were, or could be, reconstructed through exposure to partnerships. No work to date in the field of public health has been done to determine whether such a belief is justified.

Common to all interviewees was an uncritical acceptance of GHPs as a necessary and appropriate response to resolving the problem of neglected diseases. With the exception of two interviewees, who were associated with DNDi, there was no critical
commentary about GHPs. Problems associated with GHPs were restricted without exception to problems of effectiveness, cooperation and incentives – in other words, practical problems that could be resolved through reform. This lends weight to the finding noted above that a dominant discourse presented GHPs as a necessary and inevitable development – that there was no alternative.

An unexpected but strong theme that emerged from the interviews was the importance of networks. Although no interviewee made explicit reference to the term ‘network’, it was evident that the same individuals were cited and referenced by all of the interviewees. This observation prompted a return to the literature and a search for individuals who were linked to each of the three GHPs.

The neglected disease global health partnership network

How ideas are shared is of particular interest to constructivists. Adler (1997, p. 339), for example, argues: ‘an evolutionary approach requires that new or changed ideas be communicated and diffused’. Networks are one way in which ideas about partnership could have been diffused. Through interviews with key players involved in my sample GHPs, and a review of key policy documents and grey literature, it quickly became apparent that a small network of actors was instrumental in establishing and maintaining a shared understanding of partnerships for neglected diseases (Figure 1).

Network analysis has been usefully applied to global health issues such as health care financing reform (Lee and Goodman 2002). In Lee and Goodman’s (2002, p. 116) analysis, the argument focused on demonstrating that reform had been ‘fostered by the emergence of a policy elite rather than a rational convergence of health needs and solutions’. In the case of neglected disease partnerships, however, that argument is less easy to sustain. The idea of partnership was justified in part precisely because it was presented as a rational solution to a pressing health need.

What is also striking about the network is the degree of crossover that key players had between public and private sectors. For example, Yves Champey, ex-Director of DNDi, was a former Vice-President of French drug firm Rhone-Poulenc Rorer; Giorgio Roscigno, a key architect of DNDi, the TB Alliance and the Stop TB partnership, originally worked in the pharmaceutical industry, whilst Joelle Tanguy originally worked with MSF, then moved to the TB Alliance as Director of Advocacy and Public Affairs, before moving to the Global Business Coalition on HIV/AIDS.

Given such a highly interconnected network, one should not be surprised to find that a dominant discourse at once informed the development of each of the partnerships and was sustained by the reproduction of the practice of partnership. Constructivists describe this process more formally as having a structurationist character (Adler 2005). Thus, collective or intersubjective understandings emerged about particular social facts – in this case, GHPs. Crucially, actors engaged in discursive interaction and in so doing generated a structure of ideas about GHP, which in turn influenced the behaviour of agents. Again:

A cognitive evolutionary theory is structurationist to the extent that individual and social actors successfully introduce innovations that help transform or even constitute new collective understandings, which in turn shape the identities and interests, and consequently the expectations of social actors. (Adler 1997, p. 339)
From a constructivist perspective, therefore, networks are more than simply an opportunity for the most powerful economic actors to satisfy their interests and more than simply a rational response to ensure more legitimate and effective global health governance.

Conclusion
This paper has argued that ideational factors are important because they help explain how radical shifts in global health policy are possible. As new forms of GHP begin to emerge, understanding how it was possible for them develop, whose ideas informed their development and what discourse predominates is an essential first step in ensuring that these new additions to global health policy-making accord with recognised principles of good governance.

What is most exciting about Constructivism, and where future research would be most productive, is to explore the extent to which new forms of governance such as
GHPs do shape the behaviour of actors. Initial findings presented in this paper suggest that behaviour change did not occur, but a more extensive exploration of norm dynamics and logics of appropriateness could yield dividends in understanding how actors behave in partnerships.

For constructivists, how actors behave is inextricably linked to perceptions about who and what they are. It is important to remember that public–private partnerships are one model of partnership and alternative models are possible. DNDi, in particular, championed a public partnership model quite different from the public–private partnership model adopted by the TB Alliance and Stop TB. Although the argument that shared ideas have constructed the ‘identity’ of GHPs has not been explored in this paper, it is likely to find greater purchase in future research as efforts by the international community to develop principles of best practice inevitably strengthen intersubjective understandings of what global health partnership means to potential new partners.

The role of ideational factors such as discourse and ideas in global health policy, and the application of constructivist insights to help understand that role, is still largely underdeveloped in the literature. The theoretical framework presented in this paper provides the first step in developing a constructivist agenda for global health that starts with the hypothesis that ideas and discourse are about more than self-interest and material power. It is a liberating argument because it cuts through the pessimistic and dispiriting assumption implicit in many public health debates that the strongest states (e.g., the USA) or the richest actors (e.g., the Bill and Melinda Gates Foundation) ultimately shape global health. If it is true, and ideas are no more than tools wielded by the strong to defeat the weak, or do little more than reinforce predetermined self-interests, then it is doubtful whether the radical changes required for global health governance to respond adequately to the ‘grand challenges’ of global public health (Gostin and Mok 2009) will be achieved.

This paper has only skimmed the surface of the potential of Constructivism to better inform our understanding of ideational factors and their importance for global health. Constructivism provides an optimistic account of the prospects for change in global health: it therefore warrants further exploration.

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Note
1. Neither space nor probable audience render appropriate an extensive discussion of the differences between ideas, power and interest-based approaches within IR (but see Hasenclever et al. 1997). I acknowledge that there are different sub-types of Constructivism, ranging from rationalist to reflectivist variants (Wendt 2000, Christiansen et al. 2001), which are often described as ‘thin’ or ‘thick’ variants in the literature – where thin constructivists give material forces more of a say in explaining the world than thick constructivists, for whom it is ‘ideas all the way down’. This paper falls within the ‘thin’ constructivist camp, and the empirical analysis and interpretive methodology reflect that bias. Constructivist analysis does not compete with Neo-Realist, Neo-Marxist or Liberal-
institutionalist theory; indeed, as constructivists are at pains to point out, Constructivism is not a theory but more accurately described as an ‘approach’.

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