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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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POLITICAL SCIENCE IN GLOBAL HEALTH

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Introduction:
The State of Political Science Research in Global Health Politics and Policy

Eduardo J. Gómez

Over the past two decades, the study of the politics of global health has become an increasingly popular and important scholarly topic. A host of social scientists, public health researchers, medical scientists and historians have taken an interest in exploring the international and domestic political aspects of healthcare reform, ranging from government and civil societal responses to disease, to issues of health insurance coverage, health systems strengthening, and inequality in social services provision. There has also been a shift from a focus on healthcare issues in the advanced industrialized nations, such as the United States and Western Europe,[1] to the developing world[2] and more recently, select emerging economies, such as the BRICS (Brazil, Russia, India, China and South Africa).[3]

A less well known - though increasingly important - area of scholarly research examines the role that the academic discipline of political science has played in the study of global health politics and policy. In recent years only a select handful of leading political scientists in the field have tackled global health politics and policy issues, focusing on how political science theory and methods advances our understanding of these issues. Moreover, the discipline's attention to global health has gradually evolved over the years, with an initial interest spurred by the arrival of the HIV/AIDS epidemic in Africa; [4] [5] the international community's response to the epidemic;[6] [7] AIDS' effects on state capacity; the importance of regime type and ethnic conflict in policy responses;[8] [9] [10] [11] [12] the importance of federalism and decentralization[13] and human rights in access to medicine.[14] [15] Recent studies have also revisited the field of political science's contribution to the study of AIDS, highlighting the need for further research.[16]

By the late-1990s up through the mid-2000s, the ongoing rise of global health norms in universal access to medicine and treatment for disease instigated yet another wave of attention in the field of political science, with a focus on issues of international security, global health governance, and international health diplomacy, access to resources, and soft power.[17] [18] [19] Political scientists also began to pay close attention to the various factors contributing to agenda-setting processes in global health, highlighting the disconnect between international funding and priority healthcare needs.[20] More recently, there has been a growing interest in unraveling the international and domestic politics of public health challenges, such as infant mortality,[21] non-communicable disease, such as obesity, diabetes, hypertension, heart disease, and cancer.[22,23,24] Others have looked at the equitable and effective introduction of universal health insurance programs, access to care, [25] [26] and the political and social coalitions shaping international patents and access to medicines.[27]

To date, however, no effort has been made to better understand precisely how the political science community has advanced our understanding of the politics of global health. And to what extent studies in global health policy contribute to this academic discipline. More specifically, how have various theoretical schools of thought in political science, such as international relations and comparative politics theory, contributed to

our understanding of the aforementioned global health issues? Which issues have the field overlooked and what kind of research needs to be done? On the other hand, how has the study of global health policy contributed to debates in these theoretical schools of thought?

This special series of the journal *Global Health Governance* strives to address these questions. In this collection of essays, we bring together scholars focusing on various aspects of international and domestic healthcare politics and policy. The contributions range from political scientists discussing the utility of international relations (IR) theory in understanding responses to disease outbreak, research on the intersection of IR and global health, to international and domestic government linkages in policy reform, as well as the politics of policy implementation.

Findings from these essays suggest that while political science has helped to address key theoretical and empirical issues in global health, global health studies have not adequately contributed to the major theoretical debates in political science. Both political scientists and global health scholars still have a long way to go to ensure that their theoretical and empirical approaches complement and build off of each other. Several articles in this series highlight the potential areas in which these complementarities exist and the kind of research needed to achieve this. We find that while growing, the political science community needs to take global health policy issues more seriously, while the global public health community needs to do the same for political science, specifically on issues of institutional design and governance.

The first two articles in this series discus the role of IR theory, highlighting the advantages and disadvantages of this field of study in understanding and explaining global health politics and policy. First, Simukai Chigudu of Oxford University in his article titled "Health Security and the International Politics of Zimbabwe's Cholera Outbreak, 2008-2009," explains how IR constructivist theories focused on the discursive frames of "national security" and "human rights" hampers international and domestic policy responses to epidemics. Chigudu looks specifically at the case of the cholera outbreak in Zimbabwe in 2008. He claims that the usage of these discursive frameworks by western research institutions and organizations instigated tensions and distrust between these institutions and the Zimbabwean government, with the latter ultimately shifting the blame of this disease's emergence on the west. While constructivist theories in IR have helped us to better understand the lack of international and domestic cooperation in response to cholera and other diseases, Chigudu concludes by suggesting that future researchers and governments should enlist a different type of constructivist discourse when explaining the emergence of disease outbreaks in developing nations.

Next, Presalava Stoeva of the London School of Hygiene & Tropic Medicine in her article titled "International Relations and the Global Politics of Health: A State of the Art," addresses the relationship between IR theory and studies in global health politics. She maintains that there continues to be a large divide between this field of political science and global health. On one hand, IR theorists in political science have viewed global health as too policy oriented, failing to critically engage the traditional IR literature, while, on the other hand, global health scholars find the study of international politics and governance to be too subjective and unscientific. Nevertheless, she claims that there are ample opportunities for a merger between global health policy and IR theory, especially with respect to issues such as the role of the private sector and the

importance of "power" in institutions. She cautions, however, that achieving this will be a difficult task and that more scholars need to be committed to addressing this rift in the literature.

Next, Duff Gillespie, Michelle Hawkes Cuellar, Sarah Whitemarsh, Alison Bodenheimer and Sabrina Karkling of Johns Hopkins University in their article titled "Connecting Global Goals to Local Priorities," addresses the ongoing disconnect between the establishment of international policy goals and decentralization processes. Looking at the FP2020 goals to improve family planning strategies established in London in 2012, Gillespie and his collaborators claim that while donors and several political leaders from developing nations where quick to adopt these policy goals, they failed to consider the healthcare decentralization process and in particular local politicians' interest and capacity to improve family planning funding and programs. They argue that in this context, international NGOs, such as the Hopkins-based Advanced Family Planning (AFP) organization can play an important role in helping local government's prioritize family planning and achieve international goals. They conclude by emphasizing the importance of international donors and governments to include local governments into policy discussions, as well as the need to consider healthcare decentralization processes.

The next series of essays turn to the domestic politics of government response to healthcare, with a priority focus on policy implementation and social movements. In their article titled "Ideas and Policy Implementation: Understanding the Resistance Against Free Health Care in Africa," Valéry Ridde and Daniel Béland assert that an insufficient amount of scholarly research in political science and health policy has gone into understanding the intersection of policy ideas and implementation. Discussing the issue of health insurance user fees in several Sub-Saharan African nations, they show the large disconnect between national politicians' and bureaucrats' ideas in increasing the poor's access to health insurance and access through the elimination of user fees and local bureaucrats conflicting ideas and interests, leading to the latter's resistance based on disbelief in the financial viability of these programs and excessive work loads. This essay does an excellent job of illustrating the utility of political science theories focused on the role of policy ideas and their interaction with institutions, as well as the importance of this literature for understanding health policy implementation in Africa.

Next, Eduardo J. Gómez of King's College London provides an article titled "Constitutions, Civil Society, and the Politics of Pro-Poor Health Insurance Programs in the Emerging Economies." This essay discusses how the design of constitutions and electoral systems, as well as civil societal pressures, create incentives for national governments to ensure that health insurance programs targeting the poor work effectively. Looking at the cases of India, China, Russia, and Indonesia, Gómez claims that with the exception of Indonesia, the excessive powers constitutions and electoral systems provide to political leaders, the absence of health policy accountability, an over-reliance on decentralization, and the absence of effective social health movements pressuring for improved policy performance provided few political incentives to ensure that recently implemented health insurance programs in India, China, and Russia achieved their policy goals. The converse situation held in Indonesia, leading to greater coordination between national and local health officials over the regulation of hospitals and reimbursement procedures. This article concludes by illustrating the potential

advantages of applying institutional theories in political science and how they can assist in our understanding of the shortcomings of health insurance programs.

Finally, Joshua Busby and Ethan Kapstein of the University of Texas at Austin and Arizona State University, respectively, in their article titled "Framing Global Health and Human Rights: Learning from the Case of HIV/AIDS," address the importance of constructivist theory in accounting for social health movements in response to access to medication for HIV/AIDS. Through survey work conducted in the United States and India, they show that constructivist frameworks focused on the issue of "human rights" and "morality" had no meaningful impact on the scope and depth of civic mobilization; both discourses were important. Their research therefore suggests that other factors encourage and facilitate civic mobilization, while emphasizing the need to conduct further survey work on the importance of rights- and morality-based discourse among AIDS activists.

When taken together, several key lessons emerged from the essays in this special series of *Global Health Governance*. First, there needs to be a stronger connection between global health studies and the political science literature. Global health studies focused on the international community's response to diseases and their work with domestic governments have not done an adequate job of integrating and critiquing major theoretical schools of thought in political science, such as, for example, various aspects of constructivist theory in international relations – e.g., gender and Marxism, as well as comparative political theories focused on constitutional design, presidential powers, federalism and inter-governmental relations. While a myriad of global health studies exist discussing the importance of politics and governance, they are often not analytically rigorous in their critique and analysis of relevant fields in political science. On the other hand, political scientists also need to do a better job of engaging and building on the global health policy literature, especially with respect to addressing epidemiological studies, health systems research, and the evolution of international health governance regimes, norms, and institutions. While global health studies are becoming increasing popular among political scientists, more work could be done by the discipline to encourage and highlight this field as an important aspect of international relations, comparative politics, and political theory.

Second, with respect to empirical issues, the essays in this special series underscore the need for political scientists to place more attention on policy implementation processes. In the area of global health, political scientists have placed too much of an emphasis on the issue of international and domestic agenda-setting processes. More work is needed to address why national government ideas and interests at times conflict with local bureaucrats' ideas, interests, and aspirations. How do governments reconcile for these conflicting local interests and how can political scientists better address them? Furthermore, we need to better understand how formal constitutional and electoral rules shape political elite ideas and interests at the national and sub-national level. Applying political science theories focused on these domestic institutional design issues can provide additional insight into why several developing nations are still struggling to effectively implement public health and health insurance policies. Alternatively, applying theories focused on domestic institutions to the logic of institutional change at the international level, specifically among donor agencies, can provide new insight into why some agencies are more adaptable and effective than others – e.g., UNAIDS versus the WHO (Gómez, 2015).

Third, international organizations and donors need to better understand and address decentralization processes. While several political scientists have addressed the reasons for healthcare decentralization,[28] [29] [30] less attention has been given to the coordination of policy goals and implementation processes between international organizations, national and local governments. Here, political scientists working on decentralization processes could work more closely with donors to address this issue, both with respect to the design of policy as well as how to coordinate with local politicians and motivate them to adhere to international and national policy goals.

To conclude, it is important to note that political science theory does not provide the answer to all of our challenges in understanding global health politics and policy. Our message in this special series is that, as an academic discipline, political science is a useful tool that can supplement and deepen our understanding of these issues. Political scientists certainly do not have all of the answers to our theoretical and empirical questions in global health politics and policy; some of these questions require in-depth historical, sociological, anthropological, or, on the other end of the methodological spectrum, advanced econometric regression analysis.

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Ideas and Policy Implementation: Understanding the Resistance against Free Health Care in Africa

Daniel Béland and Valéry Ridde

Contributing to this special issue of Global Health Governance on "Political Science in Global Health," this exploratory article draws attention to the potential role of ideas in policy implementation, a topic that has been relatively neglected in the contemporary political science literature on ideas and public policy. First, the article presents a review of this literature, which stresses the limited attention to implementation among students of policy ideas. Next, the article illustrates its main claims about the role of ideas in policy implementation through a discussion of the resistance of policy implementers against the removal of health-care user fees currently taking place in sub-Saharan Africa. In addition to making a contribution to the study of ideas in public policy, the article helps fill a gap in the literature on global health and policymaking in Africa, in which studies about policy implementation remain rare.

INTRODUCTION

As part of this special issue of *Global Health Governance* on "Political Science in Global Health," it is most relevant to explore how this discipline has contributed to our understanding of the role of ideas (i.e., the beliefs, assumptions, and perceptions of actors) in the policy process. In recent decades, a growing number of empirical studies and theoretical contributions have stressed the central role of ideas in policy development. More recently, scholars have moved beyond the general claim that "ideas matter" to study *how* they matter.[1-3] As argued in this article, however, the recent multiplication of ideational studies in political science and related disciplines cannot hide the relative neglect of policy implementation within that scholarship. In Africa, for instance, despite the existence of some anthropological literature exploring how colonial, neoliberal, or broader cultural ideas have shaped African bureaucracies and the implementation of certain policies,[4, 5] the role of ideas in implementation is seldom explored in a detailed and systematic way.

The main objective of this article is to stress this shortcoming while beginning to address it. In order to do so, we review the ideational literature to reveal its relatively limited attention to implementation; to address this shortcoming, we draw on the existing implementation scholarship,[6-9] which sometimes explores the role of ideas, typically in an unsystematic manner. To illustrate our broad analytical claims, we turn to the recent new wave of health care reforms taking place in sub-Saharan Africa, with a focus on the ongoing implementation of policies that wave user fees for vulnerable segments of the population. As suggested, the mismatch (or the harmony) between the ideas associated with a particular policy and the assumptions of the actors tasked to implement it can directly impact the implementation process, and policy development in general. In addition to making a contribution to the study of ideas in public policy, this article helps fill a gap in the literature on health care and public policy in Africa, where implementation studies remain too rare.[10, 11] Because implementation is one of

the crucial stages of policy development,[12] this article contributes to both ideational research and policy studies, in Africa and beyond. Yet this is an exploratory article, and our goal is not to offer a systematic empirical analysis but simply to use the example of health care reform in Africa to exemplify some of our analytical claims while formulating a broad agenda for future research on the ideas-implementation nexus. We selected user fees in African health care as a topic because this is an area we know well, in part due to our existing scholarship in the field. Yet, user fees in Africa are only one possible example among many others of how ideas can shape policy implementation.

Because transnational actors frequently play a direct role in shaping national policies in Africa, the ideas these actors diffuse should not be neglected. That was particularly the case in the 1980s, when user fees became dominant in African health policy.[13, 14] However, implementation is an area in which the ideas diffused by transnational actors play a limited role, especially when the issue of free health care is concerned.[15] In this context, following the call for more research and explicit use of theory about street-level bureaucracy in Africa[16], our analysis focuses on national actors, especially street-level workers[8]. We have studied the changing nature of the discourse of transnational actors on user fees in our previous scholarship but here we do not explore the impact of this discourse on policy implementation, something that future research could assess.[17]

IDEAS AND POLICY PROCESSES

Over the last two decades, a new wave of scholarship in political science and related disciplines has stressed the role of ideas, discourse, and culture in policy development. This ideational approach to policy development has made a direct contribution to political science and policy analysis by showing how the ideas and assumptions of actors, alongside institutions and interests, can shape policy outcomes.[3, 18-21] One of the key insights of this scholarship is that interests matter, mainly through the way policy actors perceive them. The same remark extends to the goals and preferences of these actors, which are historical and political constructions rather than realities mechanically derived from the material position of these actors.[22] Lastly, ideational scholars such as Mark Blyth[22] have offered new insight on the long-standing debate about the origins of new policy institutions, which are typically introduced in a context of perceived "crisis" and acute uncertainty that weakens the legitimacy of existing institutions while also pressuring policymakers to consider alternative policy ideas, which can form the basis for these new institutions. These scholars have shown that such a "crisis" can generate acute uncertainty which, in turn, empowers new policy ideas that actors use to reshape or even replace existing institutions.[23] Increasingly, students of health care policy have turned to this growing literature on ideas and public policy to address specific empirical puzzles.[24, 25]

Although this "ideational turn"[25] has made a direct contribution to the field of policy and health care research,[24] the ideational literature has not paid equal attention to the five main stages of the policy process[12]: agenda-setting (defining and drawing attention to a policy problem), policy formulation (designing policy instruments to address a specific problem), decision-making (selecting and enacting a particular policy instrument), policy implementation (operationalizing policy provisions and instruments), and policy evaluation (drawing lessons from existing policies to shape

future decisions). Importantly, these stages can overlap and/or occur in a different order than the one stated above. This is true because, as John Kingdon[26] has suggested for the United States, and as Merilee Grindle and John Thomas,[27] Valéry Ridde,[26] and Gill Walt[27] have suggested for low- and middle-income countries, the policy process is seldom linear. Keeping this in mind, we only use the policy stage typology to map the policy literature on ideas and to stress the relative lack of attention it has been given with regard to implementation.

First, students of policy ideas have conducted extensive research on *agenda-setting* and, in a related manner, problem definition and framing processes.[3, 28-30] This scholarship explains how actors, located both inside and, especially, outside the state, help draw attention to concrete issues, which they define as collective problems worthy of public attention and state intervention. For instance, in the post-war era, "drinking and driving" was transformed into a social and policy problem worthy of policy interventions.[31] Conversely, in Africa since the 1990s, exempting the very poor from health care user fees has never become a public problem that the state needed to address.[32,33]

Second, the ideational scholarship is largely centered on the analysis of policy formulation and, more specifically, the development of policy solutions.[3, 18, 23, 34, 35] This aspect of the literature focuses primarily on the role of experts and policy paradigms in the formulation of policy alternatives and instruments. The main claim here is that the ideas of policy experts,[36, p.141] as embedded in particular policy paradigms, can shape the formulation of concrete policy solutions. For instance, to legitimize the generalization of health user fees in Africa in the 1980s, World Bank experts popularized the idea of a frivolous use of health services when care is not directly paid for by users.[37] Scholars have since shown that, in Africa, this type of discourse participated in the "building of consensus across different institutions and national settings defining the 'problem' of health care financing and potential solutions."[13] Importantly, however, policy solutions are not always developed as a direct and original response to new policy problems, as specific experts and policymakers can try to impose their preferred policy alternatives, regardless of the problem of the day.[29] For example, in the field of old-age pensions, the emergence of demographic aging as a policy problem has encouraged neoliberal experts to promote the creation of private savings accounts, a policy alternative that had emerged long before this problem first entered the policy agenda.[28]

Third, there is a sizable ideational scholarship on the decision-making stage, especially the ways in which policymakers make a discursive case for the "need to reform"[38] while attempting to convince the population and key interest groups to support specific pieces of legislation.[24, 25] For instance, to justify the enactment of the 2010 Patient Protection and Affordable Care Act in the context of the deepest economic crisis since the Great Depression, U.S. President Barack Obama claimed that this crisis made reform more urgent, as it could help improve the economic competitiveness of U.S. firms on the global stage by reducing their "high and rising health costs" (45).[40] Similarly, in Ghana, to finance the recent development of that country's national health insurance, legislators and political parties managed to convince the public of the need to increase the Value Added Tax (VAT) by 2.5 percentage points on certain products.[39]

Fourth, an extensive ideational literature on policy evaluation is available. This literature focuses on lesson drawing,[40] learning,[34, 41] and implementation fidelity.[42] On one hand, Richard Rose[40] and many other scholars—including health specialists[43]—have

shown how actors can draw lessons from policies implemented in a specific historical or geographical context to develop or revise policy in a different context. On the other hand, the scholarship on learning processes focuses on how bureaucrats and experts evaluate policies located within their jurisdiction to revise, discard, or replace them.[34, 41, 44] For example, there is evidence that policymakers can learn from different types of disasters and use this knowledge to revise existing policies.[45] Regarding financial access to health care in Africa, communities of practice have been created since 2010 to facilitate experience sharing among policymakers implementing health policies.[46] This suggests a practical awareness of the need for policy evaluation and learning on the ground.

POLICY IMPLEMENTATION: BRINGING IDEAS AND AFRICA IN

As the above discussion suggests, students of ideas and public policy have systematically contributed to our understanding of four of the five main stages of the policy cycle. Unfortunately, the same cannot be said of policy implementation, a policy stage that has been relatively neglected by ideational scholars. In addition to the limited number of detailed empirical studies about policy implementation in the contemporary ideational literature, this neglect of policy implementation is apparent in recent and influential introductions to ideational policy analysis in political science. For example, a recent policy-centered volume by Daniel Béland and Robert Henry Cox about *Ideas and Politics in Social Science Research* says virtually nothing about "implementation," a term that is simply absent from another introductory volume edited by Andreas Gofas and Colin Hay.[47] The same remark applies to Vivien Schmidt's overview of "discursive institutionalism" featured in the *Annual Review of Political Science*.[48] Finally, influential publications that have shaped the field, such as Mark Blyth's *Great Transformations*,[23] John L. Campbell's *Institutional Change and Globalization*,[18] and Peter Hall's seminal article on policy paradigms, "Policy Paradigms, Social Learning and the State Hall,"[35] are generally silent about implementation. This points to a significant gap in the policy literature on the role of ideas.

The existence of this gap would not be that problematic if implementation was a relatively marginal and inconsequential aspect of the policy process. Yet since the 1970s, empirical studies have stressed the crucial role of implementation in policy development. This literature emerged primarily in the United States in the aftermath of the apparent failure of some Great Society programs, which Martha Derthick,[7] as well as Jeffrey Pressman and Aaron Wildavsky,[9] related to implementation problems. This early scholarship encouraged authors such as Eugene Bardach[6] to take a more systematic look at policy implementation at large. Over the years, new empirical and analytical publications on implementation contributed to the expansion of implementation research.[49] More recently, scholars have called for, and participated in, a revival of implementation studies.[50, 51]

To illustrate the importance of implementation within the policy cycle, we can explore health care reform in Africa. Turning to Africa to study implementation is particularly important because research on policy implementation in Africa remains limited in scope. In fact, according to Harald Saetren,[10] only 4% of the research about policy implementation worldwide has been conducted in Africa. On this continent,

public policy research remains relatively underdeveloped and the social sciences, including political science, could play a major role in improving this situation.[52]

Since 2000, Africa has witnessed the enactment of a wave of new health financing policies which focus on the removal of user fees for vulnerable populations. In contrast to what happened in the 1980s, when many African countries followed the recommendations of international organizations such as the World Bank by adopting user fees for health services,[13] many African countries have begun lifting at least some of these fees over the last decade. This is a key trend worth exploring because Africa remains the continent where the proportion of household health expenditure at the point of service is the highest.

Although the available evidence suggests that removing user fees is effective in both reducing household health spending and increasing the use of formal health care services by low-income citizens, the implementation of fee removal policies in Africa poses great political and institutional challenges.[15, 53] This is precisely why, at the beginning of the current wave of user fee removals, policy experts stressed the need to address implementation challenges and conditions on the ground.[54] In fact, as they spread across the continent, such reforms trigger passionate debates likely to shape their implementation over time. This is true partly because attempting to remove financial barriers to access to care stemming from user fees, a reform centered on the idea of gratuity, contradicts years of practices, beliefs, and international policy recommendations. In most countries, gratuity was adopted by high-ranking government officials, frequently the president of the country himself.[55] The decision to remove user fees was largely political and was often made just before elections.[15] Health workers tasked with implementing that change rarely participated in the decision-making process.[15, 56, 57] This means that this policy has largely been imposed upon them when, for 30 years, they had been trained to believe in, and had integrated, the idea that user fees were both effective and legitimate. This example points once again to the potential role of ideas in policy implementation.

IDEAS AND POLICY IMPLEMENTATION

Unfortunately, the recent scholarship on implementation, which comes after the "ideational turn"[58] in policy research, pays relatively limited systematic attention to the role of ideas. The same remark also applies to the earlier implementation scholarship, which has paid scant attention to the role of ideas overall.[59] However, there are good reasons to believe that actors' ideas and perceptions can shape policy implementation. First, some implementation studies have stressed the role of ideas.[60] This is notably the case in the field of education research, where scholars have recognized and explored the ideational component of implementation processes.[61, 62] Second, although they seldom provide methodical insight on the topic, several introductions to policy analysis written by political scientists allude to the role of ideas in policy implementation.[12, 63, 64] Finally, going against the relative neglect of implementation identified above, several students of ideational processes explicitly emphasize the relationship between ideas and policy implementation. This is the case of political scientist Frank Fischer,[65] who, as part of his attempt to reframe policy analysis, points to the interpretative aspect of implementation. Even more relevant for the study below, in *Elites, Ideas, and the Evolution of Public Policy*, William Genieys and Marc Smyrl formulate a few general

remarks about the role of ideas in policy implementation. The most noteworthy point they make is that policy failure may occur "if a program developed in one systematic framework is implemented in a place whose ideational 'culture' is incompatible, that is, is grounded in an incompatible systematic framework" (41).[66]

Although it does draw our attention to the role of ideas in policy implementation and, more broadly, to the relevance of ideational analysis for implementation research, this remark cannot hide two significant limitations of Genieys and Smyrl's ideational perspective on implementation. First, their volume does not systematically explore this issue. Second, and especially crucial for our analysis, as opposed to what these authors suggest, the mismatch between ideas at the formulation and the implementation stages is not only about the transfer of a policy program from one country to another, which is a form of "policy transfer."[67] In reality, this type of mismatch can occur within the same country, when key actors, such as professionals and street level bureaucrats[8] tasked with implementing a policy instrument, share different ideas than the ones imbedded in that instrument, which are by and large the ideas that dominated the formulation stage (for a similar perspective, see Carroll, Patterson, Wood, Booth, et al.,[59]).

The example of health-care reform in West African countries illustrates the possibility of a mismatch between prevailing cultural assumptions at the formulation and at the implementation stages within the same country. In these countries, donors have long pushed countries to support the development of mutual health insurance schemes. But, after 15 years, the coverage rate remains below 5%. There are multiple reasons for this policy failure,[68] including the inability of many citizens to pay the premiums, the poor quality of care available with this coverage, and the cultural belief that paying for care before you become sick is likely to attract diseases. Although we reject purely culturalist arguments,[69] it is clear that this cultural idea helps explain the low coverage of mutual health insurance in Africa. More generally, this points once again to the potential impact of ideas on policy implementation.

Regarding the role of health workers and user fee removal in Africa, survey data suggest the existence of plural and ambivalent perceptions among health workers. In the context of this article, we focus primarily on the ideas of street-level workers at the heart of the implementation process,[16] assuming that actors located higher up in the chain of policy command share the same basic ideas as them about user fees. A detailed analysis of the ideas of all the actors involved in the implementation process should be conducted as part of future research in the field. Although we would have liked to cover more ground and focus on the ideas and perceptions of all actors involved in policy implementation, we decided to use examples readily available in the existing literature, which are necessarily limited in scope. Beyond these remarks about the limitations of our study, the perceptions of health care workers regarding user fees in Africa can be classified into three distinct categories, which are discussed separately below. This discussion points to the presence of contradictory ideas about user fees and free health care, not only between countries but even sometimes within the same country. This paradoxical situation further justifies the need for more research on the topic, as more data is needed to explain some of these contradictions.

Support for Free Health Care: For health workers in South Africa, free health care is a positive development leading towards universal access to health systems [56, 70]; it is an opinion shared by their colleagues in the Sudan[71] and in Ghana.[72] In Ghana, for instance, 99% of health workers interviewed in the Volta and Central regions believe

that free access facilitates medically assisted child delivery while benefiting the poorest segments of the population.[72] Similarly, in two of Niger's health districts, health-care workers have a positive perception of free health care for pregnant women and for children under 5. In fact, no fewer than 94% of the health workers interviewed agree with the statement that the abolition of user fees has increased the use of health services.[73] A similar percentage (91%) is found in Mali, where health care workers supported the idea of free health care.[74] In South Africa, some health workers see free access to ARV (*antiretroviral)* treatment as a contributing factor to their satisfaction and increased motivation to work in the sector.[75]

Opposition to User Fees: In Niger, Senegal and Ghana, many health workers believe that patients do not value free treatment.[72, 73, 76] This reluctance towards free care is sometimes justified in cultural terms, as when it is claimed that getting something for free is not the "African way." This ideological discourse persists in Mali, where receiving direct payment is considered a right of the caregiver.[74] In addition, many health workers strongly believe the lack of user fees leads to a frivolous use of health centers and services, a claim mirroring the discourse World Bank economists popularized in the 1980s.[37] For many health workers, this discourse about frivolous use constitutes the main argument to justify their enduring commitment to user fees. This points to the strength of the support for user fees among health workers, as confirmed by the results of a survey sent to health workers in South Africa, Burkina Faso, Niger, and the Democratic Republic of Congo.[56, 77, 78]

Skepticism Towards Free Health Care: This category includes health workers who recognize the legitimacy of health care gratuity but show some concerns over its potential short-term effects on the health system and its long-term sustainability as a policy instrument. In South Africa, a vast majority of officers (85%) say that free health care has increased their workload.[56] As revealed by health workers in Senegal, the increase in workload is real, as few countries have increased staff or created new financial incentives for these workers that would compensate for the growing demand for health services.[79]

The most important concern of health workers belonging to this category deals with the long-term policy sustainability of gratuity. They support it but consider it to be only temporary.[80] This type of perception is widely shared when it comes to specific user fee removal projects in Niger[73] and in the Democratic Republic of Congo.[74] Overall, this perception that gratuity cannot last as a health policy instrument reflects a more general lack of confidence in the capacity of the state to develop fiscally sustainable policies over time.

These remarks suggest the existence of divergent ideas about free health care and user fee removal among health care workers, depending on the national or regional context in which they operate. Considering this, the influence of the particular context of policy implementation on the ideas of health care workers is an important issue that requires further study.[16, 81] Beyond this specific point, it is clear that ideas are likely to impact policy implementation, and that a detailed analysis of such ideas could help explain why implementation is successful or not, depending on which ideas are dominant within a jurisdiction at a specific point it time. These remarks lead us to further explore the role of ideas in policy implementation.

LOOKING INSIDE POLICY IMPLEMENTATION

For Michael Lipsky, "ideology provides a framework in terms of which disparate bits of information are stored, comprehended, and retrieved. In street level bureaucracies ideology also can serve as a way of disciplining goal orientations" (147).[8] This is why, without explicitly referring to the role of ideas, one of the first modern students of policy implementation identified the existence of shared goals or attitudes among key policy actors as a potential source of success in implementation.[82, 83]

Based on this remark and the above discussion about health care reform in Africa, we can formulate the following ideational hypothesis about policy implementation: *under specific institutional and historical circumstances, a mismatch between the dominant assumptions of the actors in charge of implementing a policy and the assumptions at the core of that policy can negatively impact its implementation. Conversely, a convergence between the core assumptions of these actors and the policy at hand is likely to facilitate implementation*. This is a very broad hypothesis, and it needs to be adapted to the empirical case under investigation to take into account its particular institutional and historical context. For instance, considering the above discussion about health care reform, we can formulate more specific hypotheses about the implementation of user fee removal in Africa: 1) when implementation is well organized, with enough input and regard for the perceived interests of health workers, the ideas of health workers should not adversely affect the implementation process; however, 2) when the implementation process is poorly organized, without effective means and proper preparation, not directly taking the perceived interests of these workers into account, their potentially negative ideas about the policy instrument at hand should have a detrimental impact on the implementation process. This should create problems that, as a feedback effect, are likely to strengthen the negative perception of this instrument.

These hypotheses need to be empirically tested in future research but, from the analytical perspective outlined above, taking ideas directly into account in the analysis of policy implementation may help explain why some policies are smoothly implemented while others face much resistance on the ground, which can affect their performance or even jeopardize their sustainability. As future empirical studies test the above hypotheses, it is essential to examine alternative, non-ideational explanations. For instance, one could argue that resistance to the implementation of user fee waivers in African health care policy is the pure product of the objective, material, or institutional interests of health professionals and other constituencies. Considering this type of alternative argument, the only way to validate our main ideational hypotheses is to explore, and stress the limitations of, alternative explanations grounded in other logics of explanation, namely the material or the institutional logic (on this issue, see Parsons[84]).

Grounded in the policy literature on ideas reviewed above, our main hypotheses give a concrete content to our ideational perspective on policy implementation. Importantly, our goal here is not to displace existing approaches focusing on institutional and/or material obstacles and opportunities to implementation. Rather, it is to supplement these approaches, which compels us to 1) define what we mean by ideas (in contrast with other factors like institutions); and to 2) stress the analytical

boundaries, and the potential synergies, between the ideational approach and institutional as well as material explanations in political science and policy analysis.[84]

The term ideas refers broadly to the beliefs, perceptions, and policy assumptions of actors, as they are distinct from institutions and interests.[1] On one hand, ideas are distinct from institutions in part because many of them are never institutionalized. This means that ideas are not, in themselves, the formal and informal rules we call institutions. Ideas and institutions are closely related in the empirical world but it is both possible and necessary to draw an analytical line between them.[84] On the other hand, to show that ideas play a distinct role in policy implementation, scholars must show that ideas do more than simply reflect the material position and interests of actors, which are not purely objective.[18, 23, 24, 48]

As suggested above, to demonstrate that ideas have a direct impact on implementation, we must show that they cannot be reduced to the material interests and the position of actors who share these ideas (i.e., that their objective financial stakes would fully explain their behavior and attitudes). In the same way, we should be able to show that ideas do not simply reflect the institutional position of actors. Yet once the autonomous impact of ideas is demonstrated, it always remains possible to stress the fact that they can interact with institutional and/or material factors to produce certain outcomes. As Craig Parsons suggests, once a clear line has been drawn between specific factors, we can study how they interact to produce specific policy effects.[84] From this perspective, showing "how ideas matter"[2, 3] is compatible with the claim that ideational forces can interact with other factors to produce concrete policy outcomes.[85,87]

This discussion leads us to systematically discuss the alternative materialist claim that, on their own, purely objective material factors explain the resistance of many health workers towards gratuity in Africa. Two examples illustrate this counterclaim, which future scholarship on the implementation of user fee removal must address head on. First, if available health personnel in many countries are adequate to meet the increased demand generated by the removal of user fees, the fact remains that the daily workload of health workers has typically increased as a consequence of gratuity. In other words, there is a shift from under-utilization to more intense workloads, and many workers see this as an overload that they have a material interest in stopping.[55] Second, in some countries, user fees generated direct revenues for health workers, which created material incentives to preserve this system and oppose gratuity. Often, the removal of user fees created both more work for health workers and the loss of direct revenues for them.[15]

The problem with this materialist perspective is that the perception of interests is mediated through certain ideas about what is good for the actor and society at large.[1] From this angle, in a context of rapid policy change and uncertainty, the interests of actors are not always clear.[23] In this context, the ideas of actors about the nature of both their interests and the public good can be politically influential.[22] In some of the scenarios mentioned above, there is no direct evidence that health workers have been negatively impacted by the removal of user fees, which has not prevented many of them from opposing this change. Considering this, ideas as to what constitutes good medicine and the proper relationship between doctors, patients, and the state might trigger much resistance against policy change, independently from seemingly objective material realities. This means that looking exclusively at such "interests" (as separated from the

ideas and perceptions of actors) may not explain resistance against free health care services in Africa.

Regarding the potential role of institutions, the existing literature on user fee removal in Africa points to the possible existence of two distinct institutional logics. First, in countries like Mali, Niger, and Burkina Faso, the implementation of gratuity policies through pilot projects launched in selected health districts by health ministries and supported by international NGOs is typically smooth.[86] The quality of health services is maintained, medical drugs are available, both citizens and health care workers are satisfied with the new arrangements, and health facilities are reimbursed on time for the services they offer at no cost to patients.[78, 87] Second, with a few exceptions, when the state organizes user fee removal policies at the national level, often without taking into account the lessons drawn from pilot projects, implementation is chaotic, even catastrophic. In this context, the allocated budgets are not sufficient to meet the increased demand for health services, citizens are not well informed about the new policies, the resources available are in short supply, and health care workers are not satisfied with the way policy change affects their working conditions.[15, 55, 79]

The contrast between these two scenarios could suggest that, on its own, the role of institutional factors such as pilot projects and NGO activities explains the difference between success and failure in policy implementation. However, there are good reasons to believe that, alongside institutions, ideational factors play a direct role in explaining this contrast in implementation outcomes. This is the case partly because the attitudes of health workers regarding free health care vary greatly across the two scenarios above. One possible hypothesis is that NGOs and the lessons drawn from pilot projects help shape the attitudes of health workers in the sense of a greater support for gratuity, which, in turn, may facilitate implementation. This means that, in addition to the respective roles of the state and NGOs and other institutional issues of administrative capacity, funding, and governance, the ideas of the street-level health workers[8] concerning user fees and their removal may directly shape the implementation of gratuity policies in Africa. New surveys, in-depth interviews with these workers and the analysis of the debates over the implementation of such policies could help assess the role of ideas in policy implementation.

RESEARCH PROPOSITIONS

As a contribution to this special issue on "Political Science in Global Health," this article has explored the relationship between ideas and policy implementation. Based on the above discussion, it becomes clear that this relationship is a two-way street. On one hand, the problems facing the implementing of a policy such as user fee removal in Africa are likely to influence the way health workers perceive this policy. For instance, when health workers in Niger or Senegal question the value of health care gratuity for children or the elderly, this is largely because, when surveys are carried out, this type of policy suffers from significant fiscal shortcomings and challenges. In this context, it is not the idea of gratuity that is being questioned but the way it is implemented. Moreover, policy actors who are ideologically predisposed to be against this idea are likely to refer to problems stemming from its implementation to legitimize their opposition to this particular policy instrument.

On the other hand, the policy ideas of actors can genuinely impact the implementation process. In the case of the ideas of health workers, this claim is consistent with the traditional call for "a focus on intervention staff (…), as they are the major actors who continuously shape the implementation of the program" at stake (145).[88, p.145] This is true because health workers are at the heart of the implementation of user fee removal policies. As Lipsky[8] puts it, such street-level actors are actual *policymakers* in the sense that their actions, which are shaped by their ideas and perceptions, are typically instrumental to successful (or failed) implementation. This direct attention to health care workers as policymakers and the impact of their ideas on policy implementation are consistent with the general claim that "programs do not work in and of themselves; they work through the reasoning of program subjects" (186).[89, p.186] This is the case for policy development in general, including policy implementation.

Starting from our general claims about the potential role of ideas in implementation, this article suggests that the ideas of health workers can shape the implementation of user fee removal policies in Africa. As hypothesized, if health workers do not believe that this removal is a sound policy solution, they are likely, at best, to do as little as possible to facilitate its implementation or, at worst, to do everything they can to undermine it. Once again, these remarks point to the general role of ideas in policy implementation.

Based on this discussion, we suggest that future empirical research about the removal of user fees in Africa should recognize the centrality of health workers and their ideas in policy implementation in health care and tackle the following propositions:

1. The ideas actors involved in the implementation process have about specific policy problems and solutions can help account for the success or the failure of this process;

2. The more these actors witness implementation problems, the more they are likely to oppose the policies being implemented; and

3. The greater the gap between the policy solution at hand and the assumptions of these frontline workers, the more likely implementation will face opposition on their part.

Although these propositions are developed in relationship to the empirical topic discussed throughout this article (health care user fee removal in Africa), they could help global health researchers working on many other policy issues in different parts of the world better grasp the potential role of ideas in policy implementation. At the most general level, the relationship between ideas and policy implementation must become a more prominent aspect of contemporary policy studies all around the world.

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Framing Global Health as Human Rights: Learning from the Case of HIV/AIDS

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Framing is a central mechanism in the social movements literature. Human rights frames are thought to be an especially potent form of rhetorical communication because human rights are thought to trump other objectives. However, the proliferation of rights-based claims could potentially be counter-productive if overused, as rights may come in to conflict or devalue the concept. Advocates have sought to frame a variety of global health concerns as human rights, but the rights discourse is more contested for social and economic rights than it is for civil and political rights. There has been some research suggesting that efforts to frame access to antiretroviral AIDS drugs as a human right were successful. However, it remains an open question the extent to which a human rights frame is more persuasive than normative, moral rhetoric and whether a human rights frame, when applied to global health issues, resonates equally in different national contexts. This article provides an overview of arguments for and against the potential utility of a human rights frame as an advocacy strategy in access to health campaigns. The article also provides some preliminary experimental evidence from several surveys from the United States and India, in which access to medicines campaigns framed in moral terms were equally compelling as a campaign framed in terms of health as a human right.

INTRODUCTION

Does framing a global health issue—like universal access to some life-saving medications--as a human right advance and broaden the appeal of the cause? Does it make the agenda of health advocates more likely to succeed? Why do some appeals by advocates generate strong public support while other equally deserving issues fail to motivate a similar response? If transnational advocates are to "succeed" in advancing their agenda, they need to identify and publicize a compelling frame. But this statement begs the question of what counts as "compelling" and why it is important. In this article, we assess whether or not an explicit human rights claim advances the likely resonance of an advocacy movement's claims, as opposed to a moral claim that rests on some societal responsibility to address a particular disease burden.[1]

We address these issues in four sections, starting with a short exposition of framing and why it is important. The second section explores whether human rights constitutes a "compelling" frame. The third section discusses what frames advocates and opponents used as they made the case for and against universal access to AIDS treatment with a discussion of the role played by human rights rhetoric. The final section draws on several surveys that we conducted in the United States and India that provide some empirical support for our view that moral and human rights rhetoric may be equally compelling.

SECTION 1: FRAMING: WHY IS IT IMPORTANT?

Frames and framing have become common subjects of inquiry in the academic world in many areas of study, including but not limited to the social movement literature in sociology. That literature has also inspired much of the scholarship in contemporary international relations theory. For scholars of social movements, frames are interpretive meanings that people ascribe to an issue, connecting cause and effect and linking possible solutions to that causal chain.[2] Frames are rhetorical messages that describe what kind of problem is being faced, and they can invoke different and sometimes multiple dimensions such as national security, morality, religion, law, efficiency, and human rights, in the effort to capture public attention. Frames help establish why the problem occurred, connecting facts in ways that also help us determine who the responsible parties are for addressing the issue.

The decision in the late 1990's and early 2000s to frame HIV/AIDS treatment as an issue of justice and fairness was a conscious choice by advocates. It was simply unfair that developing world people living with AIDS (PWAs) did not have access to the very same drugs that were available to people in industrialized nations and that were keeping them alive there. Creating a causal connection between the poor's lack of access to drug company pricing policies was another framing device. Asking drug companies to reduce their prices and allow generic competitors to enter the market was a third. Together, these elements shaped how the problem was viewed by the public (as one of fairness), who was responsible (drug companies), and what needed to be done (lower prices).

Some scholars look at framing in a different way, focusing on framing as a product of cognition on the part of the recipient rather than the sender. As Druckman notes, scholars of public opinion and political psychology focus on the interplay between the sender and the recipient to examine frame effects or how subtle shifts in the description of a problem may trigger different cognitive processes.[3]

Whereas scholars of social movements look to historical cases to see how different campaigns framed their arguments and seek to assess the relative efficacy of frames through comparative case study, a number of scholars of public opinion use survey evidence and experiments to assess how the public responds to individual frames. Our unique contribution bridges these two approaches, first by assessing the landscape of effective historical frames before providing survey evidence we collected on the micro-foundations of persuasive messages.

Why is a compelling frame important? In brief, advocates need to build public and elite support for their aims. A compelling frame, however defined, can help enlist the public to support the campaign's goals. For some, the frame will induce them to want to volunteer their time or money to support the campaign, to write letters, to buy or boycott certain products, etc. At the very least, a compelling message can generate a reservoir of public support signaling to elites that they too can side with activists without necessarily incurring political costs or at least knowing that they will have the backing of some proportion of the public if the issue becomes contentious.

While advocates may seize on different dimensions of a problem for different audiences, they often have a dominant frame that receives the majority of their words in their messaging in press releases, public statements, website presence, etc. Frames have an important political function; successfully deployed, they can make it difficult for political opponents to have the rhetorical resources to respond by delegitimizing certain

policy positions (Krebs and Jackson 2007). Frames help fix meanings by focusing on a particular evaluative dimension and elevating its importance over other valued goals, such as prioritizing access to essential medicines over intellectual property rights.

Where frames and meanings are contested, what determines which frame dominates the public's imagination or "wins" is something the literature has struggled to answer.[4] That issue is even more problematic in the international context, where a frame that resonates with one group may not do so with another (of course, that can be a problem *within* a given society as well). Even powerful frames are unlikely on their own to make an advocacy campaign successful.

SECTION 2: WHAT FRAMES ARE COMPELLING?

In their foundational international relations work on transnational advocacy campaigns, Keck and Sikkink argue that activists need to think about the prospective universal resonance of their messages: "Norm entrepreneurs must speak to aspects of belief systems or life worlds that transcend a specific cultural or political context." They identify two characteristics that seem to have had the most historic effectiveness in mobilizing support, drawn largely from their work on human rights and environmental advocacy: "(1) issues involving bodily harm to vulnerable individuals, especially when there is a short and clear causal chain (or story) assigning responsibility; and (2) issues involving legal equality of opportunity."[5]

It is worth lingering on Keck and Sikkink's insights as they apply to global health because disease burdens pose comparable risks of bodily harm, but may have difficulty with respect to the length of the causal chain or linkage with a specific responsible party. At the same time, global health issues, as part of a basket of social issues claiming rights status, may not enjoy the same wide acceptance as legal equality of opportunity.

In terms of the first "normative logic" based on bodily harm, Keck and Sikkink suggest campaigns against bodily harm have some universal appeal because they "avoid both the indifference resulting from cultural relativism and the arrogance of cultural imperialism."[6] They assert that "[a]lthough issues of bodily harm resonate with the ideological traditions in Western liberal countries like the United States and Western Europe, they also resonate with basic ideas of human dignity common to most cultures."[7] From this perspective, anti-slavery and women's suffrage campaigns had greater global resonance than temperance movements.[8] They elaborate by suggesting that "protecting the most vulnerable parts of the population—especially infants and children" also has transcultural appeal. They suggest that campaigns for infants like the Nestlé boycott over baby milk formula were more successful at the global level than anti-tobacco campaigns perhaps for this reason.[9] As the next section details, global health and specifically the campaign for access to AIDS drugs, emphasized the connection between the lack of access to medicines and death, the most grievous bodily harm.

Moreover, the length of the causal chain, which bears responsibility for bodily harm, is also important: "But the causal chain needs to be sufficiently short and clear to make the case convincing. The responsibility of a torturer who places an electric prod to a prisoner's genitals is quite clear."[10] For this reason, they suggest that activists had more success holding the World Bank accountable for projects that had adverse environmental impact that the Bank directly funded, while the IMF has been a harder target to hold responsible for riots or hunger as a result of structural adjustment

policies: "[T]he causal chain is longer, more complex, and much less visible…."[11] Health campaigners, for their part, may have difficulty connecting some health issues to a particular responsible party, as issues like malnutrition and diarrheal disease might suffer from the long, indirect causal pathway from global inequality to local poverty to health outcomes. This is not always an obstacle for health campaigners when they can connect specific actors and policies (pharmaceutical companies and patent protection) to negative health outcomes (death).

Beyond their claims about bodily harm and short causal chains, Keck and Sikkink argue that campaigns for legal equality of opportunity are amenable to transnational advocacy but for reasons that are not clear. They suggest that there does appear to be a process of expansion of liberal values around the world, although such an observation runs the risk of "historical determinism."[12] As Finnemore and Sikkink point out elsewhere, "Arguments that the substantive content of a norm determines whether it will be successful imply that norm evolution has a clear direction if not a final endpoint." Rather than a path-dependent product of historical choices, an argument that suggests the substance of certain frames is more effective than others implies a sort of "functional" efficiency.[13]

Keck and Sikkink appear to reach these conclusions about the resonance of these kinds of claims based on inductive generalizations from their experience as largely qualitative scholars in the human rights arena.[14] However, this argument requires additional empirical support to know how valid the conclusions are. They are plausibly drawn from some important cases but would benefit from additional evidence from other cases and support from other methods such as surveys or experimental work. Moreover, despite being informed by some historical cases, the mechanisms of influence at the micro level need to be further developed. In short, their conjectures could usefully be re-conceptualized as testable propositions.

It could be that norms of legal equality of opportunity are more globally appealing than other claims such as social and economic rights, but additional evidence could be brought to bear to buttress this view. As suggested above, Keck and Sikkink assert that there is something about bodily harm related to the dignity of the individual that gives issues framed in those terms more universal resonance. This response suggests a plausible social psychological mechanism that inheres in the human condition, as if human beings are able to engage in a kind of Rawlsian experiment behind the veil of ignorance to put themselves into the shoes of another. *I would not want to be tortured.* However, one could make a similar sort of claim based on access to medicines since all humans are potentially vulnerable to disease. *Extending this idea to pharmaceuticals, I would want access to these life-saving drugs, so others should have access to them as well.* Importantly, some diseases and health harms affect some populations disproportionately which may attenuate such moral and rights-based claims of universal empathy and responsibility.

To assess whether or not human rights historically was a potentially important frame that advanced global health advocacy, the next section analyzes the role of framing, and human rights framing in particular, for the case of HIV/AIDS and global access to antiretrovirals, arguably the most successful campaign of global health advocacy to date.

SECTION 3: COMPETING FRAMES FOR ACCESS TO MEDICINES AND THE ROLE OF HUMAN RIGHTS

By the late 1990s, people in rich countries largely had access to antiretroviral medicines (ARVs), namely the triple cocktail of highly advanced antiretroviral therapy (HAART) introduced in 1996, which immediately had a tremendous effect in staving off death for many people with HIV. Meanwhile, millions in poor countries lacked access to these medications, or even to older drugs like AZT. This inequality was deemed outrageous by campaigners, and they were able to frame the argument in terms of the moral responsibility of pharmaceutical companies to lower their prices in order to right that wrong. Framing the argument in those terms pitted the "intellectual property rights" of firms against the lives of millions of poor people who could be kept alive with these drugs. As Odell and Sell argued, "In the 1980s TRIPS advocates had framed it as an alternative to tolerating piracy of private property." Access activists, for their part, sought to re-frame the issue: "Now the NGOs compared TRIPS to a different reference point saving the lives of poor people suffering from HIV/AIDS."[15] In Keck and Sikkink terms, campaigners directly connected the actions of pharmaceutical companies to the bodily harm of people suffering from HIV.

The theme that patent and drug prices policies were killing people became a dominant theme of campaigners. In 2001, activists circulated a sign-on letter directed to the major pharmaceutical companies that were then suing the South African government for national legislation that would have ostensibly allowed the government to trump patent rights for AIDS drugs. Activists wrote "You are receiving this letter because you are suing the government of South Africa in an effort to maintain high prices for patented pharmaceuticals, which will prevent millions of people from obtaining life extending treatment."[16]

While other research has recounted the history of key episodes in the modern history of AIDS,[17] this article seeks to provide a plausible explanation for why the contests between treatment advocates and opponents were resolved in favor of expanded ARV access in poor countries. Sell and Prakash offered a preliminary account. In their 2004 landmark piece, they applied insights from the literature on framing and advocacy movements to explain the logic by which the access frame ("copy=life" or what we might think of as "generics=life") trumped the intellectual property rights frame ("Patents = profits = research = cure)." In their view, advocates exploited external crises including the HIV/AIDS crisis and 9/11 and turned them into political opportunities to advance their agenda.[18] They further suggest that by tying greed of the pharmaceuticals companies to unnecessary deaths, advocates invoked "a successful recipe" based on threats to bodily harm.[19]

While a compelling moral frame was only part of the reason advocates were so effective, it was an important piece. What is needed is a richer theoretical and empirical account for why appeals based on the injustice of limited access found so much support. There are a number of different possibilities, not mutually exclusive, to explain the resonance of the moral/justice frame for HIV. Elsewhere, we have explored a variety of explanations, but in this article, we focus on the human rights frame and the extent to which human rights framing added or supplemented this logic of access to medicines based on threats to bodily harm.

Access to Treatment is a Human Right

When the world first became aware of HIV and AIDS, fears about the disease led to discriminatory practices against those who were infected with the virus, from Cuba's efforts to quarantine HIV+ individuals, to bans on travel for those living with the virus, to a host of other measures by both governments and broader societies that stigmatized vulnerable communities heavily affected by the AIDS virus. Jonathan Mann, who led the WHO's early efforts to address HIV/AIDS, was a vigorous champion of human rights for those living with HIV. He, perhaps more than any other public official, was identified as the major champion who connected health and human rights, drawing attention to the social determinants of poor health.[20]

In 1996, in the *British Medical Journal*, Mann suggested that a human rights frame would be particularly effective: "The current health and human rights movement is based on a working hypothesis: that the human rights framework provides a more useful approach for analysing and responding to modern public health challenges than any framework thus far available within the biomedical tradition."[21] Even earlier, in launching the journal *Health and Human Rights* in 1994, Mann and his co-authors suggested that human rights language might offer a way forward to improve health outcomes, noting that "[w]hile there are few legal sanctions to compel states to meet their human rights obligations, states are increasingly monitored for their compliance with human rights norms by other states, nongovernmental organizations, the media and private individuals."[22]

Gostin has argued that human rights rhetoric has a particular power because "[w]hen 'rights' language is invoked, it is intended to convey the fundamental importance of the claim…. 'Human rights' when it is invoked in reasoning or argument, commands reverence and respect."[23] Two authors with the World Health Organization wrote of the political utility offered by human rights language in the fight for access to medicines, contrasting intellectual property rights and human rights: "While intellectual property rights can be allocated, traded, amended, forfeited and are basically limited in time and scope, human rights are timeless expressions of fundamental entitlements of the human person."[24] Further, human rights are universal in scope and they inhere to each and every person. By invoking a health issue like HIV/AIDS as a human right, campaigners could potentially transcend prejudices that existed toward populations disproportionately affected by HIV.

Indeed, human rights language became more commonplace as part of the vocabulary advocates used to address the AIDS crisis as well as broader efforts to support access to essential medicines.[25] As Peter Piot noted in his memoir: "Human rights issues were never far away when working on AIDS. They were not just part of our values, but we learned that discrimination and stigma were major impediments for both prevention and access to treatment. Therefore AIDS-related human rights promotion was an essential part of our work."[26]

In terms of access to treatment, the argument might go as follows: Given the power of human rights language, framing treatment access as a human right was particularly potent both in terms of triggering public and elite support. The problem from this point of view is that while civil and political rights, as Keck and Sikkink argued, have come to have near universal acceptance, social and economic rights have a much more contentious place in international politics. As Hawkins concluded in his

study of human rights mobilization in Chile, "it is significant that the network focused on rights related to personal integrity and civil liberties, which are more established internationally than other kinds of rights. In particular, it is difficult to imagine that a network focusing on economic and social rights would have had the same level of success as the Chilean network."[27] Indicative of this perspective is the edited volume by Risse et al. *The Power of Human Rights* in which the authors explicitly note:

> We chose a central core of rights – the right to life (which we define as the right to be free from extrajudicial execution and disappearance) and the freedom from torture and arbitrary arrest and detention. By choosing to focus on these rights we do not suggest that other rights in the Declaration [of Human Rights] are unimportant. But these basic "rights of the person" have been most accepted as universal rights, and not simply rights associated with a particular political ideology or system.[28]

As Keck and Sikkink noted, rights-based framing in their view historically worked best for issues involving bodily harm and denial of equal opportunity. For some issues, human rights frames might not work as well. For example, they note that framing women's issues in terms of "rights, "with a focus on violence against women, "supplemented" if not supplanted earlier "discrimination" and "development" frames. This frame addressed some aspects of women's status but did not address inequalities unrelated to violence. Despite their potential power, some within the movement questioned the appropriateness of a human rights frame: "Other activists, especially from the developed world, believe that the rights frame privileges certain political and civil rights to the exclusion of economic, social, and cultural rights."[29]

Nonetheless, given their putative political power, human rights frames became very popular as different campaigns sought to cast or recast their issues including landmines (Price), women's issues (Keck and Sikkink, Joachim), environmental destruction (Keck and Sikkink), core labor standards (Payne), labor rights (Hertel), apartheid (Klotz), among numerous others (Keck and Sikkink 1998; Joachim 2007; Payne 2001; Hertel 2006; Klotz 1999). However, the proliferation of rights-based claims both potentially upends their power if every issue can be re-cast in terms of fundamental rights. If all desirable human ends can be rights that trump other human goals, then what specific power can rights-based language ultimately have?

Even as advocates like Mann sought to extend an appreciation for a right to health, the concept may lack analytical clarity. Gostin in 2001 wrote the following just as treatment activists were making their push:

> *Considerable disagreement exists, however, as to whether "health" is a meaningful, identifiable, operational, and enforceable right, or whether it is merely aspirational or rhetorical. A right to health that is too broadly defined lacks clear content and is less likely to have meaningful effect.*[30]

To be sure, there have been attempts by prominent ethicists like Thomas Pogge to flesh out a political, moral, and legal rationale for why lack of access to medicines constitutes a human rights violation, but the timing and tenor of this work suggests much remains to be done to inculcate a near universal embrace of access to health as a human right.[31]

Youde argues that the previous Health for All initiative in the late 1970s failed precisely because it was framed as a human rights issue "at a time when the right to health was highly contested."[32] Though Youde suggests the international normative context has become more favorable to health as a human right, it remains unclear how much further we have come in this regard.

Even if health as a human right continues to face challenges conceptually in elite circles, framing health issues as human rights still might resonate with mass audiences and be effective as a mobilizing argument. Moreover, while a right to health may be vague, a right to ARV treatment is much more specific. That said, it is difficult to imagine that a specific right to a particular health intervention could exist in the absence of a broader acceptance of global rights to health.

Since AIDS treatment advocates mobilized, they may have created near universal acceptance that AIDS treatment is something people ought to have access to wherever they live (which is akin to elevating it to the status of a human right).[33] However, the diffusion of support for universal treatment access is a product of the mobilization, not, in our view, what fundamentally explains the success of the campaign.

That said, human rights and rights language did have national significance in a number of country contexts. Certainly, in countries like Brazil and South Africa, where constitutional provisions (in the case of Brazil) and court cases (in the case of South Africa) established the legal rights to treatment of affected populations.[34] Here, rights-based claims had particular effectiveness given the legal backing such claims could command. Internationally, aspects of the AIDS crisis such as discriminatory policies that limited the freedom of movement and physical safety of people living with AIDS could be and were framed in terms of traditional understandings of human rights.[35] Treatment access, however, was more akin to contested social and economic rights except in countries where rights to health were more enshrined in the legal fabric of the country.

SECTION 4: ASSESSING THE EVIDENCE OF THE SALIENCE OF HUMAN RIGHTS THROUGH SURVEYS

Even if human rights only had nascent political support during the early 2000s mobilization for AIDS access, might it have strong public support in the 2010's that could empower health mobilization in the contemporary era? We cannot go back in time to assess the public salience of human rights frames a decade plus ago, but we can get some traction on support for human rights today.

We sought to assess the public salience of the human rights explanations through several surveys. The aim of the surveys was to surface the micro-foundations by which publics might be prepared to take political action in support of campaigns for universal access for health causes. We were able to conduct several surveys with subjects in both the United States and India using experimental methods to assess whether certain treatments (in this case slight changes in the wording of advocacy campaign ads) would generate more or less political support for a global health advocacy cause. In the experiments, we altered the nature of the disease, based on a line of argument that certain diseases are more of a threat to survival and are likely to command more universal support than other causes. In the first four experiments, we did not experimentally test whether human rights language would increase support for a health

access campaign. However, we were able to ask the baseline level of support for seeing global health as a human right with different national audiences. In this article, we go beyond those previous studies to experimentally test whether a global health access campaign framed in human rights terms is more persuasive than health access framed simply as a moral cause. To be sure, health issues can and have been framed in other ways, as threats to national security for example. However, in this case, given small sample sizes, we wanted to compare the persuasive appeal of two primary ways campaigners have framed access to medicines, one invoking human rights directly and a second more generic moral claim about access to health.

We report on both sets of surveys. Three of the four samples, conducted in 2012 were drawn from Amazon's Mechanical Turk, a web-based service that allows researchers to ask people to perform small tasks for a fee. In this case, we paid respondents $0.50 to answer the survey which was hosted on a survey platform from SurveyGizmo. Mechanical Turk subjects tend to be a little more liberal and educated on average than a national sample, but as Adam Berinsky et al. found, it has proven reliable as a means of replicating major findings in political psychology and has the advantage of being much less expensive than survey market research firms.[36] So, even though they are not nationally representative, we are able to learn something through the experimental design and random assignment about the relative persuasive power of messages, at least among the sub-populations surveyed. Both of the newer surveys, conducted in fall 2014, were also carried out using Mechanical Turk and hosted on the Qualtrics survey platform (Table 1 summarizes the main features and findings of the six surveys).

Table 1: Summary of Six Surveys

Survey	**Survey Design**	**Results**
US Baseline Pre-Test (2012)	100 US respondents	72% said health care was a human right
US Access Experiment # 1 (2012)	200 US respondents,	68% said health care was a human right
India Experiment # 1 (2012)	200 Indian respondents	85% said health care was a human right
US Access Experiment # 2 (2012)	204 US respondents	68% said health care was a human right
US Access Experiment # 3 (2014)	200 US respondents. Experimental design randomly assigning subjects to human rights or moral frame.	No statistically significant differences between willingness to support access campaigns between conditions, save for a higher willingness to talk to friends and family in the human rights frame.
India Experiment # 1 (2014)	208 Indian respondents. Experimental design randomly assigning subjects to human rights or moral frame.	No statistically significant differences between willingness to support access campaigns between conditions.

Survey 1: US Baseline Pre-Test

We initially conducted a pre-test of 100 respondents via Mechanical Turk as we were interested in what diseases the public thought were a threat to survival. The sample was majority female, highly educated, and more liberal than the general public. When asked whether access to health care is a right, 72% said health care was a right, regardless of nationality, 2% said health care was a right for Americans only, with 22% saying health care, while desirable, was not a right. These figures support the suggestion that access to health as a right still might be a potent frame, its contested legal and moral status among elites notwithstanding.

Survey 2: United States Access Experiment # 1

Based on the pre-test, we conducted a second sample of convenience with 200 US subjects using Mechanical Turk. This sample was more evenly split by gender, still tended to be over-educated (41% with a college degree) and more liberal (43% Democratic) than the general public. The experimental design in that study was not designed to test relative persuasive appeal of human rights compared to moral claims, but whether access to medicines campaigns were more persuasive for health conditions more directly linked to survival. For the purposes of the present article, the important issue is respondents' attitudes towards health and human rights. As before, we find that a large majority (68%) regarded access to health care as a human right, regardless of nationality, suggesting that these inequalities of access might be salient, particularly for problems deemed as especially serious.

Survey 3: India Experiment #1

We sought to demonstrate the generalizability of these findings by conducting another experiment via Mechanical Turk in a different country context. We selected India, in part because Indians are highly responsive to Mechanical Turk work requests but also because, as an emerging economy with a large population, health access issues are especially salient. India's generic pharmaceuticals industry is the dominant provider of HIV/AIDS drugs worldwide as well as other generic formulations, and issues surrounding the disease and the generics industry are widely reported in the Indian press. Again, like the previous study, this experiment did not test the relative persuasive appeal of human rights versus moral claims. In this first India-based survey of 200 respondents, 85% identified health as a human right regardless of nationality, a higher proportion than the US surveys but consistent with the idea that health as a human right might be a potent frame.

Survey 4: US Access Experiment # 2

We prepared another US-based experiment with Pacific Market Research, a survey market research firm, to see if our results with US subjects held up outside the context of Mechanical Turk. Our sample was 204 subjects, split nearly equally between men and women. The sample was 42% Democratic, 33% Independent, 19% Republican with 5 plus percent Other. In terms of education, this group was more like the nation as

a whole, with 29% having completed college and about 8% with a master's degree or higher. In this survey, 68% of respondents saw health as a human right, regardless of nationality. Again, this survey did not manipulate the frame in terms of human rights versus moral framing.

Survey 5: US Access Experiment # 3

Unlike the first four surveys, the next two, one from the United States and another from India, explicitly sought to test the persuasive appeal of a human rights appeal compared to a moral appeal. Our expectation is that human rights appeals might not be any more persuasive than moral appeals. We doubt that the public draws fine distinctions between a human rights and a moral frame, even though there might be practical implications of rights-based rhetoric in elite circles.

Subjects were randomly assigned to read a mock ad from Doctors Without Borders with either a moral claim or human rights frame (see Figure 1). The ads are identical in every respect, save for one line added to the human rights appeal which reads "Access to Medicine is a Basic Human Right" (see Figure 2 for the moral appeal).

Figure 1: Human Rights Appeal

Figure 2: Moral Appeal

Subjects were then asked a series of questions, beginning with their willingness to read more information about access to medicines (drawn from a frequently asked questions website from Doctors without Borders). We saw this willingness to read additional material as a more costly signal of engagement than questions about future activities that they might be willing to support. Respondents were then asked their willingness to support certain actions, including signing a petition in support of the cause, writing a letter to Congress/Parliament, writing a letter to their local paper, telling friends of family, joining an organization, and donating money to support the cause. Respondents were also asked whether or not they considered access to health a human right for everyone, for Americans only, or not at all.

The survey was deployed in both the United States and India in fall 2014, with approximately 200 respondents using Mechanical Turk. In the US survey, the respondents were disproportionately male (63%), with education levels higher than the general public (10% with postgraduate degrees, 40% with college degrees, another 35% with some college, and 10% high school only). The sample also was young, 47% ages 18-29 and another 30% aged 30-44. They were also more liberal than the general public, 50% self-identifying as Democrats, another 31% independent, and only 14% Republican.

Though the sample was not representative of the wider US public, random assignment tests whether or not a subset of Americans find a human rights appeal more persuasive than a moral appeal. Across a broad array of questions, there were

statistically significant differences between conditions in only one area, in which those assigned to a human rights frame were slightly more likely to donate to a cause. As is consistent with other surveys, costlier activities such as writing a letter to Congress or the local paper or joining an organization were less preferred options compared to signing a petition, talking to friends or family, or even donating money. There was no difference by condition in their evaluation of health as a human right, with super-majorities in both conditions convinced that health is a human right universally, suggestive that respondents do not perceive strong differences in human rights rhetoric versus broader moral framing. That being said, we did not include a manipulation check to ensure people understood the frame itself so these results on some level could be an artifact of a too subtle manipulation (see Table 2). Moreover, we did not include a control condition to see the baseline level of support for engaging in political activities related to access to medicines. It could be that merely reading a single short print ad is not a very powerful persuasive mechanism to move people to support any additional political engagement on a particular topic.

Table 2: US Experiment - Human Rights vs. Moral Framing

Question	Human Rights	Moral
Read more	56% willing	55%
Petition	76% likely/high likely	69%
Congress	33% likely/high likely	32%
Paper	21% likely/high likely	24%
Family	66% likely/high likely	62%
Donate*	53% likely/high likely	41%
Join	26% likely/high likely	24%
Health Human Rights	71% universal human right	70%

* Differences statistically significant at <.10 level

Survey 6: India Access Experiment # 2

To assess whether the previous study reflected only on a sub-population of the United States, we conducted a second experiment in India of 208 respondents to assess whether respondents of a different nationality share the same reactions to differential framing and access to medicines. Like the US sample, the India one is disproportionately male (67%), young (53% were 18-29), and highly educated (66% had a college degree with another 26% with postgraduate education). Again, this is a sample unrepresentative of the wider population in India, but has the benefit of being a non-

student, non-American sample with randomization of conditions. This study also lacks a baseline no message control condition.

There are no statistical differences between conditions, confirming the findings of the US experiment. The Indian sample was even more willing to read the additional material than the American sample. They were also more supportive of access to medicines, as measured by their willingness to sign petitions, write their local paper and their parliamentarians, talk to friends and family, join groups, and donate to causes. There was less of a marked difference for costlier actions, suggesting a particularly engaged group of respondents, not surprising given the importance of access to medicines in India and India's role as the drug maker for the world. Interestingly, the sample had similar levels of support for health as a human right (see Table 3).

Table 3: India Experiment - Human Rights vs. Moral Framing

Question	Human Rights	Moral
Read more	90% willing	91%
Petition	80% likely/highly likely	84%
Congress	91% likely/highly likely	95%
Paper	83% likely/highly likely	83%
Family	91% likely/highly likely	95%
Donate	85 % likely/highly likely	88%
Join	88 % likely/highly likely	93%
Health Human Rights	63% universal human right	75%

The two concluding survey experiments demonstrate that a human rights and moral frame are equally compelling among samples of highly educated Americans and Indians. This is suggestive, though not dispositive, that publics do not draw strong distinctions between rights-based framing and a moral/justice claim. This raises the question about whether a rights-based framing would enhance advocacy success, particularly if there are potential drawbacks at the elite level where health as a right has a more contested meaning and where rights-based language may make compromise more challenging. These studies are meant to suggest what a wider more ambitious research agenda might be. One could repeat these experiments with larger sample sizes and in different country contexts. Coming back to Keck and Sikkink, these could provide the kinds of empirical support needed to substantiate the claim that social or human rights claims lack universal appeal.

CONCLUSIONS

From this diverse set of surveys, we provisionally conclude that the broad appeal of health as a human right could help create broader support for actions to address other health causes but perhaps no more so than a moral appeal. Since these surveys are not nationally representative and limited to but two countries, it is unclear whether these findings are generalizable both within these countries and beyond. A follow-on set of experiments in more diverse national settings would be useful to assess the relative appeal of human rights appeals compared to others. As our findings in the final experiments suggest, identifying inequalities in access to health is potentially as powerful as human rights language. While the survey evidence assembled here suggests some modest support for the notion that publics view health as a human right globally, whether human rights will become a powerful organizing tool in the health space in the years to come remains to be seen.

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[1] This article builds on discussion in chapter 3 in our 2013 book *AIDS Drugs for All* (Kapstein and Busby 2013)

[2] The framing literature is extensive and has been more comprehensively discussed by one of us in previous work. See Chapter 2 in (Busby 2010). Framing in the international relations literature is imported from the social movement literature in sociology pioneered by Mayer Zald, David Snow, Sidney Tarrow and others. Snow defines framing as "the conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action" (McAdam, McCarthy, and Zald 1996, 6).

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[6] Ibid., 195.

[7] Ibid., 204–205.

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Health Security and The International Politics of Zimbabwe's Cholera Outbreak, 2008-09

Simukai Chigudu

In 2008, Zimbabwe was engulfed by a devastating cholera outbreak resulting in an unprecedented 98,000 cases and over 4,000 deaths. Cholera, however, was much more than a health crisis. The disease signified the nadir of Zimbabwe's catastrophic political and economic meltdown and became the subject of significant international attention. In this article, I examine the political discourse surrounding cholera and I demonstrate the ways in which the outbreak was framed as a global 'health security' concern. I argue that the securitization of the cholera epidemic actually hampered rather than bolstered political and global health responses to the outbreak. I suggest that political science – through theoretical and historical insights – can help us evaluate the conceptual and normative value and limitations of the ubiquitous 'health security' frame in global health governance.

INTRODUCTION

In August 2008, the impoverished urban townships in Harare's metropolitan area were engulfed by a devastating cholera outbreak. The disease rapidly spread into peri-urban and rural areas in Zimbabwe before crossing the country's borders into South Africa, Botswana, Zambia, and Mozambique. With over 98,000 suspected cases, over 4,000 confirmed deaths, and an exceptionally high case-fatality rate at the peak of the epidemic, Zimbabwe's 2008 cholera outbreak has been deemed the largest and most extensive in recorded African history[1]. Epidemiologically, the outbreak can be explained by the breakdown and cross-contamination of the city's water and sanitation systems. Such a reading, however, belies the complex interaction of political, economic, and historical factors that initially gave rise to the dysfunction of the water systems, that delineate the socio-spatial pattern of the outbreak, and that account for the fragmented and inadequate response of the national health system[2]. Cholera was thus not only a social crisis; it also signaled a new dimension to Zimbabwe's deepening political and economic crisis in 2008, which brought into question the capacity of the state and the legitimacy of the ruling party to govern. The political salience of cholera is especially apparent in the 'securitization' of the outbreak in contemporaneous public discourse. On one hand prominent outside observers, including the International Crisis Group, described cholera as 'a threat to international peace and security'[3]; while on the other, elements of the Zimbabwean government decried the outbreak as racist 'biological warfare' from the West intended to bring about regime change in the country[4].

In this article, I use Zimbabwe's cholera outbreak as a case study to engage in a wider set of debates about how political science as a discipline can help us to evaluate the conceptual and normative value of 'health security' as a guiding principle for global health governance. I locate my argument within the burgeoning scholarship on the 'securitization of health'[5,6,7] and my primary concern is with a key question in this lively and contested literature: does the security framing of disease actually improve or

diminish international attempts to govern them more effectively[8]? Methodologically, I draw on the Copenhagen School's securitization framework[9] and on 'constructivist' approaches in international relations theory[10] to analyze the discourses on cholera in global media reporting, policy papers, academic journal articles, and Zimbabwean state publications during the 2008 outbreak. My argument proceeds as follows. I begin by examining current hegemonic thinking about epidemics in the Western political imagination and I demonstrate how this relates to Africa especially with regard to the concepts of security, humanitarian crisis, and 'state failure'. Such an analysis aims to expose the different conceptions of security couched in the humanitarian disaster language used to describe Zimbabwe during the outbreak and it also foregrounds how this language was contested and co-opted by the Zimbabwean government. I then argue that the securitization of the cholera epidemic hampered rather than bolstered global health responses to the outbreak. I suggest that political science, through theoretical insights into securitization discourses and through historical insights into the trajectory of the post-colonial Zimbabwean state, can offer an account as to why the 'health security' frame can do more harm than good in certain social and political crises. I conclude by echoing calls for alternative framings of public health challenges in the domain of global health governance.

EPIDEMICS AND IDEAS REVISITED

In *Epidemics and Ideas*[11], Slack and Ranger argue that '[o]ne of the chief lessons of the [history of epidemics] is the extent to which man-made images of pestilence have shaped responses to it, whether or not they have been what we would regard as "accurate" or "rational" depictions of the phenomenon'. This insight is profoundly instructive when we examine how epidemics have emerged as a matter of global political concern. Until the early 2000s, political science as a discipline tended to ignore health issues, especially in Africa. As Boone and Batsell lament, political science and international relations were slow to grapple with Africa's public health challenges including the HIV/AIDS crisis. Such issues, it seems, were conceived of as 'too private, too biological, too microlevel and sociological, too behavioral and too cultural to attract the attention of many political scientists'[12]. However, at the turn of the twenty-first century, changes in the global politics of health have been happening apace and these developments have brought health into the central purview of political science.

Scholars frequently attribute the emergence of global health as field of study, research, and policy to the HIV/AIDS pandemic, which elevated health issues from the 'low politics' of domestic welfare and service provision to the 'high politics' of international development and security[13]. In the mid-to-late 1990s, HIV/AIDS began to garner international political attention when the World Bank redefined its paradigm for dealing with the disease: AIDS had traditionally been viewed by the Bank as a public health delivery problem but in 1999 it was reframed as a profound developmental crisis[14]. Moreover, in 2000, the disease crystallized as a major political issue when it climbed to the top of the United Nation's security agenda, second only to peacekeeping and military intervention[15]. Similarly, in the same year, the U.S. National Intelligence Council underscored the potential danger of epidemics more generally when it reported that 'the persistent infectious disease burden is likely to aggravate and, in some cases, may even provoke economic decay, social fragmentation, and political destabilization in

the hardest hit countries in the developing world'[16]. These powerful institutions thus advanced a new conceptual apparatus of thinking on health in global politics – one that highlighted the threat posed by epidemics to international security.

How do we account for this manifestly 'securitized' account of health in global politics? De Waal[17] traces the securitization of global health back to the end of the Cold War when American national security analysts began to focus on non-traditional threats to U.S. security. The case for placing health issues ever higher on national and global political agendas was advanced along fairly consistent lines: 'that new health risks appeared as a result of emerging and re-emerging diseases, increased population mobility, spreading transnational crime, environmental change and bio-terrorism; and that these posed new security dangers'[18]. Crucially, many public health advocates were actually thankful for the security alarm as it brought much-needed attention and funding[19]. Indeed, they adopted martial language themselves. Calling for the launch of a Global Fund to *Fight* HIV/AIDS, Tuberculosis and Malaria, Kofi Annan said, 'The war on AIDS will not be won without a war chest'[20].

The political prominence of the 'health security' frame has given rise to several studies, both qualitative and quantitative, seeking to delineate the empirical links between health issues and security concerns[21,22,23,24,25]. While this literature is too voluminous to summarize here, two important observations from this corpus of work must be noted for this discussion. Firstly, the putative causal links between health challenges and international instability are questionable and not supported by any strong empirical evidence[26,27,28,29,30]. But despite the lack of evidence to support such links, health issues (particularly epidemics) continue to appear on security agendas. This ties to the second observation, which is that numerous and often competing conceptions of security are deployed in this scholarship – for example: national security, biosecurity, human security and public health security[31] – thereby demonstrating that security is an 'essentially contested concept'[32]. According to Gallie, essentially contested concepts are value-laden, internally complex (that is their constituent elements are variously describable and differently valued by rival users of the concept), and mutable according to changing circumstances. Thus when security is invoked as the basis for political action, we must ask whose security is being protected and under which meaning. As such, 'health security' cannot be understood 'as an objective condition, but as something constructed by someone for some purpose'[33]. Owing to the socially constructed nature of the concept of 'health security', Elbe argues that the debate about disease and security cannot be conducted on narrow empirical grounds alone. Instead he asserts that the debate should expand to include the 'important normative questions about the long-term benefits and drawbacks of using such a security framework to respond to the disease'[34].

Securitization theory provides an analytical apparatus with which to examine the social, political, and ethical dimensions of the language of security[35]. Buzan, Wæver, and Wilde argue that labelling an issue a security threat constitutes a performative speech act. Security, they write, 'is not interesting as a sign referring to something more real; it is the utterance itself that is the act itself. By saying the words, something is done (like betting, giving a promise, naming a ship)'[36]. A security speech act has four conditions which must be fulfilled for a successful securitization to occur[37]: (1) securitizing actors must declare (2) a referent object to be existentially threatened, and must make a persuasive call for the adoption (3) of emergency measures to counter this threat, and

(4) the audience must then also accept that argument to a sufficient degree for it to become possible to do things politically that would otherwise not have been possible to do under normal or routine political conditions.

In the context of this discussion on health and global politics, securitization theory would suggest that health was historically ignored in international relations because epidemics were not framed in a way that engaged superpower interests[38]. With the end of the bipolar politics of the Cold War, perceived interests changed thereby allowing global health to emerge on the agenda of non-traditional security threats in the international system. The 'health-security' nexus has, in this way, been a primary driver for the inclusion of health on the global political agenda. This observation is born out further when one looks at the disjuncture that exists between the priority given to epidemics and the actual global burden of death and disease[39,40,41]. However other scholars in the constructivist tradition, like Prince and Marsland[42], contend that while the turn toward global health has taken shape in an ideological framework dominated by 'emergency', 'crisis', and concerns about 'global security', it has also been impelled by moral concerns for humanitarianism and that both paradigms have proven powerful forces for mobilizing resources and action. While it is tempting to read these two different ideological conceptions of global health – security and humanitarianism – as inherently contradictory, Lakoff[43] argues that they should be seen as complementary wherein humanitarianism offers 'a philanthropic palliative to nation-states lacking public health infrastructure in exchange for the right of international health organizations to monitor their populations for outbreaks that might threaten wealthy nations'.

Notably, these two approaches to global health implicitly view the nation-state, in the developing world, as threatening to either the 'international' (in the global health security paradigm) or to the 'suffering individual' (in the humanitarian paradigm). Thus, they both accord preeminence to transnational institutions and actors to remedy these pathologies of statehood in developing countries. State sovereignty, from this vantage point, is not seen as the sole prerogative of the modern state but is partially disentangled from the nation-state and mapped onto supranational and nongovernmental organizations[44]. The Zimbabwean cholera outbreak illustrates how these paradigms of global health security and humanitarianism were used to condemn the Zimbabwean state. This dynamic is accentuated and further complicated by a wider political 'demonization' of President Robert Mugabe and his party, the Zimbabwe African National Union – Patriotic Front (ZANU(PF)). To understand these dynamics and how they affected the response to cholera on the ground, it is first necessary to review what happened. In the next section, I give an account of the outbreak before going on to discuss how it was politicized in the arenas of domestic politics, international relations and global health.

AN OVERVIEW OF THE ZIMBABWEAN CHOLERA OUTBREAK

Cholera – one of the most feared infectious diseases in public health – is an acute bacterial infection of the intestine caused by the ingestion of food or water contaminated by certain strains of the organism, *Vibrio cholerae*[45] . The disease is characterized by acute watery diarrhea and vomiting and, in the most severe cases, it can be fatal due to rapid dehydration or water loss. When left untreated, mortality from 'classical' cholera

can be as high as 50%. However, with effective replacement of fluids and electrolytes, mortality can be reduced to less than 1%. Infected individuals are highly contagious, contaminating the water and food sources that their feces come into contact with. The appearance of epidemic forms of cholera is therefore treated as a public health emergency.

The world has experienced seven cholera pandemics, with the first six occurring before 1947. The seventh pandemic, defined by the emergence of a new biotype of the cholera pathogen, has primarily affected the African continent[46]. Indeed, by 1990, Africa accounted for 90% of cholera cases reported to the WHO[47]. The Horn of Africa has been particularly vulnerable. Almost all the countries in this region host refugees or have internally displaced populations living in overcrowded temporary settlements with poor sanitary conditions. The worst outbreak, in the 1990s, was among Rwandan refugees in relief camps in Goma, Democratic Republic of the Congo, resulting in 70,000 cases and 12,000 deaths[48].

Cholera outbreaks are, however, relatively rare in the absence of war. At a press teleconference in February 2009, Dr Christophe Fournier, the International Council President of Médecins Sans Frontières (MSF), made this point emphatically remarking on the exceptional health and humanitarian crisis in Zimbabwe – a country ostensibly at peace. How did such a dire situation come to pass? Musemwa[49] argues that the origins of the 2008 urban water crisis in Harare and its attendant consequences, including the cholera epidemic, extend back to the colonial period, when the present bulk water systems in the city were poorly planned and situated within the same water catchment zone as the routes of sewage discharge. Additionally, he notes, after independence the post-colonial government paid little attention to water development in the Harare where the water system had been poorly and unevenly maintained since it was first established in 1953. From 2000, when Zimbabwe's urban centers became strongholds for the opposition Movement for Democratic Change (MDC) party and voters elected MDC councilors to take charge of local authorities, ZANU(PF) embarked on a process of trying to regain urban control thereby turning urban governance into 'the object of intense political struggle, and drastically undermin[ing] the capacity of councils to deliver services'[50]. The ruling party's strategy depended on recentralizing powers over local authorities, creating 'parallel' party hierarchies, and using party-aligned militia to control key urban spaces and access to resources. In Harare's water and sanitation management, this strategy was pursued by the government's directive to the Zimbabwe National Water Authority (ZINWA) to take over the management of urban water supply and sanitation from all the urban local authorities in the country.

The consequences of the central government's increasing influence over municipal administrative functions were disastrous: a lack of accountability, an inefficient and pliable bureaucracy at the behest of the ruling party, internal struggles, and general hostility toward MDC-aligned institutions of local government[51]. Above all, such intrusive actions by ZANU(PF) in the running of the Harare City Council created political and administrative 'crisis conditions' in which the technical branches of the council were unable to deal with the emerging environmental problems competently and only received marginal control over the allocation of urban resources and services. With the economy in profound decline, Harare was afflicted by perennial water shortages. ZINWA lacked the technical, human and financial resources to supply water, to fix waterworks when pipes burst, and to dispose of sewage safely. The Integrated

Regional Information Networks (IRIN)[52] reported that ZINWA 'had been pumping raw sewage into Harare's water supply dam, Lake Chivero' and that 'when supplies are available, the water coming out of the taps often emits a pungent smell'. The water flowing through the water systems in the capital had not been chlorinated and often contained green algae owing to the failure of ZINWA to purchase the required chemicals for treatment because of a shortage of foreign currency.

These conditions engendered the 'perfect storm' for the cholera outbreak. Musemwa[53] and Youde[54] recount how the outbreak unfolded. The first cases were reported in August 2008 with 11 deaths by September. The Norwegian government responded quickly with US$7 million for water treatment but this did not stop the disease's spread. On 2 December, the WHO announced that since August, the Zimbabwean Ministry of Health and Child Welfare had recorded 11,735 cases of cholera and 484 deaths throughout the country. In some rural areas, cholera mortality rates reached a staggering 20 to 30 per cent. Having initially denied the presence of an outbreak, the Zimbabwean government declared a national emergency by early December and finally appealed to the international community for further assistance. The United Kingdom, United States, European Commission, the International Federation of the Red Cross, and MSF among others, provided funds and technical support. By February 2009, the WHO counted nearly 80,000 suspected cases of cholera and 3,713 deaths. At this point, there were 365 cholera treatment centers and units throughout the country. But even with this assistance and attention, WHO officials remained pessimistic about the chances of a quick resolution: 'Given the outbreak's dynamic, in the context of a dilapidated water and sanitation infrastructure and a weak health system, the practical implementation of control measures remains a challenge'[55]. Indeed, half of those who died of cholera failed to reach a cholera treatment facility. In March 2009, the situation started to improve as both the incidence of cases and the case fatality rate began to decline. By late May 2009, WHO had recorded a cumulative total 98,424 cases of cholera and 4,276 deaths in 55 of 62 districts since the start of the outbreak, which had had largely abated by mid-2009.

THE POLITICIZATION OF CHOLERA: 'STATE FAILURE' AND 'STATE SOVEREIGNTY'

The dramatic scale and devastating impact of the epidemic precipitated a political outcry. Many commentators in the international community asserted that the 'Zimbabwean government [had] clearly demonstrated its willingness to subvert the health needs of its citizens to its own political designs' suggesting that Mugabe and ZANU(PF) were 'pariahs' evincing blatant disregard for the wellbeing of Zimbabweans and were singularly preoccupied with the pursuit of political power[56]. The portrayal of Zimbabwe as a 'pathological', 'pariah' or 'failed' state was affirmed and circulated in a number of policy-oriented research papers, reports by humanitarian NGOs, and the mainstream international media. These accounts, as I argue further below, couched the cholera epidemic in a narrative that centered on state collapse caused by oppressive political leadership.

Patrick[57], writing for the Council on Foreign Relations, asserted that Zimbabwe's health crisis, epitomized by the cholera epidemic, could be 'attributed to the decay of state institutions and infrastructure' under the 'brutal regime' of the 'despot Robert Mugabe'. Similarly, *The New York Times* blamed Mugabe's government for the cholera

crisis because of its avaricious pursuit of 'power and money'[58]. Prominent reports by the International Crisis Group (ICG)[59] and Physicians for Human Rights[60] characterized the Zimbabwean situation, and specifically the cholera outbreak, in terms of 'state failure' and thus as a potential target for military intervention. Both reports charged that Zimbabwe ought to be dealt with according to the 'responsibility to protect' (R2P) norm – a doctrine ratified by the UN General Assembly at the 2005 World Summit and subsequently endorsed by the Security Council which, 'states that a government has the responsibility to protect its population from mass atrocity crimes … and to the extent it is unable or unwilling to do so, the responsibility falls to the international community to take appropriate action'[61]. From this, they argued that the complete collapse of the country's health system was putting at risk many thousands of lives and could itself be 'characterized as involving the commission of a crime against humanity'[62]. Furthermore, the reports stated that the regional spread of cholera could present a 'threat to international peace and security'.

While the ZANU(PF) government was receiving widespread international condemnation and *ad hominem* attacks were launched at President Mugabe, the cholera epidemic provoked a belligerent counter-narrative in Zimbabwe. President Mugabe and his ministers seized upon the cholera outbreak to launch a 'daring vitriolic attack on the West and accused it of being the source of the cholera'[63]. In charges harking back to the armed liberation struggle during which the Rhodesian army used biological warfare, by spreading weaponized anthrax pathogens on guerrillas and rural blacks[64], the Minister of Information at the time, Dr Sikhanyiso Ndlovu, accused the West of deploying similar tactics in Zimbabwe[65]. Ndlovu claimed that British agents had clandestinely entered Zimbabwe to spread cholera and anthrax as a biological weapon:

> *Cholera is a calculated racist terrorist attack on Zimbabwe by the unrepentant former colonial power [Britain] which has enlisted support from its American and Western allies so that they can invade the country, install their stooge who will allow them to repossess our resources . . . British operatives are in the country now under disguise and have increased cholera and anthrax seeding. There has been a replanting of cholera and anthrax . . . This is a serious biological and genocidal warfare on our people by the British, still fighting to recolonize Zimbabwe*[66].

This accusation fits into the discursive practices of the ZANU(PF) party that has used a narrative of 'patriotic history' to tap into grievances and popular memory in order to legitimize its regime as an on-going vanguard of Zimbabwean liberation against an external and (neo-)colonial threat as represented by the West, particularly Britain[67,68,69]. We can thus see a 'health-security' discourse being simultaneously invoked as a basis for international humanitarian intervention *and* as a claim to safeguarding national sovereignty. Rao argues that what is being contested here is a:

> *spatial allocation of culpability in which problems are represented as arising from local dynamics internal to the putatively dysfunctional states that are the objects of intervention, while the 'international' is read as a sanitized space populated by heroic actors ready to rescue people in these benighted locales. Conversely, [nationalist] voices [tend] to valorize state sovereignty by exaggerating the risks of neocolonial predation by external actors and obscuring*

> *the culpability of postcolonial states in impeding the enjoyment of self-determination by their societies.*[70]

Rao's insight helps us make sense of the fundamental ways in which Zimbabwean 'statehood' was discursively contested during the outbreak. President Mugabe himself prematurely declared the cholera outbreak over in mid-December 2008 – several months before its actual end – and argued that the disease's presence could no longer be used as a pretext for the British and Americans to justify an invasion of the country: 'Now that there is no cholera, there is no case for war'[71]. International actors[72], however, saw these pronouncements, coupled with the government's earlier inaction toward the disease, as delegitimizing the government's claim to manage cholera on its own and they argued that such statements 'raise doubts about the government's ability to serve as a good partner through which international donors can operate'[73].

Much of the political rhetoric about cholera, while morally charged and intuitively appealing, conflated highly complex processes and reduced different phenomena – for instance, the cholera outbreak, political violence, and the economic crisis – to a single debate pitting international charges of 'state failure' against nationalist claims to 'state sovereignty'. The polarization of perspectives on the cholera crisis in this way mirrors a longer trend in the relations between Zimbabwe and the West, particularly Britain, which Tendi characterizes as 'mutual demonization'[74]. Since 2000, the New Labour government and British media's representations of events in Zimbabwe frequently demonized both ZANU(PF) and Mugabe while, in response, ZANU(PF) accused Britain of 'evil' machinations and interfering in its internal affairs. Tendi draws a distinction between normative and instrumental demonization. Britain's demonization of Mugabe and ZANU(PF) was normative – that is, it drew on a set of moral beliefs about its foreign policy to 'do good' in Africa[75]. By contrast, instrumental demonization underlines the agency of Mugabe and ZANU(PF), who found it useful to demonize Britain, and the West, in order to serve domestic agendas. Demonization of Britain was useful for Mugabe, particularly insofar as ZANU(PF) portrayed the opposition MDC as a party formed and controlled by the British government and thus an illegitimate voice when critiquing the mismanagement of the cholera outbreak. For Mugabe, the MDC was 'evil' by association with Britain: 'we cannot discuss with allies of the West. The devil is the devil and we have no idea of supping with the devil'[76]. Associating the MDC with the 'evil' British government, Tendi concludes, was part of wider endeavors to undermine domestic opposition and to seal off Thabo Mbeki's attempts to mediate a meaningful negotiation between the ruling party and the MDC about the formation of a power-sharing government, which the South African president viewed as a means of resolving part of the Zimbabwean crisis. In this way, external normative demonization during a genuine public health crisis was re-appropriated in the service of internal repression.

It is also important to underscore that Mugabe's use of demonization was not exclusively instrumental. It was also born out of genuine historical grievance against the British Labour Party's ahistorical moral approach to land reform in Zimbabwe. Furthermore, Mugabe's insistence on the need to protect Zimbabwean sovereignty – while fabricated in the accusations of Britain causing cholera – did have a modicum of truth insofar as Tony Blair had, in the early 2000s, secretly canvassed for military intervention in Zimbabwe[77]. I point this out not to act as an apologist for Mugabe or

ZANU(PF) but to highlight that the statements from the Zimbabwean government, which international commentators found hostile and contrived, have a specific historical and contextual basis, which lends them some popular credence and serves certain political purposes. Moreover, the 'health security' framing of the cholera outbreak became entangled in this longer political history of Zimbabwe's troubled international relations and it carried important negative consequences – it delayed the humanitarian relief effort[78], promoted non-engagement between the Zimbabwean and Western governments[79], and narrowed down the avenues for third-party diplomatic mediation[80]:

> *Many thought that the West, through its actions, was feeding Mugabe's obduracy because, once the stand-off started, Mugabe came under pressure from his party and the army leadership not to capitulate. This began a "blinking competition," and obviously the Zimbabwean people were the victims.*[81]

Ultimately, the outbreak of cholera drew poignant attention to the vulnerability of the communities affected by the disease and the need to speed up the negotiations over the implementation of a Global Political Agreement – brokered by the Southern Africa Development Community (SADC) – between the erstwhile political enemies, the MDC-Tsvangirai (MDC-T), MDC-Mutambara (MDC-M) and ZANU-PF. The catastrophic nature of the outbreak may very well have catalyzed the final implementation of the power-sharing deal on 11 and 13 February 2009. Though by no means the only factor that spurred on negotiations between the three, the epidemic marked a 'momentous and emblematic moment' in the resolution of the conflict in that it set the scene for the SADC region and to force the MDC-T, MDC-M and ZANU(PF) to reach a compromise[82].

CONCLUSION

In this article, I have engaged seriously with a key question in the call of this special issue of *Global Health Governance*: how can political science help us better analyze the international politics of global health? By primarily using the constructivist approach in international relations theory, I have argued that there are two major discourses – global health security and humanitarianism – that animate much of the global politics of health. I have paid particular attention to how the 2008-09 cholera outbreak in Zimbabwe was constructed as a security threat and violation of human rights based on the messages, narratives and policy prescriptions of a number of important norm entrepreneurs in global health. The ICG report is the starkest example of this as it explicitly bridges a humanitarian discourse with fears that the cholera epidemic could present a threat to 'international peace and security'. Thus, it not only highlights the need for humanitarian aid but also considers military, and other aggressive, interventions to remove Mugabe from power – an eminently political agenda driven by interests that extend far beyond ensuring the health of ordinary Zimbabweans. Conversely, these same narratives were coopted and manipulated by elites in Zimbabwe and used as a pretext for the ZANU(PF) government to claim that it was protecting the country's sovereignty while blocking desperately needed humanitarian aid and initially denying the extent of the outbreak.

This case study offers a cautionary tale about the risks of framing epidemics as security threats during complex social and political crises. Of course, it must be acknowledged that the 'health security' frame can be politically expedient and it does have a lot of potential to achieve a great degree of social good. For instance, Elbe points out that securitization can be an effective tool for increasing international aid and 'provoking African governments … into taking [health issues] more seriously within their domestic politics'[83]. However, if the 'health security' frame is to remain a conceptual pillar in global health governance then it ought to be invoked with tremendous caution and contextual specificity and, where possible, epidemics, like the cholera outbreak, should be the objects of 'international and transnational humanitarian assistance, [and] not [used] for the garrisoning of states behind national boundaries and national security rhetoric'[84].

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Connecting Global Goals to Local Priorities

Duff Gillespie, Michelle Hawks Cuellar, Sarah Whitmarsh, Alison Bodenheimer and Sabrina Karklins

Like other global initiatives, the United Nations Millennium Development Goals (MDGs) have had mixed results. One reason global efforts fall short is they ignore decentralization. This paper examines the challenges of implementing global initiatives, using Family Planning 2020 (FP2020) as a case study. FP2020's goal is enabling 120 million more women and girls to use modern contraceptives by 2020. Thirty-six developing countries have made FP2020 commitments, but these countries have thousands of governing entities that will determine the priority family planning programs receive. Advance Family Planning (AFP) works with local partners to influence family planning decisions. We examine AFP's experience in Indonesia, Kenya and Senegal to describe and analyze the incongruity between FP2020's objectives and those of subnational decision makers and what must happen for local goals to reflect global goals.

INTRODUCTION

The development field is characterized by a plethora of global calls-to-action, initiatives, funding mechanisms and declarations. Some of these, such as the eradication of smallpox and the near eradication of polio, have been highly successful. However, spectacular successes are the exception and most initiatives, such as the Millennium Development Goals (MDGs), have had mixed results.[1]

One reason why global initiatives have been unsuccessful is their lack of addressing the decentralization of political systems and decision-making. Decentralization has led to the devolution of important funding and programmatic decisions to subnational governing units. As Parker notes, "devolution is the transfer of resources and power to lower level authorities, which are largely independent of higher levels of government, and which are democratic to some degree."[2] However, while most countries have decentralized administrative units, not all have devolved meaningful power to these entities.

The donor community has encouraged the decentralization and devolution of governments. For example, the World Bank allocated $10.6 billion to decentralization projects between 1990 and 2006.[3] Yet, there is no unambiguous evidence that devolving power to lower levels of governments makes them more responsive and leads to wiser and more effective decisions. The evidence showing that decentralization increases access to health services is decidedly mixed.[4,5,6]

This paper examines the tenuous link between global initiatives and decision making at the subnational level and shows how advocacy interventions, such as the Advance Family Planning SMART approach can ameliorate the link between global agendas and their implementation at lower levels of government.[7] Further, we demonstrate how non-state actors can positively impact agenda setting and policy implementation at the subnational level and in doing so help to establish a bridge

between the global and local agendas.[8] We use the Family Planning 2020 (FP2020) partnership as a case study and analyze the incongruity between FP2020's objectives and those of subnational decision makers and what must happen for local goals to reflect global goals.

FP2020 AND DECENTRALIZATION

FP2020 was launched at a 2012 London Summit organized by the United Kingdom and the Bill & Melinda Gates Foundation. Donors pledged $2.6 billion and developing countries $2 billion over the eight years leading up to 2020. Equally important, developing countries announced the steps they would take to contribute to FP2020's goal "to expand access to voluntary family planning information, services and supplies to an additional 120 million women by 2020."[9] The FP2020 partnership currently includes 44 countries, including 36 developing countries.

Of the 3 FP2020 commitments made, some were general, such as Burkina Faso's pledge to "take action in terms of policy funding and programming." Others, like Malawi's, were specific: to raise the contraceptive prevalence rate (CPR) "to 60% by 2020 with a focused increase in those aged 15 to 24 [and to] raise the age of marriage to 18 by 2014." While developing countries frequently noted the importance of providing services at the community level, their emphasis was on national budgets, policies and goals and did not mention the importance of gaining the support of subnational units of their government. Rwanda was the exception when it pledged to ensure "…the availability of family planning services in each of the 14,841 administrative villages through delivery by …45,000 health workers."[10]

The success of FP2020 cannot solely depend on the actions of national governments, but requires actions by thousands of subnational government units. While gathering accurate information on the number and characteristics of tens of thousands subnational units is problematic, a conservative estimate is that the 36 developing countries making FP2020 commitments have approximately 980,000 subnational units that will make budgetary, policy, programmatic and leadership decisions affecting FP2020's progress or lack thereof. Table 1 shows the number of government units for four governance levels in FP2020 countries.

Table 1: Governmental Units in FP2020 Commitment Countries

Countries	36
Regions/States/Provinces/Zones	1,424
Districts/Departments/Counties	20,505
Local Administrative Units	963,079
Total	**985,040**

Sources: Official Government websites, CIA World Factbook, and AFP Partner Landscape Assessments
**Numbers were calculated using internet sources and AFP partner Landscape Assessments. Calculations of administrative units at the lower levels are likely to be gross underestimates, as few FP2020 countries publish data on the number of active local government authorities.*

Established in 2009, Advance Family Planning (AFP) preceded the FP2020 partnership. AFP is an advocacy initiative comprising 20 partner organizations working to increase the financial investments and political commitment needed to ensure access to quality, voluntary family planning through evidence-based advocacy. At the heart of AFP's successes is its focused AFP SMART advocacy approach.[11] The application of this approach across the ten AFP focus countries (Bangladesh, Burkina Faso, Democratic Republic of the Congo, India, Indonesia, Kenya, Nigeria, Senegal, Tanzania and Uganda) has led to over 200 concrete policy gains.[12] As all ten project countries embraced FP2020, AFP's explicit objective became helping countries achieve their FP2020 commitments. In Keck and Sikkink's characterization, AFP is a transnational advocacy network consisting of mostly non-state advocates that share strategies and tactics to achieve FP2020's objectives.[13] Although this network operates at the global, regional, and national levels, this paper focuses on subnational advocacy.

It is difficult to generalize to what extent actual decision-making authority has devolved at each subnational level in these countries. Indeed, within countries it is not unusual to find significant variation on how subnational units apply their devolved authority. In the nine countries in which AFP works, considerable budget and programmatic authority has devolved to the district/county/commune level. However, not all important decisions involve money and programs. Some local leaders have little direct budget and programmatic decision-making authority, but their support is important in promoting government programs and holding governments accountable for poorly- performing programs.

AFP'S APPROACH TO UNDERSTANDING AND INFLUENCING DECENTRALIZATION

AFP's advocacy approach is evidence based and policymaker-centric. While the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health provides support and technical assistance for AFP, in-country advocacy activities are directed and implemented by local non-governmental organizations, usually through working groups. Working groups localize the AFP approach. The manner in which advocacy activities are implemented varies from one group to the other.

One key element of the AFP approach is that all activities align with national government goals. As one Tanzanian colleague said, "AFP swims with the current." This common ground enables AFP to work in partnership with the national government, which often participates actively in advocacy activities. Such a close working relationship would not be possible if AFP advocated for changes not usually supported by the government, such as sexual and reproductive rights.

From the outset it became clear that focusing only on the national level was necessary but not sufficient to the twin objectives of increasing resources and ensuring a favorable policy and regulatory environment for family planning. As a Nigerian colleague said,

> *There are obviously merits and demerits for both a centralized and decentralized system, but most of the support for FP (family planning) in Nigeria, whether funding, policy, etc., have mainly come from the federal government. In a decentralized system like ours, the other tiers of government*

are expected to make contributions, but most states don't, either because family planning is not a priority or there are powerful forces opposed to it.[14]

While Nigeria's 774 Local Government Agencies play an important role in health-related decisions, AFP lacked the resources to establish advocacy initiatives at that level and would be overwhelmed just thinking about starting advocacy activities in India's 594,000 villages. Independently, each country program decided what level they would concentrate on. While all countries have some national-level advocacy, their focus is on subnational levels. AFP has increasingly concentrated on subnational levels. The nomenclature for levels of governance varies greatly, but most advocacy energy is expended at levels two (state, county, province) and three (district, municipality, commune).

The AFP advocacy approach builds on the same premises as decentralization. It assumes that, relative to higher order governing jurisdictions, local government officials will be more accessible to community leaders, local actors will be more knowledgeable about local issues, and policy and programmatic decisions will better reflect the population's needs and be more effective. In a sense, AFP seeks to help communities realize the promise of devolution.

Successful governmental devolution must include some fiscal decentralization since it supplies financial resources, and some administrative decentralization since it provides the bureaucratic resources required for implementation.[15] Authorities at lower levels in political systems will flounder if they lack financial resources and the administrative capacity and sources to implement development projects.

To better understand how devolution can impact family planning programs, we look closely at Indonesia, Kenya and Senegal. Each country offers a different lens through which to examine devolution. Devolution of Indonesia's program in 2000 stalled the country's family planning program. Kenya and Senegal's devolution is quite recent, 2013 and 2014, respectively. Kenya has one of sub-Saharan Africa's stronger family planning programs and it is too early to determine if decentralization will be a positive or negative force for family planning. In contrast, Senegal only recently mounted a serious family planning program. Also, Senegal is much smaller and has fewer resources than Indonesia and Kenya.

INDONESIA

Indonesia's national family planning program was at the forefront of promoting a community-based approach using mass media and evidence-based planning to improve contraceptive method mix, including the pioneering of the use of implants. The country's family planning program was strongly supported by former President Suharto and was driven and funded by a 55,000 person strong National Family Planning Coordinating Board, BKKBN.

This top-down, well-funded program increased the modern contraceptive prevalence rate (mCPR) from 47 percent in 1991 to around 57 percent in 2003. During this same period, the total fertility rate (TFR) dropped from 3 to 2.6. However, the program has stagnated. The country's mCPR is essentially the same as it was in 2003, and its TFR has stalled at 2.6 since 2003.[16]

Indonesia's national leaders are quite concerned by the country's stalled program and see the devolution of its health program in 2000 as the cause. Speaking in a 2013 conference on the country's FP2020 goals, then-Vice President Boediono noted that, "Since *Reformasi,* the post-Suharto democracy movement leading to denationalization, over a decade ago, family planning …has not received the same spotlight as other development issues…." He went on to say,

> *Not all heads of provinces and districts care about family planning because it is considered a long term program….This does not go well with the local political cycle. It is up to us to get them to care about it again. It will be a matter of using persuasive communication.*[17]

Devolution has transformed governance in Indonesia. At independence in 1945 the country had eight provinces. It now has 34 provinces with 413 districts, 98 municipalities, 6,982 sub-districts and 80,714 villages.[18] This proliferation of subnational governments makes Vice President Boediono's charge to make local political leaders care about family planning a daunting challenge.

Revitalizing Family Planning Efforts at the District Level

Overwhelmingly, Indonesian policymakers at all levels believe in family planning, but since devolution, seldom do they include it on their agendas. AFP-Indonesia aims to convince local policymakers to increase their commitment to family planning in concrete ways, such as increased funding. As in other AFP countries, the primary change agent is the district working group. Using the AFP SMART approach to guide them, groups developed specific, actionable asks for policymakers. A local BKKBN representative usually leads the group.

AFP-Indonesia has worked in five districts for three to five years. All working groups identified increasing the funding for family planning. Table 2 shows their efforts have resulted in dramatic yearly budget increases in family planning and related budgets. On average, most of Indonesia's 500+ districts allocate only about 0.04-0.2% of their annual district budget to family planning. Seldom do they…….. increase funds more than 5% annually. In AFP's, yearly district budgets have increased by 34.7% (2012), 36.6% (2013), and 20.2% (2014). Or, taken together, an average yearly district budget increase of 30.5%. Not all districts broke their budgets down to specific areas, but rather indicated that funds were allocated for women's empowerment, family planning and community development. For those that did have a family planning line, the percent for family planning ranged from 16% to 31%.

The additional financial resources fund activities intended to increase access to long-acting and permanent methods (LAPM) of contraceptives, (i.e. IUDs, implants, and male and female sterilization). The districts were successful in increasing the availability of LAPMs. From 2012 to 2014, the percentage of new LAPM acceptors increased by 9.5%, a major increase for a population with over 60% contraceptive prevalence.[19]

Although most district working groups focused on district-level objectives, they appreciated that their actions needed impact on programs at the community level. For instance, Bandung's working group worked to increase family planning in the district's 270 villages. Working with the influential Associations of Indonesian Village

Governments (Asosiasi Pemerintahan Desa Seluruh Indonesia, or APDESI), discussions and workshops were held with village leaders on how they might improve the family planning program in their communities. All villages have a small, discretionary budget, the Village Equity Budget. As a result of these discussions, AFP-Indonesia and APDESI convinced all 270 villages in 2012 to allocate 2.5 million IDR ($200 USD) for such things as counseling and transportation to health centers. By 2014 the village budgets for family planning ranged from $410 to $1,200 USD.

Table 2: AFP District Budgets for Family Planning and Family Planning-related Programs, USD

Districts	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Bandung	587,753	511,441	612,909	700,473	1,060,718	n/a
% increase/year		**-13%**	**19.8%**	**14.3%**	**51.4%**	
*Bogor**		716,548	951,219	1,405,646	2,272,727	n/a
% increase/year			**32.8%**	**47.8%**	**61.7%**	
*Karanganyar**		n/a	104,039	174,927	208,189	398,745
% increase/year				**68.1%**	**19%**	**91.5%**
*Karawang**		40,962	80,113	95,897	98,881	102,670
% increase/year			**95.6%**	**19.7%**	**3.1%**	**3.8%**
Pontianak	62,556	124,877	113,112	150,750	99,066	86,201
% increase/year		**99.6%**	**-9.4%**	**33.3%**	**-34.3%**	**-13.0%**

Source: CIPTA Annual Report: 2014
**AFP advocacy activities began in 2012. Bandung and Pontianak began in 2010; Bandung and Bogor ended in 2014.*
***Indonesian Rupiahs were converted to US Dollars using average historical exchange rates for each corresponding year using oanda.com.*

Next Steps: Sustainability and Scale-up

All externally funded projects face two formidable challenges. First, will the activity continue after the project ends? And, second, can the project be scaled-up to be sufficiently large to have an impact at the national level? If either of these challenges is not met, the lasting benefits flowing from the project will, at best, be marginal.

In order to encourage their longevity, mayoral decrees have formalized the working groups. All the districts are seeking district funds to pay for modest operational costs. In 2014 the district of Karanganyar allocated $1,180 USD to its working group. Similar support remains an advocacy objective in the other four districts.

Spreading district working groups throughout the archipelago requires adaptation and adoption by the government. Beginning late in 2014, BKKBN and AFP-Indonesia began a process to scale-up working groups to new districts. As part of the government's family planning revitalization program, KB Kencana, BKKBN and AFP-Indonesia partnered on a cost-sharing initiative to establish working groups in 30 additional districts. BKKBN has budgeted $1.2 million and AFP $231,000 USD. The expansion into the four provinces of Maluku, Papua, South Sulawesi, and East Java began in September 2014.

KENYA

After years of negotiations, Kenya promulgated a boldly progressive Constitution in 2010. Its Bill of Rights ensures, among other things, the right to reproductive health. The centerpiece of the Constitution was the creation of 47 counties and county assemblies, and the devolution of considerable power to this new level of governance, including the provision of health services. Official decentralization, also referred to as 'devolved system of government' took place in March 2013 when 47 governors and county legislators were elected to office.[20, 21]

The timing and speed of decentralization of fiscal and administrative authority to the counties did not take into account that governing structures were not yet in place. Governors and other key decision-makers also lacked prior experience in operating a devolved system of government. As a result, devolution is in a nascent stage. AFP's role was to accelerate the transfer of skills and knowledge in order for county leadership to adequately budget and implement policies to not only continue, but also improve family programs within selected counties.

Kenya made a comprehensive FP2020 commitment in London with an ambitious goal to increase contraceptive prevalence to 70% by 2030.[22] With budget and programmatic decisions now in the hands of county leaders facing a long list of competing priorities, how to effectively implement the FP2020 commitment was uncertain. With the possibility of stock-outs in the not-too-distant future, an immediate concern was funding for contraceptives and family planning services in general. Prior to decentralization, family planning was the responsibility of the national government with an annual budget allocation of approximately $6.5 million earmarked for contraceptives. The National Treasury circulated a template for counties to use when submitting their annual budget requests to the Controller of Budget. Unfortunately, the template did not include a budget line allocation for contraceptives or family planning in general.

Meetings between AFP-Kenya and the Controller of the Budget coupled with additional efforts by Ministry of Health and key family planning stakeholders resulted in the National Treasury issuing supplementary instructions to counties on how to allocate funds not only from the national budget, but also how to access donor funds.[23] The "how" to get contraceptives was now addressed, but making sure counties actually requested funds for contraceptives and family planning as a whole was the next step and required additional advocacy.

Next Steps: Ensuring Family Planning Prioritization with Decentralization

The National Family Planning Costed Implementation Plan 2012-2016[24] provides an outline of activities that county governments are expected to implement. While counties did develop health plans they neglected to draft plans for family planning. Without inclusion in the plan, there is no basis for prioritizing and budgeting family planning. Working in four counties (Kakamega, Kitui, Siaya, and Tharaka Nithi), AFP-Kenya convinced and helped decision makers to draft, approve, and implement five-year (2014-2018) county costed implementation plans (CIP) for family planning. Counties now have a framework to allocate funding for family planning.

Gaining support for CIPs among county decision-makers required a multi-prong advocacy strategy. Multiple meetings with the county health management teams, county ministers of health, and the governors' offices emphasized the importance of family planning for socioeconomic progress. After receiving the leaders' endorsement, an assessment of the county's program was completed, civil society groups' support was gained, and CIP drafting workshops conducted with local stakeholders. Each CIP outlined a number of objectives including provider trainings, efficient commodities procurement, infrastructure improvements, and demand creation.

The county leadership in AFP focus counties- Kakamaga, Tharaka Nithi, Kitui, and Siaya approved the CIPs. These plans had five-year total budget allocations of, respectively: $3 million for Kakamega and Tharaka Nithi, $6.8 million for Kitui, and $9.2 million for Siaya. AFP-Kenya worked intensively with civil society groups, key community leaders, and influential decision-makers throughout the eight-month process leading to the CIPs. Family planning CIPs are a powerful way to ensure that family planning remains a priority in a decentralized system. This foundation has led to concrete budget allocations for family planning. In the 2015-2016 fiscal year, the four counties allocated approximately US$246,300 towards family planning for the first time.

SENEGAL

Following Senegal's independence in 1960, decentralization occurred in three stages through acts passed in 1972, 1996 and 2014. Senegal now has 14 regions, 45 departments, 172 urban communes, 385 rural communes, and 12,544 villages.[20, 21] A mayor who is elected every five years and is assisted by a municipal council of elected officials governs each of the 557 communes of Senegal.

At the London Summit, Senegal pledged to increase its annual budget for reproductive health from 2.5% to 5%, increase the budget for contraceptives by 200%, and increase CPR from 12% in 2010 to 27% by 2015.[22] This commitment builds on an earlier 2011 pledge made as part of the Ouagadougou Partnership, in which nine Francophone West African countries agreed to take concrete actions to increase the use of family planning.[23] Senegal has made progress toward achieving these ambitious goals, with the CPR reaching 21% in 2015[24] and achieving a 200% increase in the allocation and expenditure of the contraceptive budget, a total of 300 million FCFA ($507,000 USD).[25]

Unlike most global initiatives, the Ouagadougou Partnership recognizes the importance of decentralization in its three D framework of Democratize, Demedicalize, and Decentralize. Its Call to Action states:

> *Decentralization aims to strengthen health systems at the regional, district, and community levels to be able to effectively manage quality family planning services while improving governance, accountability, and cross-sectorial collaboration.*[26]

Following the London Summit, the government's Directorate for Reproductive Health and Child Survival and within it, Division for Family Planning, launched its National Family Planning Action Plan for 2012-2015 (NFPAP). Decentralization is a

fundamental principle in the NFPAP such that the regions and not just the national government were involved in all steps in its development. As the Minister of Health and Social Welfare Dr. Awa Marie Coll-Seck outlined in the foreword to the NFPAP, the plan "essentially concerns the decentralization and democratization of health and reproductive services, as well as the task-shifting/sharing."[27] Further, the NFPAP emphasizes coordination of family planning activities at both the central and regional levels, since it relies on more significant involvement of the regions in the monitoring of activities than previous initiatives.[28]

Gaining FP Support at the Commune Level

When Senegal made its FP2020 commitment, it highlighted the important role that subnational governments would play in its implementation. In presenting Senegal's FP2020 commitment, Dr. Coll-Seck called upon stakeholders to "leverage networks of… local champions to advocate for family planning."[29] Specifically, each of the country's 557 mayors has decision-making power over his or her annual communal development plan and accompanying budget. However, there was little evidence that mayors knew about FP2020, much less championed it. Implementing a communal advocacy plan to convince mayors to support family planning was AFP-Senegal's top priority.

AFP-Senegal and local stakeholders responded to Coll-Seck's Call to Action by encouraging mayors to allocate their own funds to family planning. As of August 1, 2016, the mayors of 16 communes have allocated a total of $58,100 USD from their communal budgets to family planning. These were the first ever allocations made for family planning. The communes funded or will fund the most pressing needs identified by local service providers. Such responsiveness is possible by devolution.

Next Steps: Scaling Up Mayoral Commitment

Clearly, mobilizing the country's mayors is key to achieving Senegal's FP2020 goals. There are many challenges in obtaining mayoral commitment, including the needed actions at the national level. Mayors get their budgets from their domains, which, in turn, have funds, transferred from the national budget. These transfers have been extremely slow, making it difficult to implement commune-funding plans. For a mobilization of mayors to happen, there needs to be a parallel effort to make the central government more responsive to local government needs. AFP-Senegal has found that support from the national government is also critical in establishing a system to define and track indicators to ensure that targeted financial allocations at the commune level are leading to impact. To this end, the representative of the national government in the department of Pikine, the Prefect, signed an Act in November 2015 creating the first departmental committee to monitor mayors' allocations and evaluate subsequent family planning activities. This subnational accountability mechanism is to be replicated in additional departments in Senegal.

CONCLUSION

As a result of decentralization and subsequent devolution, important funding and programmatic decisions have been vested to subnational units of governments. National priorities, including commitments to global initiatives like FP2020, cannot be realized unless decisions supporting them are made at subnational levels. In countries where AFP works the FP2020 commitment was well known at the national level but less so at the second and much less so at lower levels of governance. An Indian partner's assessment is typical.

> *Some senior officials at the national level have internalized the FP2020 philosophy quite well. Dissemination of FP2020 priorities was organized and most state officials are at least aware of the state's commitments. Still, it will not be wrong to say that leadership at the subnational level does not have knowledge about national initiatives.*[30]

Of course, not all international initiatives are unknown at the subnational level. Well financed, donor-driven initiatives that are characterized by organized educational and service campaigns, such as polio eradication and the fight against HIV/AIDS, are widely known throughout their focus countries. But most development areas will not have such a high donor priority and be so well financed. Also, donors and host countries are much less enamored with such campaigns that distort or bypass a country's health system. Lastly, it is highly unlikely that the donor community has a willingness to fund more of these effective but very expensive initiatives. Instead, future global initiatives will be more like FP2020 where donor and developing world partners promote the global undertaking, but individual countries are expected to support and implement their national commitment. If national commitments are not driven at the subnational level, both global and national goals will be missed. Considering the importance of decentralization to the success of development programs, we examined if it is featured in the conversation around the post-2015 development agenda.

The Sustainable Development Goals (SDGs), which succeeded the MDGs, were launched in September 2015. To determine the attention decentralization receives, we used ATLAS.ti 6.2, to conduct a word and content analysis of three key documents to capture important streams in the deliberations of the post-2015 agenda.[31,32,33]Also examined is the second annual progress report for FP2020.[34] Decentralization, and such related concepts as devolution and subnational governance, was noted only 26 times in the combined 384 pages of the four reports. Specifically, out of the 116,389 words in the report only 1,498 words directly or indirectly discussed decentralization. The FP2020 Progress report gave decentralization the most attention and explicitly, albeit briefly, recognized the importance of addressing decentralization if FP2020's goals were to be realized. Still, less than half-a-page out of the report's 215 pages was dedicated to the subject. Appreciating that the success of the SDGs is dependent on the support of subnational governance, the lack of any strategy mobilizing support is surprising and does not bode well for their success.[35]

Global initiatives can be embraced by subnational governments if national leaders and other change agents, such as donors and nongovernmental organizations, promote them. This is happening in Kenya. As one Kenyan advocate said,

> *The FP2020 initiative has rejuvenated family planning and is propelling actors in Kenya to engage with decision-makers to increase investment and commitment to achieve FP2020's goals. It is the drive behind setting up national and county level advocacy groups and eliminating policy barriers.*[36]

Convincing government officials at all levels to invest in family planning can help FP2020. The Kenyan colleague quoted above also noted that county governors seldom come from the health sector and lack familiarity with health and family planning. In AFP much of the advocacy process involves educating decision-makers about why family planning should be their priority. Messages framed by the governments' FP2020 commitment gives them legitimacy and importance.

In advocacy, the devil is often in the details. A decision-maker's decision to do something does not mean it will be done or done well. In Kenya's newly created counties, not only was there no budget allocation for family planning, but government officials were uncertain how to estimate their counties' needs. Advocacy often involves learning minutiae in the governing process. How are contraceptives procured? Who has to approve a new guidance? What is the accreditation requirement for midwives? These are the questions that must be effectively addressed at the subnational level if FP2020's goal is to be realized.

One of the most difficult parts of advocacy is sustaining a win. Getting funding for one year does not mean that funding will be secured for subsequent years or that the amount will increase. The village and district budget increases over time in Indonesia were a product of ongoing advocacy by the district working group.

Sustainability and scaling-up are more likely to be achieved if the advocacy wins are mainstreamed into the government process. Having a family planning line item in the budget template for Kenya's counties increases the probability that counties will request money for family planning. Likewise, the Indonesia government adoption of AFP-Indonesia's advocacy tools and approach for expansion into other provinces and districts increases the likelihood of family planning advocacy groups scaling up nationwide.

Our experience shows that national goals, including those derived from global initiatives are unlikely to be implemented at the subnational level without promotion by local advocates. Where there was no or little commitment to FP2020 related activities, AFP colleagues were able to mobilize resources and gain political support for family planning. While we cannot determine the relative merits of a centralized, top-down versus decentralized implementation of FP2020, we can say that an advocacy-driven FP2020 commitment can be implemented successfully at the subnational level.

Advocacy at subnational levels should be done in tandem with national advocacy. We saw that Senegalese mayors cannot access funds unless the central government's budgeting process improves and Kenya's central government guidance still plays an important part in county-level governance.

The advocacy enterprise at the subnational level is not simple or easy. However, for the goals of global and national development initiatives, such as the SDGs to be realized, they need to explicitly address how decentralization affects achieving their goals. Advocates must determine how best to use decentralized systems to advance global and national initiatives.

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Constitutions, Civil Society, and the Politics of Pro-Poor Health Insurance Programs in the Emerging Economies

Eduardo J. Gómez

In recent years, several emerging economies, such as India, China, Russia, and Indonesia, have introduced national health insurance programs targeting the poor, safeguarding them from increased out-of-pocket and catastrophic expenses. With the exception of Indonesia, increased government spending for these programs has not helped to safeguard the poor from these expenses. This article introduces an analytical framework combining the importance of constitutional design, decentralization, and social health movements to account for these differences in policy outcomes. The author's proposed analytical framework differs from those studies emphasizing financial constraints, the effective targeting of funds to the poor, and administrative capacity, suggesting instead that the design of political institutions and the incentives that they create for policy implementation and regulation may provide greater insight into why these targeted health insurance programs are not achieving their goals.

INTRODUCTION

In recent years, several emerging economies, such as the BRICS (Brazil, Russia, India, China, and South Africa), as well as Mexico, Colombia, and Indonesia, have joined the international community in striving to achieve universal access to healthcare.[1] [2] [3] [4] In their quest to achieve this, in the past 10 years these governments have substantially increased spending for the provision of national health insurance programs, either as a single-payer government subsidized option, jointly financed between governments, employers, and civil society, or public-private partnerships.[5] Realizing the ongoing challenge of poverty and inequality, however, several governments have also introduced national health insurance programs targeting the poor, explicitly protecting them from the financial hardships associated with obtaining healthcare, such as out-of-pocket (OOP) and catastrophic expenses. This has been viewed as a key strategy for avoiding increased poverty, while ensuring that the poor have access to quality healthcare.

Nevertheless, this article claims that several emerging economies, such as India, China, Russia, and Indonesia, vary considerably in ensuring that national health insurance programs targeting the poor achieve their goals. Unfortunately, evidence suggests that despite a sizeable increase in national government spending for these programs, with the exception of Indonesia, OOP and catastrophic expenses among the poor have continued to increase. [6] [7] This is puzzling considering how financially and politically committed these governments are to eradicating poverty and inequality.

In accounting for these differences in policy outcomes, this article proposes a potentially useful analytical framework that combines the importance of constitutional electoral designs, degrees of decentralization, and the role of social health movements in policy implementation processes. As seen in the cases of India, China, and Russia, it is argued that those governments with constitutions providing an excessive amount of political authority to the executive,[1] a low level of electoral accountability, as well as

preexisting commitments to decentralization will lead to weak government incentives for effective policy implementation. More specifically, these institutional constraints will generate few incentives for executives to coordinate with national and sub-national health agencies in order to ensure that insurance programs are implemented well, while neglecting to regulate hospitals and physicians, ensuring that they are not proscribing unnecessary and uninsured medications and tests. Furthermore, in these countries the absence of proactive social health movements and NGOs pressuring the government for effective policy implementation has also contributed to government apathy and policy inaction.

Conversely, and as seen with the case of Indonesia, when constitutions provide executives with less political authority, are accountable to the electorate, and are not as politically committed to decentralization, governments will be more proactive and effective at ensuring that national insurance programs targeting the poor achieve their goals. In this context, presidents and national and state-level health agencies will not only better coordinate for policy implementation, but the central government will also create federal regulatory agencies monitoring hospitals and physicians, in turn revealing a general lack of trust in decentralization processes. At the same time, the case of Indonesia illustrates how a well-organized social health movement taking advantage of changes to constitutional electoral rules and increased electoral accountability can incentivize executives to sustain these policy efforts.

With respect to methodology, this study conducted a qualitative comparative case study design. The nations of India, China, Russia, and Indonesia[2] were chosen because of their status as emerging economies[3] as well as their recent efforts to introduce national health insurance programs targeting the poor. The purpose of this comparative study was to highlight the uniqueness of each country, illustrating how their different political institutions and state-civil societal relationships accounted for differences in policy outcomes. These casestudies were also used to illustrate the potential efficacy of a proposed analytical framework that combines constitutional electoral design, decentralization processes, and the role of civil society. With respect to data, the author obtained information from multilateral health agencies, such as the World Health Organization (WHO), not-for-profit research agencies and governments.

1In this article, the term "executive" will refer to governing heads of state, such as presidents and prime ministers.

2Readers may be puzzled as to why the case of Brazil was omitted from this study, considering the government's universal health insurance program (SUS, Sistema Único de Saúde) and well-known commitment to poverty alleviation. Brazil was omitted for two reasons: first, there has been a considerable amount of research discussing the politics of heath insurance and poverty alleviation in Brazil; because of this, the author wanted to focus on other emerging economies that have not received as much scholarly attention in this area of research; second, the author was interested in examining the implementation of recent national health insurance programs targeting the poor, rather than insurance programs that have existed for several decades, such as SUS.

3One may question why the case of Russia is introduced in this study. Russia's economy in the past two years has been in a deep recession, suggesting that it is no longer an emerging economy. However, in this article I focus on the national health insurance reforms that took place during Russia's period of increased economic growth, which occurred mainly between 2000 and 2012.

HEALTH SPENDING, INSURANCE, AND FINANCIAL PROTECTION FOR THE POOR

In recent years, scholars have argued that an increase in federal healthcare spending can lead to an overall decline in the individual financial costs associated with obtaining healthcare, especially among the poor.[8] [9] [10] This is often achieved through the government's provision of health insurance programs targeting the poor, an approach that has been distinct from the universal provision of health insurance, either as a single payer option or through a patchwork of several federal programs for different socioeconomic groups. The provision of targeted health insurance programs for the poor has become increasingly common among emerging economies experiencing consistently high levels of poverty and inequality.[11] [12] [13] [14]

In theory, national health insurance programs targeting the poor provide financial protection from OOP and catastrophic expenses.[15] [16] [17] These types of health insurance programs often include the provision of insurance cards that beneficiaries can use at hospitals when seeking inpatient and outpatient services.[18] [19] [20] Through the usage of these cards, moreover, most of these services can be insured, thus reducing the poor's need to spend out of pocket.[21] But this benefit can also lead to not only increased savings but also additional income for the purchase of food, clothing, and housing, in turn enhancing the poor's health and wellbeing.[22]

Nevertheless, some claim that there is no guarantee that an increase in federal spending for the provision of targeted health insurance programs for the poor will lead to increased financial protection. Some claim that the government simply does not spend enough money to cover all inpatient and outpatient services, while others emphasize the government's repeated failure to locate the poor and effectively target funding.[23] Alternatively, some claim that the poor design and implementation of health policy decentralization processes accounts for the mismatch between federal spending and poorly implemented financial protection programs. Specifically, timing is at stake: sub-national governments are given too much financial and administrative responsibility to quickly, without ensuring that they have the revenue raising, administrative, and institutional capacity needed to ensure that federal funds provide adequate coverage for all healthcare services.[24] Bastagli[25] has in fact argued that poor budgetary management, corruption, and lack of accountability have reduced local government capacity to effectively use federal funding for these health insurance programs.

The recent literature therefore focuses on the policy design of national health insurance programs targeting the poor, their benefits, as well as the financial, institutional, and administrative challenges for effective policy implementation. However, this perspective fails to consider the factors that motivate political leaders to ensure that targeted insurance programs meet their objectives. That is, what institutional and civil societal factors motivate politicians to ensure that targeted financial protection programs work well? By answering this question, we can provide insight into explaining the paradox behind a heightened increase in federal spending for national health insurance programs targeting the poor and the limitations to achieving policy objectives.

In this article, I submit an alternative analytical perspective providing potential insight into why this paradox has emerged. In contrast to the aforementioned literature, this perspective focuses on understanding how a combination of constitutional rules

determining levels of executive authority and accountability, preexisting government commitments to decentralization, and the presence of well-organized social health movements motivate executives to ensure that health insurance programs targeting the poor achieve their goals.

Here, government commitment is defined as executives working with ministries of health to ensure that health insurance policies are effectively implemented. In the case of financial protection for the poor, effective implementation takes the form of executives working with ministries of health to coordinate with sub-national health agencies in order to ensure that the poor receive the benefits that they are entitled to, while increasing the monitoring and regulation of hospital practices in order to ensure that the poor are not being charged for unnecessary medications and services.

The degree of government commitment present (low or high) is shaped by two factors. First, constitutional design, such as the electoral rules determining who the executive is accountable to, as well as the level of policy decree authority present, both proactive decree (creating legislation sans legislative vote) and reactive veto processes (blocking the passage of legislation).[26] [27] When constitutions give executives a high level of decree authority, and when executives are not accountable to the electorate - instead, to the governing party that chose them, they are perceived as strong executives; when the converse situation is present, they are perceived as weak executives – weak in the sense of not being able to fully control the policy creation and implementation process on their own, without legislative and/or electoral interference. For there to be a high level of government commitment, then, as well as successful policy outcomes, constitutional rules must make executives weak by making them accountable to the electorate while providing them with minimal decree authority. Furthermore, when executives are weak, constitutional rules will make them more accountable to the poor's health insurance needs, with the prospect of being voted out of office should they fail to provide effective financial protection.

Second, preexisting national government commitments to decentralization can also shape levels of government commitment and the incentives that executives have to seek greater coordination with the states for policy implementation and regulation. When executives have a high level of respect for state government autonomy and decentralize a great deal of financial and administrative authority, they will not be motivated to intervene in order to ensure that national health insurance programs targeting the poor achieve their goals. This is often due to the executives' realization that safeguarding the states' political rights and economic autonomy is vital for economic growth. Conversely, when executives do not have a high level of trust and support in decentralization processes, they will seek to intervene, closely coordinating with state health agencies for effective policy implementation, while carefully regulating hospital practices. In essence, in this context, executives do not trust state and local governments to implement policy due mainly to financial and administrative inexperience. Such views have mainly been seen in nations that quickly decentralized financial and policy responsibility, whereas the former's commitment to decentralization is more emblematic of federations with a long history of decentralization.[28]

Finally, these constitutional rules and decentralization processes also shape civil society's ability to pressure the government for more effective policy implementation. When constitutions provide strong executives with low levels of accountability, social health movements and NGOs will be less likely to influence policy implementation. The

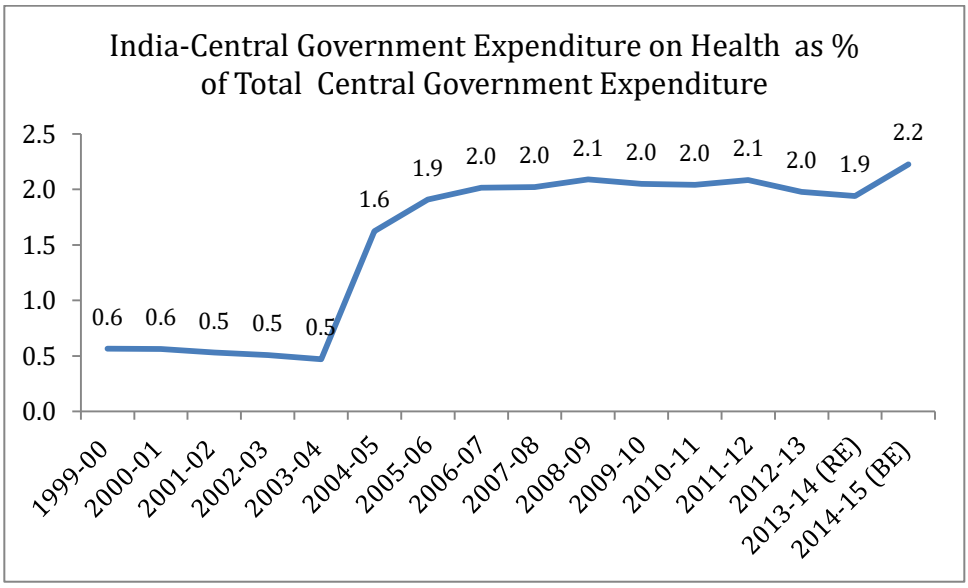
converse holds when constitutional electoral rules generate weak presidents, making them accountable to civil society. Civil society's ability to influence national health insurance programs targeting the poor will also be influenced by their ability to mobilize resources, organize and coordinate to collectively pressure the state.[29]

Taken together, then, the extent to which national governments are committed to providing effective national health insurance programs targeting the poor is shaped by constitutional design, decentralization processes, and the proactive efforts of civil society. This analytical framework may provide further insight into why India, China, Russia, and Indonesia were different in their levels of government commitment, capacity and willingness to protect the poor from excessive healthcare costs.

It is important to note, however, that the author's proposed analytical framework does not suggest that strong executives are never successful at implementing public health policy. There have been instances in which strong executives reacted quickly to health crisis, as seen with China's response to SARS and Cuba's response to HIV/AIDS.[30] [31] In both China and Cuba, the centralization of decision-making and resources engendered strong state capacity and expeditious policy implementation.[32] The key issue here is the *type* of health issue present. When a severe public health threat emerges, strong executives may take aggressive policy action in order to avoid a major economic crisis and a decline an international reputation and influence, seen in China with SARS;[33] in contrast, this may not be the case when a health threat is not perceived by strong executives as posing such as severe threat, such as health insurance coverage and financial protection for the poor.[34] Alternatively, not all constitutionally weak executives are successful at addressing the poor's healthcare needs. For example, while the United States (U.S.) shares with Indonesia an electorally accountable president and congress, historically the U.S. has been perceived as being ineffective at providing universal health insurance coverage for the poor, due to mainly several conflicting private sector interests and influential lobbying efforts.[35]

Thus, there are empirical limitations to the author's proposed analytical framework. This framework is not intended to be a generalizable institutional theory accounting for all policy failures and success within all types of political institutions in emerging economies. The success of institutional designs is often context dependent, shaped by unique historical and global factors.[36] The utility of my proposed analytical framework is therefore to propose a political science perspective that may be helpful in explaining the unique success of particular nations, while posing an alternative analytical framework that can be further examined with case study evidence from other nations.

Figure 1



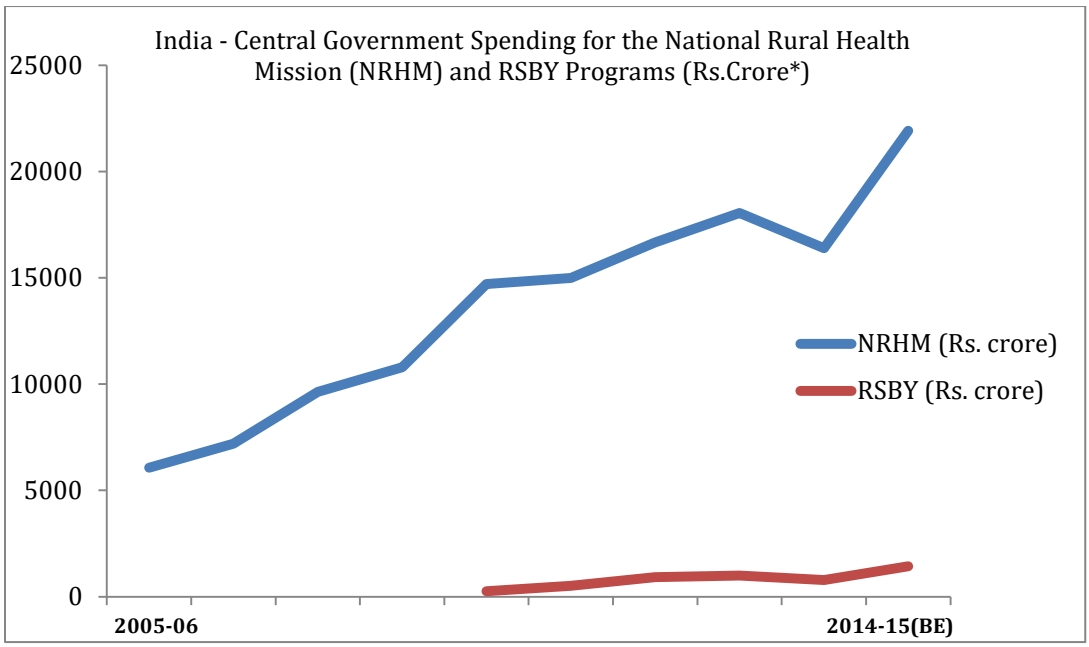
Source: Center for Budget and Governance Accountability, 2014

INDIA

In recent years, India's central government expenditures for healthcare, when measured as a percentage of total central government expenditures, has gradually increased – see Figure 1. In addition to increased spending for public health programs, this spending has also entailed programs providing health insurance for the poor. For example, the 2009 National Rural Health Mission (NRHM) was focused on funding primary healthcare in poor rural areas, while in 2013 the Ministry of Health & Social Welfare combined the NRHM with the National Urban Health Mission to create the National Health Mission.[37]

In 2009, the government heightened its efforts to protect the poor from out-of-pocket and catastrophic expenses through the *Rashtriya Swasthya Bima Yojana* (RSBY) program. The Ministry of Labor and Employment (MLE) is the government agency responsible for policy formulation. The MLE delegates responsibilities to State Nodal Agencies, who in turn manage the RSBY program's implementation.[38] The RSBY program is explicitly designed to target those individuals falling below the poverty line, ensuring that they not only have access to healthcare and insurance but that they no longer experience financial hardship through OOP and catastrophic expenses.[39] Those families enrolling in the RSBY program receive a registration card, which they then use at public and private hospitals. The RSBY program is intended to mainly provide coverage for long-term inpatient care, with limited coverage for outpatient services, especially medications, and ambulatory services.[40] RSBY is primarily funded by the central government, covering approximately 75% of premium charges from insurance companies, with the state governments paying for any remaining amount.[41] Finally, families must pay a RS. 30 annual registration fee to enroll in the program.[42] As Figure 2 illustrates, federal spending for the RSBY program increased from 264.5 million in 2009 to 1,434 billion Rs. Crore in 2014.[43]

Figure 2



* 1 Crore= 10 million
Source: Centre for Budget and Accountability, 2014

Prior to the implementation of the RSBY program in 2009, OOP expenses at the national level, as well as among urban and rural households were high. As Table 1 illustrates, national surveys suggest that average per capita monthly OOP expenditures in Rupees Crore (Rs) increased from 16.78 in 1993-1994 to 41.83 in 2004-2005 at the national level; from 20.99 in 1993-1994 to 57.64 in 2004-2005 in urban areas; and from 15.28 in 1993-1994 to 36.47 in 2004-2005 for rural residents.[44]

Nevertheless, it is questionable to what extent the RSBY program has helped to reduce OOP expenditures. This is especially the case in the poorer states, such as Bihar, Orissa, Uttar Pradesh, and Jummar, studies suggests that OOP continues to decrease household savings and increase poverty levels. [45] Furthermore, others suggest that approximately 75% of RSBY beneficiaries still experienced OOP expenses prior to hospitalization – e.g., at smaller clinics.[46] Many families that are enrolled in RSBY still have to pay for inpatient (hospitalization) services, thus reflecting only partial coverage from RSBY beneficiaries.[47] In recent years there has also been a doubling of payments for private sector inpatient services among the poor in rural areas, at a rate that is much higher than the poor in urban areas.[48]

Because of these OOP costs, many of the poor have opted not to pursue medical attention. Recent studies suggest that nearly 20% of urban and 28% rural households attributed their reluctance to seek care due to financial constraints.[49] What's more, for those that have engaged in such expenses, they have proved catastrophic.[50] According to some estimates approximately 3.1 million households fall below the poverty line ($1 per day) each year because of high OOP hospitalization costs.[51]

Table 1 - India: National, Urban, and Rural Household Out-of-Pocket Expenditures (1993-1994, 1999-2000, 2004-05, Rs Crore.)

	Average Per Capita Monthly OOP (Rs. at current prices)	OOP of Total Household Expenditure	Household Reporting of OOP	Household Paying more than 10% as OOP from total household expenditure
National				
1993-1994	16.78	5.12	59.19	11.92
1999-2000	33.08	5.78	69.23	10.84
2004-2005	41.83	5.87	64.42	15.37
Urban				
1993-1994	20.99	4.6	54.61	10.78
1999-2000	43.33	4.76	69.13	11.7
2004-2005	57.64	5.22	65.41	15.82
Rural				
1993-1994	15.28	5.3	59.94	12.69
1999-2000	29.62	6.21	69.97	11.7
2004-2005	36.47	6.3	64.05	15.82

Source: Selvaraj and Karan, 2009

The voluntary RSBY program has also only partially improved access to healthcare for the poor. Recent estimates suggest that only 50 to 60 percent of the poor are enrolled in RSBY.[52] Worse still, according to recent government estimates only 10% of the poor falling below the poverty line are enrolled in RSBY.[53]

Despite a substantial rise in federal spending for the RSBY program, what accounts for the government's unwillingness to ensure that the RSBY program achieve its intended objectives? First, it seems that there has been an ongoing lack of government commitment to working with the MLE to coordinate with the state health departments in order to ensure that the RSBY program achieves its goals.[54] This lack of commitment has been shaped by preexisting constitutional rules over how India's prime ministers are elected into office, as well as the constitutional design of inter-governmental relations.

Because the constitution states that the majority governing party in parliament is to select the prime minister, there is a low level of electoral accountability to constituents needs. In this context, the prime minister (PM) is more accountable to supportive coalition party members as well as the parliament in general, as a vote of no confidence could lead to their removal from office.[55] This has led to the rise of prime ministerial office that is more interested in building and sustaining confidence within the governing party rather than ensuring that targeted health insurance programs, such as the RSBY, provide complete financial coverage, reach out to and serve the poor.[56]

At the same time, preexisting federal government commitments to decentralization have generated few incentives for the PM and the MLE to closely coordinate with state health departments in order to ensure that the RSBY program achieve its goals.[57] Since the 73rd and 74th amendments to the Indian constitution in 1993, the state governors have been delegated a high level of autonomy for health policy

administration.[58] While the central government provides most of the financing for the RSBY program, the PM and MLE have for the most part respected the state governors' rights over healthcare policy administration and implementation. Governors have sought to sustain this sense of policy autonomy, a concentration of power that at times has motivated state heath departments not to provide financial and administrative resources to rural governments.[59] While the RSBY is de facto a federal government health insurance program under the national MLE's auspices, in practice the center does not interfere with State Nodule Agency (SNA) responsibility to administer and regulate the RSBY program.[60] In this context, the center has had no incentives to ensure the RSBY program's effectiveness in avoiding OOP and catastrophic expenses among the poor.

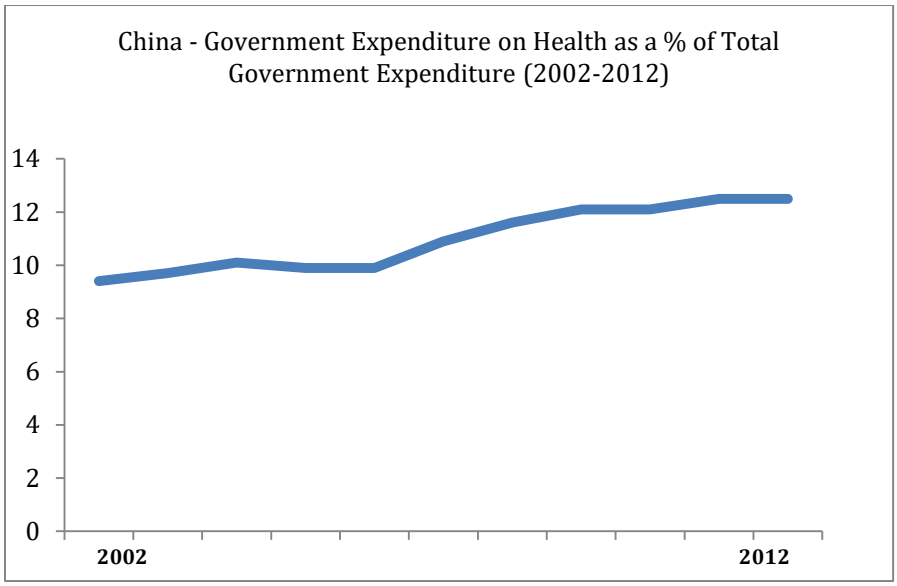
Furthermore, in this context the MLE has had no interest in increasing its regulation of how the RSBY program is implemented, as well as its efforts to locate and register the poor for RSBY benefits. On one hand, the MLE has not tried to work closely with SNA's to monitor and regulate physicians' practices in hospitals, so as to ensure that they are not charging patients with co-payments, extra fees for services and medication, at levels that surpass RSBY reimbursement rates.[61] It is the SNA that works through state government departments (mainly health, but at times labor as well), which manages RSBY program implementation.[62] Furthermore, the SNAs have repeatedly failed to adopt these regulatory practices themselves.[63] At the same time, the MLE and SNAs have not done a good job of trying to locate and educate the poor about their RSBY – and other health insurance – benefits.[64] [65] In some states, such as Assam, only 11% of the poor are enrolled in RSBY.[66] Moreover, many of the poor are unaware that they are eligible for RSBY benefits; and even if they are enrolled, many do not know how to use their RSBY cards, or fear that even if they did use them, hospitals would not recognize them.

Finally, social health movements have not been very effective in pressuring the government to improve the effectiveness of government sponsored health insurance programs providing financial protection for the poor.[67] While a public health movement does exist, namely the *Jan Swasthya Abhiyan* (India's regional association of the International People's Health Movement), which is comprised of NGOs, social activists, intellectuals, community-based organizations, and healthcare professionals, it is relatively new and not well established - originating since the early-2000s.[68] And while NGOs have a long history of providing health insurance for the poor, as well as prevention and treatment services,[69] civil society lacks the adequate legal channels, guidance, and experience needed for community participation, mobilization, and effective pressures for ensuring the efficacy of the RSBY program.[70] [71] There are also no clear channels of federal and local representation, such as participatory health councils, which civil society can use to help mobilize and pressure the state.[72] NGOs also suffer from a general lack of credibility, due to ongoing corruption and false representation in particular health sectors, such as HIV/AIDS.[73]

CHINA

In recent years, China's government has joined India's in increasing central government spending for healthcare, as seen in Figure 3. This spending has mainly reflected the government's resolve to provide universal healthcare through the implementation of several national health insurance programs, such as the Urban Employee Basic Medical Care (UEBMI) of 1998, the Medical Financial Assistance (MFA) program of 2002, the New Cooperative Medical Scheme (NCMS) of 2003, and the Urban Residents Basic Medical Insurance (URBMI) program of 2007. With the exception of UEBMI, it is the MFA, NCMS, and URBMI that focus exclusively on targeting the poor and providing protection from catastrophic and out-of-pocket (OOP) expenses.

Figure 3



Source: WHO, Global Health Observatory, 2014

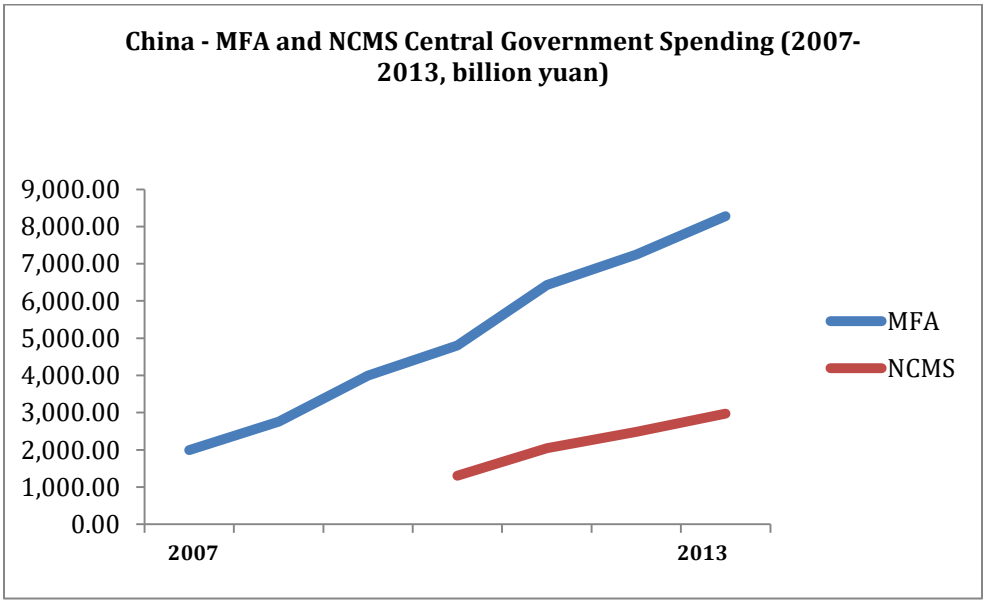
It is important to note, however, that the MFA is not a government-sponsored health insurance program; rather, it provides central funding to provincial governments in order to ensure that there is sufficient funding to subsidize the poor's enrollment in insurance programs, such as the NCMS. As Figures 4 and 5 illustrates, central government spending for the MFA has burgeoned in recent years, suggesting a strong government commitment to ensuring that the poor have access to health insurance and financial protection through the NCMS and URBMI programs. By 2007, and as Figure 5 illustrates, the central government's financial contributions to urban and rural MFA programs began to surpass local government contributions, further suggesting the center's commitment to protecting the poor.

Since 2003 and 2007, the county and municipal level governments have managed the NCMS and the URBMI programs, respectively, determining deductible, ceiling, and reimbursement rates.[74] With respect to financing, The NCMS is subsidized by the central government, local governments, and individual premiums at 10 RMB

each annually.[75] By 2010, however, the central and local governments increased their contribution to the NCMS to 50 RMB per year.[76] And with respect to the URBMI, the central government provides approximately 80 RMB per year for each employee, employers approximately 6% of payroll revenue and employees 2% of their payroll earnings.[77]

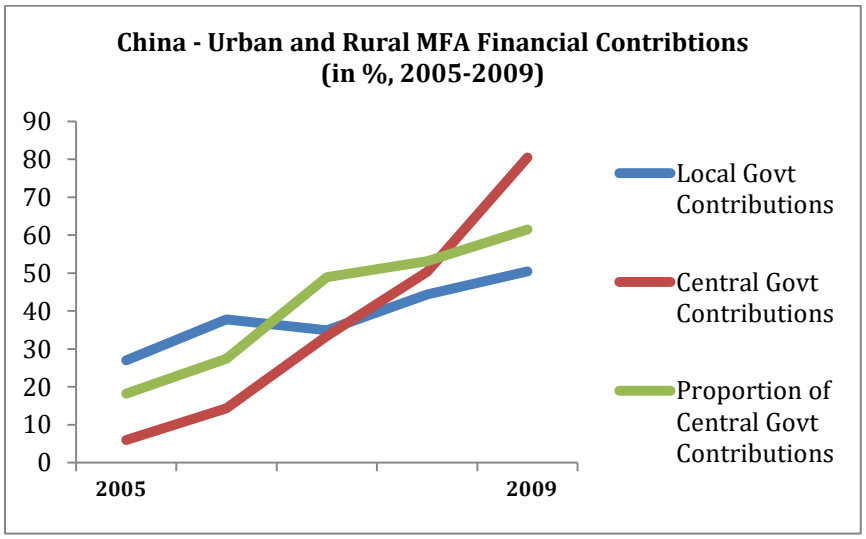
It is important to emphasize, however, that the URBMI is a centrally mandated insurance program, while the NCMS is purely voluntary, depending on provincial government interest and their fiscal capacity to participate. While the NCMS provides financial coverage for inpatient and outpatient services for the poor, 2010 estimates suggest that only 41% of inpatient services were covered, 45% for URBMI.[78] There are also reimbursement caps for inpatient and especially outpatient care services for NCSM beneficiaries,[79] while most outpatient services, especially for mediations, are not being covered through all of the aforementioned insurance programs.

Figure 4



Source: China National Statistics Bureau, 2014

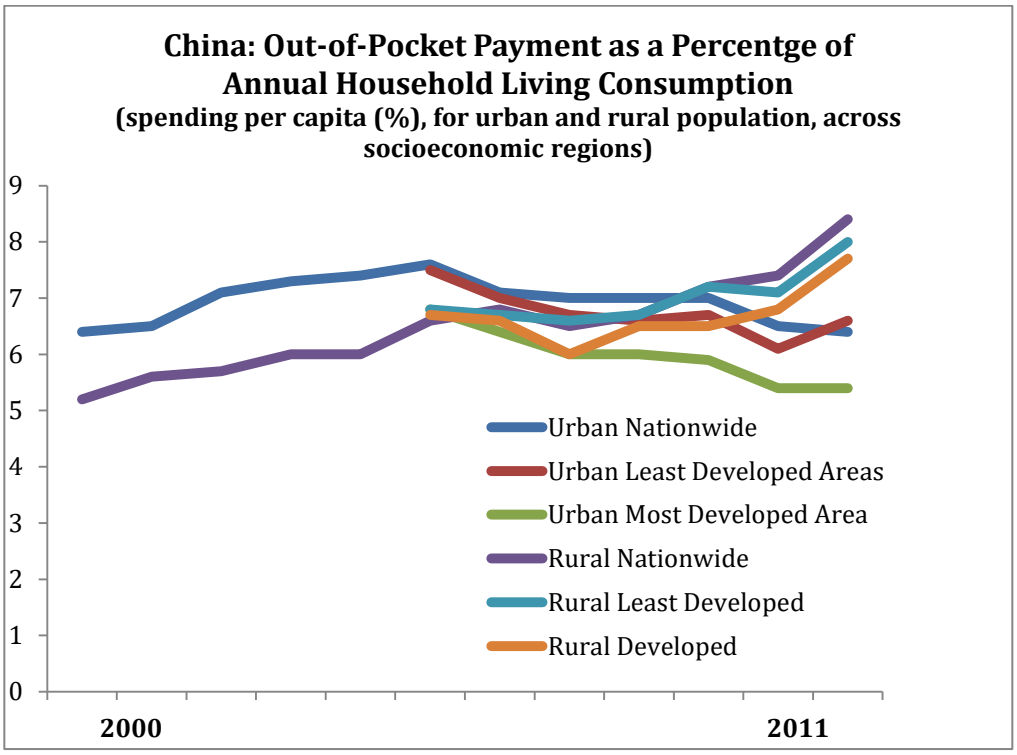
Figure 5



Source: Barber and Yao, 2010

In fact, approximately 34.8% of the poor participating in the NCMS have continued to experience catastrophic medical expenses,[87] with the poorer western region of the country seeing the highest expenditures among NCMS participants.[88] And in the poorer rural areas of the nation, OOP expenditures increased from 5.2% in 2000 to 8.4% in 2011[89] – as Figure 6 illustrates. OOP expenses have also increased for those enrolled in the URBMI.[90] Finally, URBMI reimbursement rates for medical expenses have been low, estimated at approximately 45%. Rather than reducing inequalities and poverty levels, then, the NCMS and URBMI appear to be contributing to these problems, especially among the poor.[91] [92]

Figure 6



Source: Long et al. 2013

Furthermore, studies suggest that NCMS and URBMI have been contributing to rising OOP and catastrophic expenses because beneficiaries now have greater incentives to seek healthcare.[93] However, NCMS participants end up paying high co-payment fees for specialists, fees for additional tests, and medications.[94] These additional expenses are often associated with hospitals' needs for charging patients with additional drugs and services in order to make up for the insufficient revenue and coverage provided by contracted insurance companies through the NCMS and URBMI;[95] these additional charges are also due to the insufficient amount of funding hospitals receive from the state, as well as hospitals' legal right to keep all revenues earned through the sale of medication.[96]

The inability of health insurance programs to protect the poor can be attributed to several factors. First, China exhibits a high degree of strong executive power, where all policy-making authority rests with the Premier of the State Council, who in turn is selected by the Standing Committee of the National People's Congress (NPC) (comprised of approximately 150 Chinese Communist Party [CCP] members) and the President – elected by the NPC.[97] The Premier is therefore accountable to the NPC, not to citizens, for his reelection. Full policy-making authority rests with the Premier and the State Council.[98] Nevertheless, in recent years, while the Premier and the State Council have been committed to increased healthcare spending,[99] the Premier has not emphasized policies that directly address the effectiveness of health insurance programs, especially those offering financial protection to the poor.[100] [101] This is mainly attributed to low levels of State Council/CCP interests in ensuring equality in access to

affordable healthcare for all.[102] Instead, the Premier and State Council have been more concerned with accelerating economic growth and channeling funding from high growth to the health sector via a general increase in government spending.[103]

Indeed, others note that the Premier has been more concerned with a general increase in healthcare spending rather than ensuring the NCMS and URBMI's effectiveness, such as imposing regulations that reduce high hospital costs and the resulting fees contributing to OOP and catastrophic expenses.[104] [105] This is reflected in the fact that central government spending for the NCMS has been insufficient, while spending for other insurance programs for urban residents and government officials, namely UEBMI, has increased.[106] When the concentration of policy-making interests, authority, and accountability rests *within* government and not civil society, unless providing effective financial protection for the poor becomes a government priority, there will continue to be low levels of government commitment to these issues and, therefore, few efforts to address them. Indeed, Lui and Rao (2006)[107] maintain that in a context where the electorate does not prompt effective health policy reform, it is the state elite that must find an interest in doing so.

Preexisting constitutional commitments to decentralization has also contributed to a low level of government commitment to ensuring that the NCMS and URBMI work effectively. Similar to India, China's efforts to decentralize fiscal and economic responsibility to the states began several decades ago.[108] With respect to healthcare, while the central government plays a significant role in sharing fiscal resources to fund specific central government programs (such as NCMS and URBMI), it is the provinces and county governments that have been mainly responsible for allocating these revenues and managing insurance programs.[109] At the same time, basic expenditures for public health (save for hospitals), education, and social services have been the provinces' responsibility.[110] The provinces therefore provide the lion's share of financing and are primarily responsible for providing health services.[111]

In this context, the central government has not had an incentive to intervene and to provide the provinces with additional funding for healthcare, instead becoming increasingly reliant on the provinces. Beginning in the 1980s, respecting the states' fiscal and policy-making autonomy and viewing this as the cornerstone to ongoing economic growth has also created few incentives for the central government to interfere with health policy implementation processes.[112] Furthermore, the ministry of health also lacks the administrative capacity and resources needed to monitor the implementation of health policies. In this context, unless the central government has been fully committed to a particular health issue, as was the case with respect to the HIV/AIDS or SARS epidemics, which garnered considerable international pressures and government attention, the center has had no incentive to intervene and ensure that the NCMS and URBMI work effectively. In fact, scholars note that the center in recent years has become increasingly reliant on provincial governments to protect consumers from excessive healthcare costs as well as hospital reform.[113]

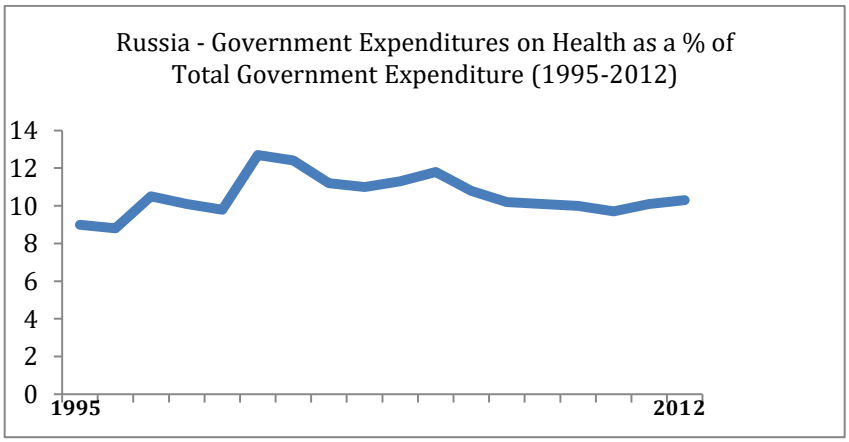
Finally, there has been an ongoing dearth of social health movements and NGOs that are autonomous from central government influence, well organized and effective at pressuring the government to ensure that health insurance programs achieve their objectives.[114] Most healthcare NGOs comprise governing boards that are composed of government officials and are consequently less accountable to civil societal needs.[115] Extensive legal regulations over NGO registration, requiring government agency

sponsorship and fees, has also made it difficult to create NGOs.[116] At the same time, those individuals mostly affected by OOP and catastrophic expenses, such as the rural poor, have been unwilling to mobilize due to the absence of rural associations, a by product of the collapse of the rural cooperative healthcare system.[117]

RUSSIA

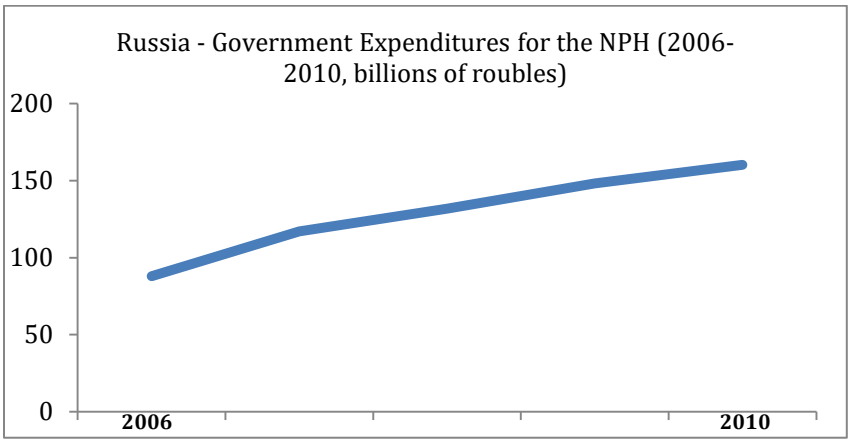
Since the mid-1990s, in Russia government expenditures for healthcare has gradually increased – see Figure 7. Most of this funding went towards the government's universal healthcare system, as well as federal programs for the universal provision of medication, namely the 2005 DLO (Provision of Supplemental Medicine); the OLNS and VZN of 2008 for the purchase of expensive medications, which is mainly provided for those who cannot afford medicine. In 2006, the government also allocated funding for the National Priority-Health (NPH) initiative, while further solidifying its commitment to universal healthcare through the 2010 Law of Mandatory Health Insurance (LMHI). As Figure 8 illustrates, government expenditures for the NPH increased substantially between 2006 and 2010. Unlike India and China, however, in Russia, there are no federal programs that target the poor and protect them from healthcare-related financial hardship.

Figure 7



Source: WHO, Global Health Observatory, Data Repository, 2014

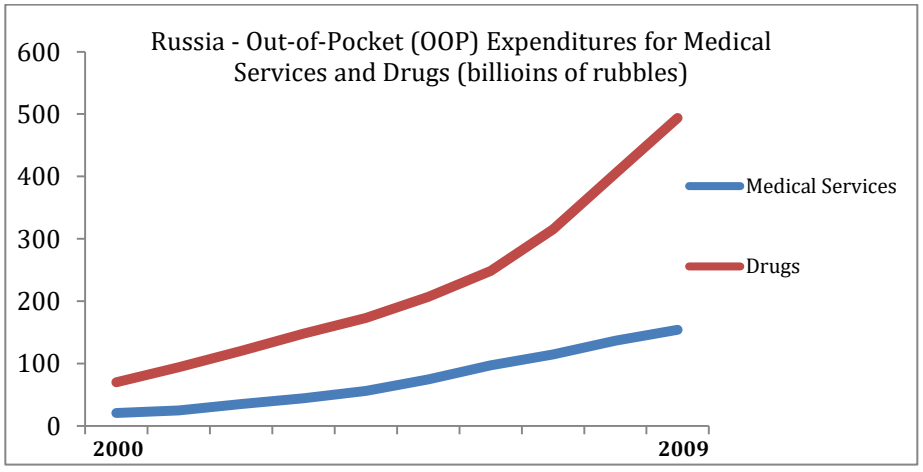
Figure 8



Source: Popovich et al. 2011

Nevertheless, similar to India and China, government-sponsored national health insurance programs that are in general supposed to safeguard the poor from OOP and catastrophic expenses do not appear to be achieving their goals. For instance, and as Figure 9 illustrates, OOP expenses have increased, mainly due to the lack of sufficient funding and insurance coverage through the government's purchase of medication through the DLO, OLNS, and VCN.[118] Total OOP expenses have increased by 7.5 times since 2000.[119] The poor have experienced the highest economic burden, which has pushed them further into poverty.[120] These personal expenditures mainly have to do with the high price for medications, thus reducing medicine affordability. [121]

Figure 9



Source: Popovich et al., 2011

In Russia, the presence of a strong executive appears to have led to a lack of interest in addressing these ongoing healthcare challenges. The president in Russia has a high level of policy-making power, capable, through the constitution, of initiating executive decrees as well as vetoing legislation.[122] In recent years President Vladimir

Putin has taken advantage of his executive decree authority in several policy areas.[123] And while the president is elected into office by the citizenry, elections are known to be manipulated in favor of candidates siding with the governing United Russia party.[124] In this context, presidents, such as Vladimir Putin, do not feel accountable to the citizenry for reelection, thus leading to a low level of government sensitivity to ongoing healthcare needs, such as financial protection from healthcare costs.[125] This context has generated few incentives for the Putin administration to coordinate with the ministry of health to ensure that health insurance programs are well implemented and that the poor are protected from increased OOP and catastrophic expenses.[126] Moreover, there have been no incentives to increase the ministry of health's regulation of doctors' medical practices, ensuring that they are not charging for unnecessary medications and examinations.[127] Federal oversight of hospital practices in general is essentially non-existent. This context has facilitated – and indeed encouraged – doctors to engage in the ongoing corrupt practices of charging patients with additional and often unnecessary medicines and examinations.

The presence of a strong executive was most vividly seen when President Vladimir Putin decided to reduce healthcare spending in favor of an increase in military spending. Despite increased social protests against this idea, in 2013 the Putin administration decided to reduce healthcare spending by 8.7 percent and by 17.8 percent by 2015.[128] This was done in order to make room in the federal budget for increased expenditures for military and security spending, by 25 percent, estimated at 2.3 trillion rubbles ($76 billion) in 2013.[129]

As in India and China, a high degree of decentralization has also created few incentives for the central government to interfere at the oblast level and to ensure that national government health insurance programs achieve their objectives. Since the early-1990s, Russia's healthcare system has been devolved to the regional oblast governments.[130] The regional and municipal governments have had a great deal of financial and administrative autonomy, allowing them to design policy as they see fit.[131] Consequently, the central government has relied on the oblast state governments to implement national insurance programs. The center's only effort in reasserting its control and influence over policy has been in the area of financing, where in recent years, the Federal MHI financial fund has become the key source for funding insurance programs at the state and municipal level.[132] Some poorer oblasts have therefore become more dependent on the center to ensure that insurance programs and services are provided.[133] Despite this fiscal influence, the oblasts have remained autonomous in administrative and policy enforcement manners, while the center has for the most part respected this autonomy and has not desired to intervene for policy implementation purposes. Because of this there have been few incentives for the Putin administration and the MOH to ensure that health insurance programs targeting the poor are adequately implemented.

And finally, the absence of effective social health movements and NGOs pressures on the state for providing sufficient insurance coverage for the poor has also been a problem. This mainly has to do with the lack of sufficient funding for social health movements and NGOs, as well as the government's ban of external donor aid funding for NGOs,[134] government crackdowns on NGOs, as well as the lack of government interest and trust in working with them on healthcare issues.[135] While NGOs do exist and have provided important healthcare services to families in need of counseling and

support,[136] NGOs have not been successful in obtaining funding (especially because of the legal ban on donor assistance), mobilizing, and representing the poor when pressuring the state for more effective health insurance coverage.[137]

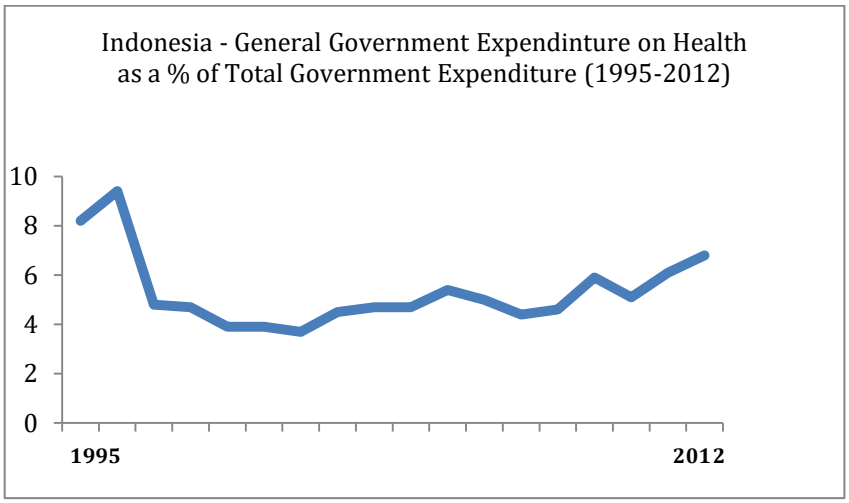
INDONESIA

In recent years, Indonesia's government has substantially increased federal spending for healthcare – see Figure 10. Most of this spending has gone towards the creation of universal healthcare programs, such as the 2004 Law No. 40, *University Health Insurance Coverage*, the *Sistem Jaminan Socsial Nasional* (SJSN), a social security program mainly for employed workers, which provided insurance through the *Jamsostek* program; and the 2005 *Askeskin* health insurance program for the poor, later renamed *Jamkesmas* in 2008. Additionally, in 2011 federal Law 24 was established, creating the Social Security Agency BJPS (*Badan Penyelenggara Jaminan Sosial*) and, through this agency, a more expansive universal health insurance system. BJPS officially replaced the SJSN and *Jamsostek* in 2013, while further guaranteeing universal healthcare for all formal workers and the poor through a pledged increase in government spending of US$ 2.6 billion.[138]

Similar to India's RSBY program and China's NCMS and URBMI programs, Indonesia's *Jamkesmas* is a government sponsored national health insurance program that is explicitly designed to not only increase access to healthcare but also to protect the poor from out-of-pocket (OOP) and catastrophic expenses.[139] Through this program, all inpatient and outpatient services are provided for at public hospitals and clinics; moreover, unlike the previous SJSN and current BJPS programs, *Jamkesmas* insures the poor for cancer care, cardiac surgery, hemodyalisis, and congenial diseases.[140] The *Jamkesmas* is managed and funded entirely by the Ministry of Health.[141]

Furthermore, several provincial governments have their own health insurance programs targeting the poor, collectively known as *Jamkesda*. This program is intended for those that for some reason are not enrolled in the *Jamkesmas* program, as well as those that have recently become poor.[142] Managed and funded by the provincial health departments, with supportive grants also obtained from the central government, the *Jamkesda* program also provides insurance for all inpatient and outpatient services, including ambulatory care and inpatient services in district hospitals.[143]

Figure 10



Source: Global Health Observatory Data Repository, 2014

In contrast to India, China, and Russia, Indonesia's *Jamkesmas* program appears to be more successful in reducing OOP and catastrophic expenses among the poor. In recent years, some claim that the rural poor have not had to incur high OOP expenses.[144] [145] Furthermore, it is the more affluent economic classes that are experiencing higher OOP and catastrophic expenses, thus narrowing the gap between the rich and poor in the area of individual healthcare financing.[146] In 2014, the World Bank in fact claimed that most of the OOP spending is born by the rich, as the top three deciles accounted for more than 50 percent of all OOP spending – the bottom three deciles less than 15 percent.[147] This finding of course does not condone a higher burden for the rich. But it does support the notion that Indonesia's efforts to safeguard the poor from OOP expenses have been successful.

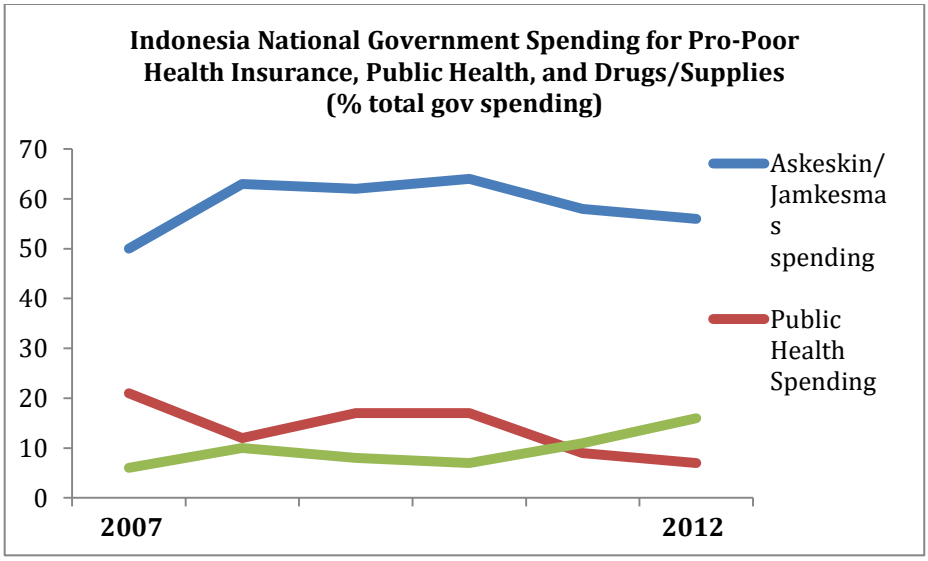
Nevertheless, there have been instances in which the poor have had to pay out of pocket for services; this is mainly associated with the scarcity of high priced medications in rural areas;[148] and yet these OOP expenses are rare, as the *Jamkesmas* program has been known to successfully cover all types of inpatient and outpatient expenses[149] – which is not the case in India, China, and Russia.

In 2013, the World Bank also found that inpatient and outpatient services for the poor has increased since the *Jaskesmas* program was implemented.[150] World Bank findings in 2011 also found that those that were enrolled in the program were more like to seek outpatient services than those that did not have health insurance, especially those in the bottom three deciles of poverty.[151] Other work suggests that outpatient services through *Jamskesmas* increased by 10 percent among the poor.[152] This, in turn, reflects the poor's increased interest in seeking medical attention, as well as the wider availability of hospital clinics present – which has increased given the private hospital sector's growing participation in the program.[153] What's more, 5 years after the program's implementation, the World Bank also found that health insurance coverage for the poor increased from 16.5 percent in 2004 to 43 percent in 2009, almost a triple percentage increase in coverage.[154]

Another positive aspect of Indonesia's reforms are the health insurance programs provided at the municipal district level, namely the *Jamkesda*. These programs are funded both by federal government transfers and municipal governments. *Jamkesda* has succeeded in targeting and providing coverage for those individuals that are not covered through the *Jamkesmas* program.[155] For the first time ever most rural poor residents now have medical coverage and have been able to avoid catastrophic expenses.[156] In the richer regions, such as Asche, healthcare coverage for the poor, through Asche's 2009 *Jamanin Kesehatan Asche* program, has been extensive, in turn motivating residents from other regions to move to Asche to obtain benefits.[157] While the provision of *Jamkesma* programs in other poorer districts has placed some municipal governments in a financial burden, health insurance coverage is now at an all time high.[158]

There have nevertheless been several limitations. There is still an ongoing need for more doctors and nurses in rural areas, as well as hospital infrastructure, such as beds and x-ray machines.[159] Furthermore, the government could do a better job of seeking out and targeting those individuals in need of enrolling into *Jaskesmas* or *Jamkesda*.[160] Many of the poor in distant rural areas are often unaware of these insurance programs.[161] The central government should therefore work more closely with local health departments to find and enroll the poor into these programs.

Figure 11



Source: Jaya, 2013

Several factors account for Indonesia's success in protecting most of the poor from catastrophic medical expenses. First, since 2004 Indonesia's president has been directly elected by its citizens, for a 5-year term, and not the governing party[162] – as seen in India and China. Furthermore, since the constitutional amendments of 2001 and 2002, in contrast to the past, the president's powers are now checked by the legislature, namely the DPR (elected via proportional representation), the House of Local Representatives (*Dewan Perwakilan Daerah*, DPD), and the judicial branch.[163] Since the 1999 constitutional reforms, the representative DPR has been the main body

initiating and passing legislation, at times even without the consent of the president, as the 1999 constitutional amendments took away the president's ability to veto legislation after the passage of bills in parliament.[164] This presidential system made presidents, such as Susilo Bambang Yudoyono (2004-2014), much more accountable to civil society's healthcare needs.[165] Given the long history of proactive state commitment to providing public health services and targeting the poor under the Suharto dictatorship, as well as Suharto's firm believe in access to universal healthcare as a human right,[166] [167] [168] Yudoyono felt compelled to sustain this policy tradition considering most of the electorate's knowledge and expectation it; this was further fueled by Yudoyono's recognition of the public's dissatisfaction with the quality of healthcare services. His campaign on rejuvenating the government's commitment to universal healthcare comported nicely with civil societal needs – especially the poor - and helped him to get re-elected in 2009.[169] Since 2004, Indonesia's constitutional reforms have therefore led to the emergence of a weak executive, that is, a president that is highly accountable to the electorate and who's power and influence has steadily declined through a checks and balances system.

In addition, unlike India, China, and Russia, the degree of healthcare decentralization is far less extreme, in turn creating greater incentives to intervene and ensure that national government health insurance programs targeted at the poor are working effectively. While Indonesia went through a fast past decentralization of social welfare services in 1999, a form a de-concentration occurred thereafter, whereby the center provided most funding for social welfare services.[170] In fact, Pisani (2014) claims that approximately 90% of all funding for healthcare comes from the central government. All decisions regarding the assignment and financing of healthcare personnel is also determined by the center.[171] With so much invested in the provincial governments, the office of the president and the Ministry of Health have had an ongoing interest in ensuring that national health insurance programs are effectively implemented. Furthermore, given the inexperience, financial and administrative incapacity of provincial governments,[172] which reinforced the central government's worries and doubts that the provinces could effectively provide health insurance,[173] federal health officials appear to have always had little confidence in the provinces' ability to implement policy; this context has dovetailed with a weak and accountable president, thus generating ongoing incentives to ensure that health insurance programs offering financial protection for the poor achieve their goals.

This increase in government commitment has also led to policy innovations helping ensure that the *Jamkesmas* program works effectively. A particular innovation that stands out is the increased federal regulation of hospital procedures, with the goal of ensuring that the poor do not fall prey to corrupt doctors charging for unnecessary medicines and services.

Indeed, beginning in 2000 the government began to regulate doctor practices, mainly through mandated registration and licensing through the *Law on Medical Practice* (UU 29/2004).[174] This law also required that hospitals be accredited. Falling under the purview of the Ministry of Health, a semi-autonomous hospital regulatory agency was also established, KARS (*Komisi Akreditasi Rumah Sakit*).[175] Since 2000, KARS has increased its regulation of hospital and doctor practices, while coordinating with provincial and municipal governments to strengthen their oversight and regulatory roles.[176] These activities have helped to increase hospital transparency and to discourage

doctors and administrators from engaging in corrupt practices – especially in a context where roughly 90% of funding for healthcare still comes from the central government.[177]

What's more, in 2010 the Hospital Law bill required that the ministry of health closely monitor and regulate hospitals, with an emphasis on human resource practices. Oversight and regulation was also improved with the Health Law's creation of independent national and provincial hospital oversight boards (BPRS). The BPRS reports directly to the president and governors of the provinces.[178] When compared to India, China, and Russia, then, Indonesia's ministry of health appears to be much more committed to accrediting, monitoring, and regulating hospitals and doctors' activities. These efforts appear to be helping central- and provincially-managed hospitals ensure that the *Jamkesmas* program achieves its goals.

In further contrast to India, China, and Russia, Indonesia also saw the rise of a very proactive, demanding social health movement, which dovetailed with the movement for increased democratization. In recent years, citizens have been extremely critical of the government for failing to meet basic healthcare needs, especially after the financial and administrative challenges of decentralization ensued.[179] As in Brazil, heath activists and NGOs have used their access to the congressional legislature (at the national and local level), committees, and the media to effectively pressure the state for improved access to healthcare.[180] In a context of weak executives and heightened sensitivity to the poor's healthcare needs, these pressures from civil society have created even further incentives to ensure that the *Jamkesmas* program works effectively.

CONCLUSION

In recent years, India, China, Russia, and Indonesia have joined the international community in demonstrating a strong commitment to providing universal healthcare. While federal funding for universal healthcare has increased in all of these nations, they have varied considerably in the types of health insurance programs pursued. Nevertheless, a common policy area that all of these nations adopted was the creation of national health insurance programs targeting the poor, protecting them from out-of-pocket (OOP) and catastrophic healthcare expenses. For all of these governments have realized that in the past, these health-induced economic hardships have deepened the poor's poverty level while limiting access to healthcare. Nevertheless, despite the introduction of similar types of policies, most of these nations failed to avoid these challenges. With the exception of Indonesia, in India, China, and Russia, OOP and catastrophic expenses have continued to increase, leading public health activists and scholars to question the efficacy of these national health insurance programs.[181] But what explains this variation in policy outcomes?

This article has argued that differences in the design of constitutional rules, government commitments to decentralization, and the ability of civil society to pressure for successful policy implementation accounts for these policy outcomes. In those nations exhibiting constitutional rules providing executives with a high level of policy-making power – such as executive decree authority - and low levels of electoral accountability, as seen in India, China, and Russia, executives have had few incentives to coordinate with national and sub-national health agencies in order to ensure that national health insurance programs targeting the poor achieve their goals; this problem is further compounded with India, China, and Russia governments' respect for sub-

national government autonomy and decentralization, viewed as a cornerstone to economic growth and development. And yet, this context has also created few incentives for these governments to carefully regulate hospitals and doctor malpractice, ensuring that doctors do not prescribe unnecessary drugs and tests. At the same time, social health movements advocating for the poor's right to healthcare through health insurance and public health programs has been weak and ineffective in these nations.

In contrast, Indonesia's constitutional rules have engendered a weak executive with a low level of policy-making authority and a high level of electoral accountability. This context has incentivized the executive to coordinate with national and sub-national health agencies in order to ensure that pro-poor health insurance programs work well. Furthermore, in contrast to India, China, and Russia, there is a greater degree of fiscal centralization and a weaker federal structure, exhibiting a low level of central government commitment and trust in decentralization processes. In recent years this has incentivized the ministry of health to carefully regulate hospital and doctor performance, insuring that the poor are financially protected through national health insurance programs targeting the poor, such as the *Jaskesmas* program. Finally, building upon years of social protest and mobilization under the Suharto military dictatorship, civil society has emerged as a proactive, well-organized force taking advantage of Indonesia's turn to electoral presidentialism, holding the executive and the congress accountable for health policies targeting the poor.

This study has therefore shown that to better understand why the emerging economies very in their ability to provide financial protection for the poor through national health insurance programs, one must first understand how constitutional rules, decentralization, and civil societal pressures combine to shape the incentives that political leaders have to ensure that these programs achieve their goals. For it is not only the insufficient level of funding, poor targeting of funds and the design of decentralization processes that is critical for effective policy implementation,[182] [183] but also – and perhaps more importantly – the preexisting constitutional rules that generate incentives for effective policy action.

My theoretical approach and comparative analysis also suggests future areas of research and policy lessons. First, given the importance of constitutional rules, future researchers may wish to extend this kind of analysis to the *sub-national* constitutional level. In so doing, we may be able to better understand differences in governor and mayor electoral and veto powers, and therefore, differences in not only state and local government willingness to comply with national government interests in implementing national health insurance programs targeting the poor, but also differences in government responsiveness to the poor's healthcare needs. Second, the decentralization of healthcare financing and administration (especially in India, China, and Russia) does not appear to be facilitating the implementation of these types of national health insurance programs; this dilemma may require that central governments find innovative ways to increase their monitoring and regulation of insurance companies and hospitals that are responsible for providing benefits. As seen in Indonesia, the creation of national agencies regulating hospitals, as well as increased ministry of health leadership in coordinating with hospitals, can help to ensure that healthcare providers are adhering to national policy goals.

Finally, researchers may wish to extend my theoretical and empirical approach to other emerging economies, such as Brazil, South Africa, Thailand, and Mexico. In recent

years, each of these nations have implemented national health insurance programs targeting the poor, ensuring that they not only have access to healthcare but that they are also protected from all healthcare related expenses. And yet, the design of constitutional rules, as well as preexisting national government commitments to decentralization and the efficacy of social heath movements are very different in these nations. Researchers will need to explore if these institutional and civil societal factors are important in explaining variation in policy outcomes, while exploring other potential factors not addressed in this study.

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International Relations and the Global Politics of Health: A State of the Art

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Despite consistent political attention to health-related issues crossing national borders, public health and international relations have not engaged in a coherent dialogue. Public health scholars denounce studies of politics as not directly relevant to the governance of health, which they envisage as based on evidence and medical knowledge. The marginal place of the global politics of health in international relations is surprising given the richness of political interactions, diversity of actors involved, and the existential nature of health politics. This article outlines the main themes in the literature on global and public health politics, highlights the points of convergence and divergence, and discusses how we can build on the strengths and overcome the differences in search of a more comprehensive dialogue between the two disciplines.

INTRODUCTION

Health issues have been the subject of transnational political cooperation since international efforts to contain infectious disease epidemics began in the nineteenth century. They secured a permanent place on the global political agenda with the establishment of the League of Nations Health Organisation in 1922, whose work was inherited by the World Health Organisation (WHO) in 1948. The body of literature covering different aspects of the global politics of health including governance, health security, the political economy of health, and the impact of globalisation and trade liberalisation on health, experienced intense expansion in recent decades. But despite such consistent political attention, public health and international relations (IR) have not engaged in a coherent dialogue.[1] International relations' engagement with the politics of public health is limited and its discussion of global health politics has remained on the margins of the discipline. Other than a small number of studies, public health scholars continue to shun studies of politics and governance as not directly relevant to the governance of health, which they envisage as being evidence-based and driven by medical knowledge.

The marginal place of the global politics of health in the discipline of IR is surprising, given the richness of political interactions, the diversity of public and private actors involved, and the existential value of health politics for people across the world. This article discusses some of the reasons for the limited engagement of the IR community with the global politics of health and looks into some of the obvious obstacles to more in-depth collaboration between public health and international relations. Overcoming some of these barriers, could potentially contribute to an improved understanding of international politics and enrich theoretical debates. It would also better inform the public health community about the complexity of global political interactions and institutional structures and their impact on health issues of national and international concern. The influence of politics, power relations, and

institutional dynamics on public health is inevitable and significant, and cannot be ignored by those in the field. Equally, international relations scholars cannot fully understand health politics without insight from the practical and academic fields of public health and health policy analysis. Attention to politics, policy implementation, and evaluation has already been drawn upon in the health policy analysis (HPA) literature. However, the latter focuses primarily on domestic politics and policy dynamics, as well as policy implementation in low- and middle-income countries, thus excluding analysis of global power relationships, norms, priorities, and policies.

This article consists of four parts. The first one reviews the literature on global health and public health politics, identifying some of the main themes. The second deliberates further possible contributions from the field of international relations, while the third part outlines the points of convergence and divergence between the international relations and public health literature. The concluding fourth part discusses how we can build on the strengths and overcome the differences in search of a more comprehensive dialogue between the disciplines.

THE GLOBAL POLITICS OF HEALTH – A STATE OF THE ART

The International Relations View of Health Politics

Health issues secured a permanent place on the international political agenda early on in the twentieth century, evidenced by the relatively early creation of regional and global inter-governmental institutions.[2] They remained outside the purview of international relations, however, because they were classified by traditional IR scholars as issues of 'low politics,' i.e. not of strategic significance. It was not until the 1990s in the post-Cold War context and in search of the next set of threats to security that U.S. analysts pointed to the dangers that global pandemics of emerging and re-emerging infectious diseases and bioterrorism posed to the United States.[3] Other IR scholars argued that the problem was one facing the whole world, not just the United States —that this was an issue that IR ought to deal with under the rubrics of national security, foreign policy, and global security politics.[4] Since then, various aspects of health politics have been examined in an IR context with a focus on questions of governance, intergovernmental institutions, human rights, trade, globalisation, and intellectual property rights.

Attention was drawn to the role of civil society, epistemic communities and corporate actors in the governance of health issues, to the work of the World Health Organisation and the fact that the World Bank had surpassed it as the largest donor to health programmes worldwide, which were all at the heart of the rapidly expanding global health governance literature.[5] The creation of the World Trade Organisation and the associated signing of the TRIPs and GATS agreements in Marrakesh in 1994 generated studies of the political economy of global health, which examined questions of global trade and health, as well as the impact of TRIPs on health, including access to and affordability of medicines and the relationship between GATS and the delivery of health services.[6] The increased volume of transnational trade and travel often referred to as the core of globalisation have also been studied in relation to health by IR academics. They examine both the impact of globalisation on health and the consequences of ill-health for a globalised economy.[7] These studies have been built around existing theoretical frameworks (predominantly constructivism), making them accessible to scholars in the

field. They have, however, rarely sought to engage in dialogue or themselves contribute to IR's theoretical debates, confining the politics of health governance to a more marginal position in the broader field.

Some political scientists also sought to develop analysis infused with epidemiological insight regarding emerging and re-emerging infectious diseases. Articles discussing actual and potential global epidemics of HIV/AIDS and influenza, in particular, and their impact on national and global security appeared on the pages of political science journals in the early 2000s.[8] Overall, the predicted doomsday scenarios did not materialise, even though the world came close to some of them with the rapid spread of HIV/AIDS prior to the development of anti-retroviral drugs. As a result, some interest in infectious diseases and bioterrorism as security threats has been lost and some IR scholars have argued that health issues no longer belong on the global security agenda.[9] The high mortality resulting from ill-health, however, compared with any other factor, including violence and war, leaves open important questions about the way we view health politics in relation to other aspects of global politics.

The Public Health View of Politics

In 1966, Herbert Kaufman argued that public health has paid far too little attention to politics, and that political science has largely ignored the field of public health.[10] He drew attention to the political character of the creation and jurisdiction of public health agencies, their financing, selection of personnel, relationship with other agencies, etc. as relevant political questions for public health. At the start of the twenty-first century, the situation has not changed much and the politics of public health remain largely understudied.[11] This is attributed by Brown to public health's aversion to politics, seen as too subjective and 'tainted' by competing interests, in contrast to health's scientific and objective nature,[12] while Bambra *et al* argue that political science's limited view of public health merely as the provision of healthcare is to blame.[13] Walt and Gilson further emphasise the 'paucity of theoretical and conceptual approaches to analysis of the processes of health policy in low- and middle-income countries,'[14] which hinders political analysis. While there are different views about the causes of the insufficient dialogue between political science and public health, there seems to be agreement that such engagement ought to be encouraged in order to foster a deeper and more detailed understanding of the complexities of health politics.

Scholars of public health recognise the lack of an unequivocal definition of the term 'public health' as a significant obstacle to effective policy advocacy and policymaking.[15] Public health is broadly defined as a collection of organised measures aimed at preventing disease, prolonging life, and promoting health and wellbeing for the whole of society.[16] In practice, however, policymaking and resources are often directed towards responding to disease, rather than at health promotion and prophylaxis. As Bambra *et al* discuss, 'the conceptualization of health as non-political is also in part due to medicalization – the transfer of power over and responsibility for health from individuals, the public and therefore political life, to powerful elites, namely the medical and health professions and the multinational pharmaceutical companies.'[17] Such contrasting views of health and public health result in a mismatch between overall political intention (as defined by the WHO and academics) and the practical reality of policy responses.

The identity of the central authority in public health is also subject to debate. Thomas Oliver postulates that public health commonly involves 'governmental action to produce outcomes – injury and disease prevention or health promotion – that individuals are unlikely or unable to produce by themselves.'[18] Lawrence Brown defines public health as the 'arts and science, which advisors to and agents of the State employ in exercising their public authority to identify and address threats that derive from sources in the *environment* for the health of *populations*.'[19] Others, however, see a role for private and public bodies in the governance of public health. The Institute of Medicine in the United States, for example, argues that the organisational framework of public health includes activities undertaken not only by the government and its agencies, but also 'the associated efforts of private and voluntary organizations and individuals.'[20] The WHO also refers to public health as including 'all organised measures (whether private or public) to prevent disease, promote health and prolong life among the population as a whole.'[21] Bambra *et al* observe the role pharmaceutical companies have carved out for themselves in regards to individual health.[22] Other studies examine the influence of private philanthropy on the development of health systems,[23] the pressures from the World Bank to streamline healthcare, reduce costs, and increase private provision,[24] as well as the role of civil society organisations and think tanks in public health.[25] This discussion is deeply political because it hinges on questions of legitimacy, authority, governance, and responsibility, all of which are central to political science and international relations. It demonstrates the complexity of the politics of public health and the broad spectrum of actors involved in them, giving rise to concerns about the role of public and private interests, power relations, and institutions.

Analyses of agenda setting and health policy formulation and implementation are the focus of Health Policy Analysis (HPA), which has attempted to bring together studies of public health and political economy, sociology, political science, and other social sciences. In one of the field's most influential works, Walt and Gilson outline the 'policy triangle' as a way of developing a better understanding of policy development and implementation. It draws attention not only to the content of policies, but also to actors, processes, and context.[26] The policy triangle has now become the framework of choice for much of health policy analysis, but while it links political science to the field of public health, HPA studies are no substitute for substantive engagement between PH and IR. HPA studies are not particularly theory oriented and are predominantly dedicated to analysing health policy formulation and implementation in low and middle-income countries,[27] while international relations seeks a more global perspective. They do not sufficiently question international policy dynamics, power inequalities, or how power and knowledge influence policy-making and implementation, which are questions at the core of international relations analysis.

Looking at the state of the art, there are two main directions for further development of the politics of health discussion. Firstly, the international relations analysis of health politics can be enhanced by infusing it with a more theoretical discussion – both as a means of critically evaluating the current state of the literature (including health security, globalisation and health, global health governance, and the political economy of health) and seeking to engage further in the disciplinary theoretical debates. Secondly, it is vital to build more substantial and enduring bridges between the fields of public health and international relations. This will require a more sustained

interdisciplinary dialogue and further diffusion of knowledge from disciplines with contradictory epistemologies and mismatched ontologies, as will be discussed below.

GLOBAL HEALTH POLITICS AND IR THEORY

Health politics are of great significance to people across the world. Health issues are closely connected to other prominent themes in international relations such as conflict and security, development, poverty alleviation, trade, human rights, environmental degradation, and global governance. It is therefore surprising that discussions of the global politics of health governance have not engaged with and informed the broader field of international relations theory more extensively. This section combines an overview of some of the shortcomings of the current global health literature with reflections on how these might have contributed to health issues that do not draw greater attention from the wider field of international relations. Four interrelated issues are explored in the remainder of this section – the over-reliance on conventional constructivism as a framework for analysis, the resulting state-centrism of global health politics analysis, the limited attention paid to differentials of political power, and the lack of attempts to use empirical analysis to contribute to broader IR theorising, testing, or critiquing existing theories.

Firstly, there is a relatively small community of scholars analysing the global politics of health, many of whom have gravitated towards constructivism as their preferred theoretical paradigm. Constructivism has been very *en vogue* post-Cold War. At its core, it is premised upon the importance of ideas, norms, identities, and interests in international politics.[28] Constructivism is more of an approach than a traditional grand theory of international relations and brings together scholars with various ontological preferences - state-centric, institutionalist, structural, agentic.[29] Constructivists are divided in their epistemological views in two identifiable groups – critical and conventional.[30] Studies of the global politics of health have premised analysis on conventional constructivism, which is mostly state-centric, preferences a positivist epistemology, and does not depart too radically from mainstream international relations. The global health literature does not reflect critically on this choice of a theoretical framework, or its implications for the resulting analysis.

Conventional constructivism is only one, and perhaps a rather weak, example of critical approaches to international politics.[31] Others include Marxism, feminist approaches, post-structuralism, and postcolonialism. As Robert Cox highlights, critical theory 'stands apart from the prevailing order of the world and asks how that order came about.' It does not 'take institutions and social power relations for granted but call[s] them into question by concerning itself with their origins and how and whether they might be in the process of changing.'[32] Critical theories offer different perspectives on the sources and implications of power differentials in world politics, on identities and interests, values, and norms. They raise questions about the legitimacy of political authority, the pathologies of power, the relationship between authority/power and knowledge, and the consequences of this relationship - questions relevant in one form or another to studies of the global politics of health.

Secondly, most global health studies remain implicitly state-centric. This is a direct consequence of using conventional constructivism as a theoretical framework. Only a small proportion of scholars highlight the influence of civil society organisations,

charities, philanthropic foundations, or the indirect coercion exercised by corporate power on health politics. While the activities of these actors are documented in the political economy, global health politics, and global health governance studies, their consequences for understanding governance processes or the implications of their work for people in different income settings are rarely examined in great depth. Neoliberal economics dictate that private actors generally have a positive impact on health in low- and middle-income countries in particular, and their work and influence is almost taken for granted.[33] Further analysis is needed of the influence of non-state actors, as they interfere with government policymaking, generating dynamics which cannot be explained solely by focusing on the politics between states and inter-governmental institutions.

Philanthropic foundations, for example, have been shown to modify national health systems, to determine the focus of national health campaigns, and pre-select the health priorities for recipient governments, thus shifting the direction of domestic politics and policies.[34] Therefore, an omission of such actors from the overall analysis of health politics obscures important power dynamics, as well as the reasons for and constraints on the policy choices of some governments. An overall conclusion that public health is better off with private actors and public-private health partnerships draws a veil over the politics of unequal power relations and their consequences. The work of civil society organisations comes with its own benefits and weaknesses, which have also been underexplored. Agentic constructivism is one framework for analysis that explores the role and influence of a broad spectrum of actors on formulating norms and principles in international politics.[35] Ontologically, critical theory and feminisms also stand apart from state centric paradigms. Their proponents see state-centrism as obscuring power relationships and inequalities at the grassroots level.[36] Health politics are very complex, spanning different levels of analysis (global, regional, state, local) and if we try to understand them solely at the international or national level in isolation from other political, social and economic dynamics and influences, our analysis is likely to be rather deficient.

Continuing on from this theme, a third limitation of global health studies, particularly of health security, but also of global health governance, is the little attention paid to the analysis of power relations and authority. These are two central themes in international relations. Power relations among states, between states and different types of international actors (including intergovernmental organisations) lie at the heart of both traditional and critical paradigms of international politics, but for different reasons. Power inequalities within states, however, are the purview of feminist and postmodernist thought. Postmodernists pay specific attention to the relationship between power, knowledge, and language.[37] Such issues, along with the politics of power and its consequences, demand attention in the realm of global health politics, as well. Power relationships influence and shape international agendas, policy priorities, funding, etc. and power differentials impact weaker states and actors in many ways. Multisectoralism is a distinct characteristic of politics in the field of health governance, signifying the existence of multiple and competing sources of authority.[38] With the World Bank and private philanthropic foundations as the largest donors to public health and health programmes, questions about authority and its legitimacy are particularly prominent. While current health governance studies have identified the idiosyncrasies of governance in the field, further analysis is needed of the causes and consequences of

these features, particularly if we are aiming to understand, inform, and improve global policy.

The final shortcoming of the field to be discussed here is the little effort that has been made to engage with, challenge, or test IR theories. Virtually no insight from global health governance studies has been used to contribute to theoretical debates in IR. Discussions about governance, power, authority, legitimacy, the form and nature of international and global cooperation and coercion, and the creation and implementation of international norms can all enrich theoretical debates. Other IR subfields formerly considered as 'low politics' – such as environmental politics, human rights politics, trade politics, and political economy – have all made such contributions. We now talk about green IR theory, about building bridges between the disciplines of international law and international relations, understanding international cooperation through trade regimes, etc. This has provided crucial points of engagement and debate between the subfields and the theoretical core of the subject, also feeding back critical questions from theoretical debates back to the subfields. Broader engagement with the discipline and theories of international relations can draw attention to aspects of global health politics that may have otherwise been neglected, or highlight areas of concern often omitted by mainstream theorising.

DIALOGUES BETWEEN INTERNATIONAL RELATIONS AND PUBLIC HEALTH – DIVERGENCE AND CONVERGENCE

The dialogue between international relations and public health has not flowed seamlessly or naturally. There are a number of reasons for this. Firstly, as previously discussed, even though public health and political analysis have expanded in practical and theoretical terms, 'their trajectories are mainly parallel, rarely convergent.'[39] On the one hand, as the review of the literature suggests, public health professionals prefer to define their field as scientific, objective, and apolitical, seeing politics as an unnecessary distraction that subjects science to political interests. They often distance themselves from analysis of political power and institutions, believing that medical knowledge alone drives decision-making. On the other hand, understanding public health requires complex specialist knowledge. This makes it harder for non-specialists such as political science and international relations scholars to gain good working knowledge and a competent understanding of the subject matter sufficient for an informed discussion of the politics of the field.

Secondly, there are some ontological and epistemological differences between international relations and public health. Ontologically, international relations and public health 'see' the world differently. International relations 'sees' a world of sovereign states and other non-state actors operating in a system with no authority higher than the state. Mainstream theories acknowledge the state as the core unit of analysis, due to its sovereignty, defined as the freedom of states to conduct their internal and external affairs free from intervention. This sets it apart from all other actors in the global arena. Some IR scholars recognise the agency of non-state actors in the global arena on the basis that these actors, although not sovereign, have the capacity to influence global politics. Public health operates at a different level of analysis, as it is governed primarily within national borders by government agencies.[40] In some cases, private actors (both for-profit and not-for-profit) and public-private partnerships

influence public health policy. Most definitions of public health do not specify where agency lies in public health governance, but if agency is defined as authority and capacity to create policy, then we can argue that it lies with governments and government agencies, supplemented by the influence of private actors. A point of convergence between the fields of international relations and public health is that they are both seeking to better understand the role of private actors in health policymaking, the interplay between public and private power in health politics, the definition of power and authority, as well as the role of ideas, social constructions, and scientific knowledge – all of which are questions of significance for both fields and require further research. Debates will be significantly enriched by a more focused dialogue between the two disciplines.

The differences in relevant agency in IR and PH are set in the context of differences in the character of the structure within which politics are taking place. Structure in international politics is anarchic – defined by the lack of an authority above sovereign states that can force them to behave in a particular way. Authority is, therefore, distributed horizontally, and states are both the governors and the governed in the international system. Domestic political structures, within which public health is governed, are vertical structures of authority – where political authority resides with the state – the government (legislature), the executive, and the judiciary - and all other actors are subject to its jurisdiction. These qualitatively different structures affect the nature and character of political processes and the forces that drive them. In IR, the anarchic structure of international politics and differentials in the power capabilities of states are believed to determine the conflictual nature of international politics.[41] International politics are competitive because the possession and access to scarce resources define the power capabilities of states. Domestic politics are also driven by competition for scarce resources, but these are distributed by the government. The relationship between the anarchic and hierarchic structures of global and domestic governance, along with its influence on the politics of health governance is virtually unexplored.

In epistemological terms, public health and international relations are almost at the opposite ends of the spectrum. Public health relies on empirical epistemologies and scientific methodologies.[42] Epidemiology, health systems, and health promotion, which are all part of public health, are all evidence-based fields, grounded in scientific knowledge.[43] International relations belongs to the family of social sciences. Under the influence of American social science, traditional IR scholars have embraced a positivist epistemology in an attempt to emulate the natural sciences.[44] Traditional IR scholars, however, are also the ones who perceive health as an issue of 'low politics' and therefore of little relevance to the strategic political agenda. Critical IR theories (broadly defined) are the ones which do not differentiate between high and low politics and provide space for consideration of topics such as health on the global political agenda. They are also the ones, however, that adopt post-positivist epistemologies and qualitative research methods in direct contrast to the positivism and empiricism of public health. Exploring the possibilities in such epistemological debates could have profound effects on both PH and IR understanding of the global politics and governance of health.

If we accept the possibility of objective and neutral scientific knowledge, the epistemological schism between public health and international relations would be impossible to bridge or close. However, if we consider scientific knowledge as socially-

conditioned and constructed, as proposed by the sociologists of scientific knowledge, then the links between the local and global political contexts and the knowledge produced by public health practitioners and scholars become more discernible. Sociology of scientific knowledge (SSK) scholars argue that knowledge is produced through a social process and is shaped and influenced not purely by the discoveries of scientific research, but also by social, cultural, political, and economic factors and power relations, premised on professional standing and influence.[45] This is assuming a social nature of scientific knowledge makes a dialogue between political scientists and public health scholars compulsory.

CONCLUSIONS: POLITICS AT THE JUNCTION OF INTERNATIONAL RELATIONS AND PUBLIC HEALTH

This article set out to provide a broad overview of the main themes and discussions in the global politics of health governance literature with the aim of identifying avenues for its further development and improvement. The literature review has demonstrated that in some areas like security politics, for example, we have reached an impasse in the dialogue between IR and public health, while in others, like governance and trade analysis, the dialogue has become a bit closed and stale. Discussions of the global politics of health governance remain on the margins of the discipline of international relations, due in part to their limited engagement with theory testing and development, while public health continues to be myopic about the impact of global political dynamics and institutions on health policy and financing.

In a globalised world, ill-health can neither be contained within state borders, nor is it determined solely by domestic factors in isolation from external ones. With by far the largest number of deaths per year caused by disease, the politics of health are of existential importance, more so even than the politics of security. The stakes are high, as political decisions in health governance directly affect individual well-being. The discipline of international relations provides comparative frameworks and theories from the analysis of inter-state politics in different political realms including governance, the politics of power, conflict, competition, cooperation, law, economics, etc. that can build a more in-depth understanding of the global governance of health. Critical and post-modernist approaches, for example, can help to draw attention to inequalities and power differentials, and the mechanisms through which authority is re-enforcing these. Feminist approaches can highlight the gender-based nature of contemporary health politics and pinpoint gender-driven policies. Political economy can expose the impact of neoliberal economics on health politics. At the same time, a more sophisticated understanding of the global politics of health can raise new challenges for the understanding of security politics, the role of public-private partnerships in global governance, and the interplay between different sub-fields of international relations. It can provide new insight into agency with analysis that cuts through different levels of aggregation – i.e. individual/state/international.

Engaging public health knowledge in the political analysis of the governance of health is of great importance, as the latter will be infused with specialist knowledge. Such engagement also has the potential to expose causal relationships that shape political interactions, which may otherwise remain obscure. A dialogue between public health and international relations is overdue, but is unlikely to be easy due to the

ontological and epistemological differences between the disciplines. New approaches ought to be sought out in order to facilitate such dialogue – the overreliance on constructivism and qualitative methodologies on the part of IR scholarship and the over-commitment to evidence-based scientific knowledge of public health have not delivered the full potential of bridging these two disciplines.

The governance of health is taking place in an ever-changing political context - political spaces of domestic and international politics are increasingly overlapping, watering down the inside/outside dichotomy that has defined the field of international relations since its inception. International agendas set by intergovernmental institutions influence national health policies. Intensifying international trade and travel, the internationalisation of production, and the emerging global trends in consumption mean that no part of the world can remain isolated from emerging and re-emerging communicable diseases, nor from the prevailing non-communicable diseases. The health-related agendas of state and non-state actors stretch beyond state borders, creating an urgent need to examine public health politics and international politics in tandem.

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