Narratives of Prevention

Making Sense of the Global Health Crisis: Policy Narratives, Conflict, and Global Health Governance

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Abstract Health has become a policy issue of global concern. Worried that the unstructured, polycentric, and pluralist nature of global health governance is undermining the ability to serve emergent global public health interests, some commentators are calling for a more systematic institutional response to the "global health crisis." Yet global health is a complex and uncertain policy issue. This article uses narrative analysis to explore how actors deal with these complexities and how uncertainties affect global health governance. By comparing three narratives in terms of their basic assumptions, the way they define problems as well as the solutions they propose, the analysis shows how the unstructured pluralism of global health policy making creates a wide scope of policy conflict over the global health crisis. This wide scope of conflict enables effective policy-oriented learning about global health issues. The article also shows how exclusionary patterns of cooperation and competition are emerging in health policy making at the global level. These patterns threaten effective learning by risking both polarization of the policy debate and unanticipated consequences of health policy. Avoiding these pitfalls, the analysis suggests, means creating global health governance regimes that promote openness and responsiveness in deliberation about the global health crisis.

Introduction

Health has, somewhat belatedly, become an issue of global concern. Globalization has intensified long-standing health disparities between rich and poor. While these health inequities are not new, the global reach of these disparities today is. Networks and pathways across the globe not only expedite information and people but also have proved effective high-

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ways for health threats. As the spread of new infectious diseases such as SARS, HIV/AIDS, and influenza has shown, a local issue in one part of the world can rapidly become a problem for everyone else (Dodgson, Lee, and Drager 2002). Increasing sociocultural globalization does the same for noncommunicable diseases. The exposure to "global culture" that often accompanies growing prosperity (Held and McGrew 2007) has arguably increased the incidence of noncommunicable diseases in the developing world.

This so-called global health crisis gives rise to global public health interests (Schrecker, Labonté, and de Vogli 2008). Since new health threats are transboundary and global, argue such researchers as Dodgson, Lee, and Drager (2002) and Fidler (2007, 2009), these public health interests are inadequately served by individual national health policies. What is needed instead is enlightened and effective global health governance (Kickbusch and Payne 2004; Fidler and Gostin 2006; Gostin and Mok 2009).

But globalization has also transformed the political, economic, and institutional contexts for health policy making. Until recently, international health governance was dominated by states that regulated their affairs through treaties negotiated in the rarefied arenas of international diplomacy. Today, a plethora of state and nonstate actors untidily compete and cooperate at and across many different levels and in many different institutional contexts. Because it departs so fundamentally from the decorum of interstate anarchy, Fidler (2007, 2009) calls this unstructured and polycentric pluralism "open-source anarchy."

Like globalization, the impact of open-source anarchy on global health policy making has been profoundly ambiguous. On the one hand, some contend that open-source anarchy has spurred policy makers' interest, attention, and, more importantly, willingness to invest in global public health issues (Fidler 2009). On the other hand, many argue that the messy pluralism of open-source anarchy undermines the ability to properly pursue global public health interests.

For one thing, lack of global leadership, sensible priority setting, and effective coordination are squandering the many new resources that have become available for health policy (Kickbusch and Payne 2004; Gostin and Mok 2009). If global public health interests are to be met, so the argument goes, global health governance needs to "harness creativity, energy and resources for global health" (Gostin and Mok 2009: 9) and direct them at the most pressing health challenges.

Then there is the issue of power. The unstructured and unregulated pluralism of open-source anarchy makes it difficult to enforce global public

health goods in the face of powerful, mostly economic interests (Kickbusch and Payne 2004; Schrecker, Labonté, and de Vogli 2008; Sridhar, Khagram, and Pang 2009; Smith 2010). So, commentators conclude, without proper global governance structures equipped with formal powers (and the financial clout) to set agendas, coordinate activities, and sanction digressions, the powerful and rich will use the unstructured nature of open-source anarchy to scupper global public health objectives. In short, many commentators conclude, unstructured and unregulated pluralism in global health is both unfair and ineffective.

But is it really? And is "harnessing, regulating, and coordinating" necessarily the remedy?

This article argues that reining in and straightening out open-source anarchy may be only part of the solution. This is because the global health crisis is a messy or wicked policy problem (Rittel and Webber 1973; Verweij and Thompson 2006; Ney 2009). Like other global policy challenges such as climate change or financial regulation, health spills sloppily into a wide range of other policy domains. What is more, key determinants of health — both at the individual and at the societal levels — are fundamentally uncertain.

Under these circumstances, health policy making is as much about figuring out what to do next as about decisive priority setting, competent coordination, and effective implementation. Determining the global public health interest requires exploration and learning, a process the British political scientist Hugh Heclo (1974) has called "puzzling."

Using narrative analysis, this article explores whether open-source anarchy helps or hinders puzzling about the global health crisis. It does so by first outlining how narrative analysis explains how policy actors "puzzle" about messy policy challenges (the first section). This section also introduces the methods and sampling procedures used in the analysis. The second section analyzes the narratives that emerge from 173 policy documents from forty-five different organizations from the public, private, and citizen sectors. This analysis reveals that "puzzling" about global health governance takes place in a policy space delineated by (at least) three contending policy stories. The third section, then, uses these three policy narratives to investigate how, in the absence of formal structures of power, actors exclude and out-voice contending narratives in open-source anarchy. The analysis suggests that no single narrative drowns out the other voices on all issues all of the time. However, pairwise alliances based on settlements across narratives manage to shut out contending voices from policy deliberation.

Finally, the fourth section shows how patterns of exclusion are risky for effective puzzling. On the one hand, exclusion contributes to the polarization of the global health governance debate. Data from the narrative analysis suggest that there is but modest learning among contending policy actors. Given that policy debate about global health governance is inherently conflictual, polarization may lead to the degeneration of debate into a shouting match. In this case, puzzling breaks down, and policy actors revert to "powering." This always favors the stronger and more resourceful actors. In this sense, then, critics of open-source anarchy are not altogether wrong to claim that unstructured pluralism may be unfair. Avoiding powerful actors from opting out of "puzzling" may call for some form of strategy to moderate between contending actors.

On the other hand, out-voicing also risks policy failure (Thompson, Rayner, and Ney 1998; Scoones and Forster 2008). Excluding stories from policy deliberation leaves pairwise alliances vulnerable to conceptual blind spots built in to narratives. However, the narrative analysis suggests that open-source anarchy provides both institutional space and the requisite scope of policy conflict to prevent these types of policy failures. In this sense, then, the claim that open-source anarchy is ineffective in tackling the global health crisis is questionable. This suggests that effective global health governance will need to encourage more, rather than less, pluralism and provide all voices with a fair hearing; this implies some form of equalization strategy.

Messy Issues, Persistent Conflict, and Narrative Analysis

Theory: Uncertainty, Frames, and Narratives

Narrative analysis provides insight into policy processes about uncertain and complex policy challenges — sometimes referred to as "messy" or "wicked" policy issues (Rittel and Webber 1973; Rein and Schön 1993; Roe 1994; Stone 2002; Ney 2009). Although messy policy challenges tend to be technical and scientific, science and technology alone provide few practical clues about what policy makers ought to do next. Answering that question requires bringing the masses of data about messy issues into some order that makes practical sense (Adler and Haas 1992). Policy actors need to show a potentially skeptical audience how scientific knowledge translates into a particular course of policy action (Fischer and Forester 1993). This kind of argumentation requires selection and interpretation of data.

To do this, policy actors rely on systems of ideas and values — "frames" (Rein and Schön 1993) — to guide selection and interpretation. Frames help actors coordinate social values, epistemological commitments, and collective action. It is by refracting data about messy problems through frames that policy actors recognize and formulate their political preferences (Rein and Schön 1993; Thompson, Rayner, and Ney 1998; Stone 2002). Using frames as their guides, policy actors construct plausible albeit selective accounts of what is and what they believe ought to be going on (Dryzek 1993; Rein and Schön 1993; Stone 2002). But because each frame emerges from ideas rooted in specific institutional and social contexts, they are not reducible to one another (Dryzek 1993; Thompson, Rayner, and Ney 1998; Fischer 2003). This is why different frame-based accounts of messy issues are likely to conflict: the accounts reflect the incompatible social and epistemological commitments of the respective frame.

Making policy for messy issues is an argumentative process (Fischer and Forester 1993; Fischer 2003). Narratives are not only accounts of what is going on, they are also political arguments for or against a particular course of action. This is action that aims to reproduce (at least in the particular policy arena) the institutional and social commitments that make up the particular frame. These policy arguments, then, are the conceptual material from which policy outputs emerge.

The conflict between advocates of contending narratives tells us something about the nature of the political system in which it takes place. This is particularly useful in political contexts where access, debate, and the exercise of power are regulated loosely or informally, such as policy networks and policy subsystems. Here narrative analysis sets out to understand how some accounts of messy issues, as Schattschneider (1960) tells us, are "organised into politics while others are organised out." A wide scope of policy conflict over a messy policy issue, then, points to an open and pluralist policy subsystem. Conversely, a narrow scope of conflict or policy consensus would suggest that contending voices and their arguments have been excluded from policy making.

This implies a three-stage analytic strategy. First, narrative analysis needs to gauge the scope of policy conflict about a messy issue (second section). Second, the analysis needs to establish to what extent this scope is reflected in actual processes of puzzling and policy deliberation (third section). Third, the narrative analysis needs to determine the implications for policy making of the scope of policy conflict.

Method: Content and Network Analysis

Population. The basic unit of analysis is the individual organization active in the global health policy debate. Any individual organization can belong to either the group of governance or public-sector organizations, market or private-sector organizations, and civil society or citizen-sector organizations (CSOs).

The total population of public-sector organizations at the international level consists of the so-called global governance institutions (Held and McGrew 2007; Steger 2009). These institutions comprise both the intergovernmental organizations and regional political bodies (Steger 2009). From this pool of organizations, the present study sampled those that are active in the debate about global health and that execute some form of regulatory function internationally.

The total population of all private-sector actors consists of all firms that trade internationally. The sampling criteria were that they take part in global health policy debates and that their actions (or inactions) are perceived by other actors to have policy-relevant impacts. This best describes the firms of the pharmaceutical industry. Based on Wikipedia's 2010 ranking of the twelve largest pharmaceutical firms, the five firms with the largest revenue were chosen.

Unfortunately, there is no easy way to limit the number of relevant organizations in the citizen sector. Unlike governance and market organizations, the citizen sector consists of a rich plurality of organizational forms and institutional missions. Since there are no obvious exclusion criteria, the number of potentially relevant organizations in the citizen sector is substantial. The methodological challenge, then, is to draw a boundary without unduly excluding voices from the debate while ensuring that marginal voices do not dominate.

The total population of citizen-sector actors was limited to organizations listed in databases (see table 1). As table 1 shows, the databases all imply that entrants are at least aware of international policy making. Moreover, either the organizational mission of the database compiler (e.g., WHO, UNODC, Health@WEF, NGOs for Health, and the Health Policy Consultant) or the keyword search (e.g., UNOG, EC, EEN-EPHA) ensured that the organizations in the lists have an interest in health policy. All eight lists contain 848 different organizations.

Dealing with the plurality of organizations meant further subdividing the population into types. Table 1 also presents the distribution of these organizational types across the population.

Table 1 Total Organizations in Population by Origin and Type

	WHO	UNODC	NGOs for Health	EC	Consultant	UNOG	Health @WEF	EEN-EPHA	Total
Therapy-based	16	0	0	1	0	6	0	4	27
Disease-based	31	5	4	25	0	32	2	14	113
Interest groups	23	2	5	40	0	28	0	8	106
Professional association	59	0	3	18	0	71	7	19	177
Single issue	43	56	6	65	12	89	4	99	374
Humanitarian	14	2	4	50	8	11	1	5	95
Environmental	3	0	0	15	0	0	0	2	20
Think tank	0	0	1	32	2	3	0	0	38
Total	189	65	23	246	22	240	14	151	950[a]

Source: Ney 2011

[a]Total includes double entries across the lists.

Sample. The sampling strategy took into account the different organizational types as well as the relative position in institutional networks. An approximate indicator for this institutional position was the frequency with which organizations were listed on different databases. Eighty-six organizations were mentioned on at least two different lists. Of these, eleven were listed on three or more databases.

A two-pronged sampling strategy combining bottom-up and top-down elements aimed to provide as fair and balanced a hearing as possible to as many actors as possible. All eleven organizations listed in more than two lists were included in the sample. The rationale here is that these organizations are making an effort to have their voices heard in the global public sphere. These organizations emerged entirely from the analysis of the databases. This is the core of organizations of the civil society organizations sample.

Of the organizations listed on at least two databases (the center of organizations of the CSO sample) as well as of the organizations mentioned only on one list (the periphery of organizations of CSOs), two per organizational category were chosen. One organization was chosen at random, another according to varying selection criteria (e.g., to avoid an overrepresentation of, say, cancer-oriented organizations or to include particularly prominent or interesting organization, such as Oxfam). The rationale for the two-pronged approach was to give a voice in the simulated conversation to both relatively unknown organizations without ignoring the loud voices of the well-known actors. This stage combined a bottom-up and top-down approach. This amounted to another eleven organizations.

Finally, as a way to calibrate contending narratives that emerged from the bottom-up analysis, I chose organizations not listed on any database about which, through previous research, I had prior knowledge of the content and orientation of the policy story they told. This stage relied entirely on a top-down sampling approach. This added another six organizations to the CSO sample (see table 2).

Documents. The main selection criterion for the documents was that it told a story about one or more health issues of global relevance. Many of the sampled institutions have prepared short pieces on a range of contested issues in the global health debate. These short, nontechnical papers are called "position statements," "policy positions," "declarations," "briefing papers," or "fact sheets." Where available, the study relied on these types of documents. The issues were chosen according to either policy relevance

Table 2 Overview of All Organizations Sampled

Public Sector	Private Sector	Civil Society
WHO, World Bank, European Commission, ISSA, ILO	Johnson and Johnson, Pfizer, Novartis, Roche, Glaxo-SmithKline	International Council of Nurses, World Medical Association, International Hospital Federation, Medical Women's International Association, World Federation for Mental Health, International Union against Cancer, International Diabetes Federation, World Confederation for Physical Therapy, World Heart Federation, World Vision International, World Federation of Occupational Therapists, World Psychiatric Association, International Federation of Pharmaceutical Manufacturers Associations, World Federation of the Deaf, International Agency for the Prevention of Blindness, Association of European Cancer Leagues, World Federation for Medical Education, International Union for Health Promotion and Education, Global Health Council, Aga Khan Foundation, Global Forum for Health Research, World Federation of Parasitologists, British Medical Association, International Association of Counselling, European Public Health Alliance, International Healthcare and Health Insurance Institute, Helen Keller International (Worldwide) Inc., European Patients' Forum, Rehabilitation International, Health Action, People's Health Movement, Oxfam, Save the Children, European Policy Centre, Bertelsmann Stiftung, Bundesärztekammer, European Federation of Pharmaceutical Industries and Associations, International Alliance of Patients Organisations, PNHP, Adam Smith Institute, Economist

Source: Ney 2011

Table 3 Documents Sampled by Sector

	Organizations	Documents
Public	4	7
Private	5	49
Citizen	36	113
Sum	45	169

Source: Ney 2011

(is this an important issue) or dialogical exchange (have two or more organizations addressed this issue).

Not all organizations prepare short policy positions. In this case, the study used what was available. This wide range of documents included research papers, publicity material (e.g., corporate social responsibility reports), pamphlets, or annual reports (e.g., the WHO's *World Health Report*). In terms of issues chosen, the sampling strategy applied the two criteria of general policy relevance and dialogical exchange.

Wherever possible, the study looked at two or more documents from each sampled organization. Again, the sampling strategy aimed for a rough balance across sampled organizations (see table 3): for institutions that provided shorter policy statements, more documents were included than for organizations providing longer documents.

Analysis and Coding. The coding, done by one person using the TAMS Analyzer software, was based on a simple code-frame. Each text was coded in terms of its assumptions, the problems it identified, and the solutions it proposed. The emergent policy stories were compared and sorted. Once basic policy narratives crystallized from this material, ambiguous or uncertain data were, if possible, recoded.

Network Analysis. The third section relies on a simple network analysis to ascertain how organizations from the CSO population are included or excluded from participation in global health partnerships (GHPs). Using Buse and Harmer's (2007) study of 23 GHPs, I created a population of organizations that participate in GHPs either at board or at partner level for 17 of the 23 GHPs.[1] A count of organizations involved in 17 of these 23

1. For 5 of the 23 GHPs on Buse and Harmer's list, partnership information was not readily available. These also include the Global Fund and the GAVI whose partnership structure is undergoing reform and has become rather complex (Buse and Harmer 2007).

GHPs both as partners and as board members yields about 1,075 different organizations from the public, private, and civil society sector. These lists of partners were compared with the CSO population for overlaps. What is more, the GHP population also subdivides into a periphery (organizations that participate in only 1 GHP of the 17), a center (organizations that participate in more than 1 and less than 3 GHPs), and a core (organizations involved in more than 3 GHPs).

The Scope of Conflict in Global Health Governance

The analysis of 170 policy documents revealed the potential for a lively policy debate about global health governance. In this debate, claims and counterclaims fly thick and fast as actors identify salient issues, draw lines of causality, take credit, and apportion blame. The narrative analysis teases out basic story lines in this conversation. Stories have beginnings, middles, and ends (Roe 1994) in which they create a setting (the underlying assumption), identify villains (the policy problem), and point to a hero (the solution) (Stone 2002; Ney 2009). Using these structural characteristics of narratives to compare the documents, the analysis distilled three basic narratives about the global health crisis: the Choices Story, the Rights Story and the Stewardship Story.

Health Choices

The global health crisis, the Choices Story argues, is a problem of public health care systems that can no longer keep up with the dynamic global economy. Its proponents include international organizations such as the World Bank, the pharmaceutical industry, and libertarians such as the *Economist*.

The setting for this story is a world in which wealth begets health (Musgrove and Zeramdini 2001). By pursuing profits, competitive firms generate the resources needed for developing the costly medical therapies that "have brought huge benefits to the health and quality of life of millions of people over the last 100 years" (GlaxoSmithKline [GSK] 2006b). At the same time, health industries drive economic growth by creating employment and wealth (GSK 2005, 2006a, 2006b; International Federation of Pharmaceutical Manufacturers and Associations [IFPMA] 2007; Johnson and Johnson 2010a, 2010b, 2010c, 2010d). This is also a world in which health — and the value people put on health — is as variegated as

are individuals (Hansen 2007; Roche 2009). Medical innovation, then, is about tailoring health care to individuals, something Roche (2009) calls "personalised health care."

The villains of this piece are politicians and public officials who mismanage public health systems (World Bank 1993; Wallace 2004; Hansen 2007; GSK 2005, 2006a; Vasella 2004). In developing countries, the World Bank (1993) argues, inefficiency caused by mismanagement and malfeasance creates gross health inequalities. If they are lucky, people in developing countries are offered high-tech services, more often than not funded by public subsidies, whose location and price put them beyond reach for the neediest (World Bank 1993). Yet for many millions of people, corruption squanders scarce resources for health on such things as weapons, luxuries, or political favors. In the developed world, the recent history of health-sector reform has been a protracted but largely unsuccessful battle against rising costs without a commensurate increase in value (Organisation for Economic Co-operation and Development 2004; GSK 2005). By pandering to powerful interests — such as the labor unions and public-sector employees — politicians in the global North have timidly and ineffectively tinkered with flawed public health systems (Wallace 2004; GSK 2006a; Hansen 2007; Johnson and Johnson 2010c).

These political failures corrode individual responsibility for health (Wallace 2004; Hansen 2007). In the developed world, systemic flaws, such as third-party financing, create disincentives for adopting healthy lifestyles (Wallace 2004; Hansen 2007). In the developing world, corruption, inefficiency, and inequality robs the poor of opportunities to make rational health choices.

The heroes of this tale, argues the Choices Story, is to promote patient choice. At the systemic level, this means improving access to health care in poor countries by shifting the focus of public health care from expensive treatments (such as curative treatment for terminal cancers) to a limited but cost-effective package of "essential clinical services" (World Bank 1993). It also means excluding those who can afford to pay for their own health care from public provision (World Bank 1993). In rich countries, health care reforms need to create incentives for individual responsibility. This includes, among other things, a shift to outcome-oriented financing of health services (Wallace 2004), greater cost-transparency by standardizing services (e.g., through DRGs), or insurance premiums that reflect risk profiles (Wallace 2004; Hansen 2007). Ideally, so the argument goes, scrapping third-party finance of health would return full control of health expenditure to consumers.

At an individual level, information and education about health encourages cost-effective consumer choices. In the developing world, much can be achieved by strengthening basic education of the poor (World Bank 1993). In rich countries, information technologies and the Internet enable patients to take responsibility for their health (Wallace 2004; GSK 2005; Hansen 2007).

Most importantly, advocates of the Choices Story see scope for more competition and diversity in health care provision. Rather than provide health services, governments need to focus on building strong markets for health (GSK 2005, 2006a). In addition to expanding choice, privatization and decentralization of health services in developing countries free up public resources to alleviate poverty and regulate private health care providers (World Bank 1993). The same is true in the developed world: efficient health care provision, the *Economist* argues, "should be striving to promote competition while upholding social values about equity in health care" (Wallace 2004).

Peoples' health depends on their wealth. That is why, the World Bank (1993: 7) reminds us, "economic policies conducive to sustained growth are thus among the most important measures governments can take to improve their citizen's health."

Health Rights

For the proponents of the Health Rights Story — nongovernmental organizations, humanitarian organizations, new social movements, some academics but also health care professionals — an unjust and unsustainable world order has precipitated the global health crisis. The mess we are in, they argue, is beyond technocratic fixes or market utopias. What we need — quickly — is fundamental changes to our institutions and our lifestyles.

This story takes place in a world where health is "a state of complete physical mental and social well-being, and not merely the absence of disease or infirmity" (World Health Organization and United Nations Children's Fund 1978: 2). In this wide definition, not only the biological but primarily the social determine our well-being. Wherever people and nature are oppressed and exploited, proponents tell us, we will find suffering and disease. In turn, just and sustainable societies promote health and happiness (Sanders 2003; Negri and Bollars 2007; International Council of Nurses [ICN] 2008a, 2008b, 2009a). Since there is no legitimate reason why any human should live in an unjust society, health is more than

a condition: it is a human right. This is also why, so the argument goes, real health care provision always is an integrative and holistic project that spans different policy areas and needs the active participation of stakeholders (Sanders 2003; Werner 2003; World Federation of Occupational Therapists [WFOT] 2006).

The villain of this story is a system that spends a mere 10 percent of its multibillion-dollar medical R&D budget on diseases that account for 90 percent of the global disease burden (Oxfam, VSO, and Save the Children 2002: 19). Northern elites and their Southern henchmen have used all their power to commercialize health care around the globe. A powerful political machinery—situated in institutions like the IMF, the World Bank, and the WTO—continually erodes public health care systems to make room for profitable but unnecessary health business (Werner 2003; Negri and Bollars 2007). As the ability to pay for health squeezes out the right to health, proponents tell us, it is always the weakest and most vulnerable who get punished hardest. Wherever it operates, commercial and technocratic health care marginalizes the needs of the poor, children, the old, the disabled, and women (Islam and Tahir 1999; Benson 2001; ICN 2009a; World Vision 2009; Global Health Council 2006a, 2006b, 2010). At the same time, profit corrupts the quality of health care for people in rich countries by providing expensive rather than necessary interventions (Schiff et al. 1994; People's Health Movement [PHM] 2000; Negri and Bollars 2007; Oxfam International 2009). As a result, global and local health inequities continue to grow.

The heroes of this tale are those who stand up for equitable health care at the local and global levels. At the local level, proponents of Health Rights demand free and universal access to primary health care everywhere (PHM 2000; ICN 2001; Negri and Bollars 2007; Oxfam International 2009). This is a task best entrusted to the public sector and civil society (PHM 2000; Negri and Bollars 2007; Health Action International [HAI] 2009; Oxfam International 2009). This implies holistic health policy processes that need to empower patients and alternative health professionals through active participation (Werner 2003: 15; ICN 2001; European Public Health Alliance 2008; HAI 2009). In this way, so the argument goes, people can emancipate themselves from unsustainable and unhealthy lifestyles.

At the global level, the Health Rights Story demands that rampant commercial interests be brought back in line with global public health imperatives (Kickbusch and Payne 2004; PHM 2000). Exploitative global economic processes and the morally bankrupt legal frameworks on which

they are founded (such as intellectual property rights) need to go (PHM 2000; WFOT 2006; Oxfam International 2009; HAI 2009). For this, international organizations, most prominently the WHO, need to realign their missions toward an uncompromising commitment to health rights, global public health goods, and "equitable social investment" (Werner 2003; Sanders 2003; Kickbusch and Payne 2004).

Anything other than a just world order, the proponents of the Health Rights Story argue, inevitably leads to suffering and disease. For this reason, the Peoples' Health Charter proclaims:

> Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world—a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. (PHM 2000)

Health Stewardship

Effective health care, the last story contends, requires expertise and professionalism. Whenever this professionalism is not at hand, international organizations such as the WHO or the International Labour Office (ILO), professional associations, and some academics tell us, health is in crisis.

For proponents of this story, health is both a commodity and a right. When sold as commodity or used as a productive input, health generates considerable prosperity (European Commission 2007). But unlike any other commodity, health affects people in uncomfortably immediate ways (WHO 2000: 4). This is why, in addition to fulfilling health wants through market mechanisms, health systems also must provide for the basic health needs of everyone. Health care, then, is about striking a balance between these competing aspects of health. The art of striking this balance is called stewardship: a "function of government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry" (Saltman and Ferrousier-Davis 2000: 735).

Poor health system stewardship—the villain of this story—leads to health system imbalances locally and globally. In poor countries lacking capacities for provision, regulation and administration create gross imbalances in access and quality of health care (World Medical Association [WMA] 2006). Not only are incapacitated health care systems in the

global South failing to satisfy basic health needs for all but the very rich, they are vulnerable to political manipulation and corruption (WHO 2000; WMA 2009). In developed countries, demographic aging and social change threaten the balance of high-performance health systems (Organisation for Economic Co-operation and Development 2004; European Commission 2007). Yet reforms aimed at cutting costs by introducing competition have actually undermined stewardship (Bundesärztekammer 2003; British Medical Association [BMA] 2004). Instead of strengthening health system capacities when they are most needed, ideologically driven reforms have — ostensibly in the name of efficiency and effectiveness — closed down hospitals, concentrated resources geographically, and transferred control over clinical decisions from physicians to health insurers (Bundesärztekammer 2003; BMA 2004).

At the global level, the impotence of health governance structures in the face of powerful players, on the one hand, and the sheer plurality of CSO actors, on the other, have made any sensible coordination of efforts impossible (Gostin and Mok 2009; Schrecker, Labonté, and de Vogli 2008; Ruger and Yach 2008).

What is to be done? In the developing world, health systems must provide basic health services to all who need them while building financing mechanisms that protect the vulnerable (WHO 2000; International Labour Office [ILO] 2007; WMA 2006). In the developed world, the challenge is to maintain high-quality health care in the face of social and demographic change (Organisation for Economic Co-operation and Development 2004). Globally, institutions need to be put in place and mandated — through binding international treaties — that can harness, coordinate, and direct the multitude of activities toward combating the health crisis.

All this, however, is predicated on getting stewardship right. Only then can policy makers balance the many things in health care provision that pull in opposite directions: public and private interests, choice and guidance, patient rights and professional autonomy, global and local health care needs. And because stewardship must square these contradictory pressures, "the ultimate responsibility for the overall performance of a country's health system must always lie with government" (WHO 2000: 119). Far from drowning health in bureaucracy, the WHO argues that stewardship's "key role is one of oversight and trusteeship — to follow the advice of 'row less and steer more' " (ibid.: 119). In essence, then, health stewards today need to create a governance space — replete with institutions, rules, and sanctions — in which other policy actors can effectively

deliver health care services (ILO 2007; International Social Security Association 2007; WHO 2000; European Commission 2007).

Effectively tackling the global health crisis requires a new mind-set. Leaving health care entirely to the market or to participative primary care, the Stewardship Story tells us, is a recipe for failure. This, then, is what the WHO (2000: xiii) refers to as "New Universalism":

> Rather than all possible care for everyone, or only the simplest and most basic care for the poor, this means delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability. It implies explicit choice of priorities among interventions, respecting the ethical principle that it may be necessary and efficient to ration services, but that it is inadmissible to exclude whole groups of the population.

Policy actors, then, come to terms with the global health crisis by using incommensurable frames to construct contending policy narratives. These stories, as I have shown, provide plausible but selective and conflicting accounts of the causes, impacts, and resolution of the global health crisis (see table 4).

Giving actors a fair hearing, as the sampling strategy has done, creates a discursive space for puzzling as depicted in figure 1, at least in terms of analysis. This triangle's apexes represent the purest and most combative articulations of each narrative. By pulling at these apexes (with equal strength), the contending actors create a "large" discursive space. Here the reservoir of contending ideas is wide and deep; nutritious conditions for Kingdon's (1984) primeval soup of policy solutions.

How do policy actors make use of this reservoir of ideas and concepts in the open-source anarchy of global health policy making?

The Structure of Conflict: Exclusion and Out-Voicing in Open-Source Anarchy

The triangular policy space is an artifact of a sampling strategy designed to give all voices a fair hearing. Despite the open and unstructured nature of open-source anarchy, however, it would be rash to conclude that the global public sphere for health issues resembles Habermas's (1987) "ideal speech situation." But how, in the absence of formal structures of power, can we come to grips with the way power gets exercised in open-source anarchy?

Table 4 Three Narratives about the Global Health Crisis

	Choice	Rights	Stewardship
Setting	Wealth means health	Health is a right	Health is not quite a commodity or a right
	Health is what you think it is	Broad definition of health	Health care provision is about striking a balance between contradictory tendencies
	Health care provision is about satisfying health wants	Health care provision is about meeting basic health needs	
Villains	Public health care systems do not encourage efficient consumption of health goods; not only ineffective but also unfair	Global inequality cause disease	Different worlds, different problems
		Inequitable economic system has eroded access to health for billions	Poor: health systems are imbalanced because of poor stewardship
	Poor countries: inefficiency, misallocation of resources, corruption	Inequitable political system; exclusion at all levels	Rich: balanced systems are being undermined by ideological commitment to choice
	Rich countries: skyrocketing costs		
Heroes	Create real choices in health care provision	Eliminate inequities	Strengthen stewardship
	Health-enabling environments	Break down financial, geographic, ideological, and political barriers in health systems	Steer more, row less
	Empower consumers, namely, providers (information, education)		Create appropriate public-sector institutions: insulate from politics
		Equitable global governance	Processes for goal setting
	Right incentives for individual responsibility; encourage diversity and plurality	New global development paradigm	Skillful day-to-day management: education, management of networks, guidance; good regulation

Source: Ney 2011

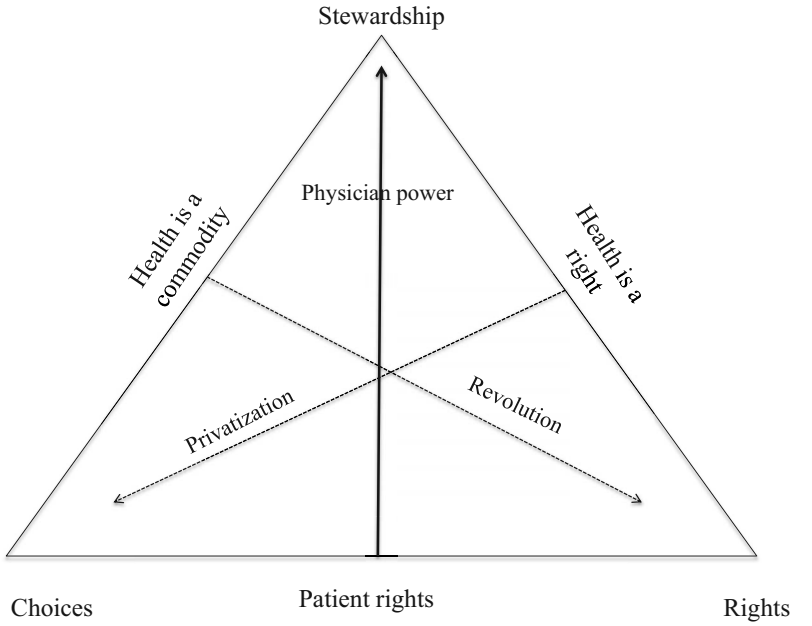

Figure 1 The Triangular Policy Space

Source: Ney 2009

Here the triangular policy space can help calibrate our inquiry into the use of power in the global public sphere. On this view we can recognize an exercise of power by narrowing the scope of conflict. Specifically, this means that we can identify an exercise of power when one or more policy narratives are excluded from puzzling about global health policy.

In terms of the triangular policy space, exclusion can take two basic forms. First, advocates of a single narrative can exclude the other two contending stories. There is little in the data or the literature to suggest that any one story dominates global health governance processes at present (Dodgson, Lee, and Drager 2002; Kickbusch and Paine 2004). Second, advocates of contending stories form pairwise alliances based on settlements across policy narratives. Here policy actors strike settlements based on points of agreement and mutual rejection.

The next section examines these settlements and alliances by triangulating data from the narrative analysis, a simple network analysis, and the findings of the wider global health governance literature. The analysis suggests that open-source anarchy may be structured in terms of exclusionary pairwise alliances across the triangular policy space.

The Classical Public Health Consensus: Stewardship and Rights

Stewardship and Rights Stories, the narrative analysis reveals, agree that health is a social right (ICN 2009a; WMA 2006; Global Health Council 2009). Providing everyone with access to appropriate health care, advocates believe, is best left to the public sector (WHO 2000; PHM 2000). Health policies are good when they fortify the public provision of health care. These typically include classical public health tasks (vaccinations, maternal and child health programs) as well as integrated packages of services that deal with new challenges such as HIV/AIDS or aging (WHO 2000; ICN 2009b). Commercial health care, both Rights and Stewardship advocates agree, invariably undersupplies public health goods in favor of unnecessary but profitable health services (Negri and Bollars 2007; HAI 2009). Above all, profit-oriented health care creates almost irresistible incentives to exploit inevitable information asymmetries between patients and physicians (BMA 2004).

The pattern of argumentation within the CSO sector points to an organizational substrate for the classic public health consensus. Of the 36 organizations sampled in the CSO sector, 11 championed the Rights Story and 15 advocated the Stewardship narrative. Only 4 — the Adam Smith Institute, the *Economist*, the EFPIA, and the IFPMA — argued in favor of the Choices Story. Further, the distribution of stories within the group of organizations that emerged from the bottom-up sampling process suggests that the sample divides into a periphery, a center, and a core. Of the 21 organizations that appeared on more than one list (this described 104 organizations in all, of which 21 were chosen for analysis), only the IFPMA advocates the Choices Story. This compares with 10 organizations that tell the Stewardship Story, 4 that advocate the Rights Story, and 7 that incorporate elements of both the Stewardship and the Rights Stories.[2]

The composition of this center and core group is also suggestive of an alliance across the Stewardship and Rights Stories. Table 5 shows that professional associations and disease-related organizations are overrepresented in the center and core relative to the CSO sample as a whole.

There is some indication in the global health governance literature that these ideational and structural affinities get reflected in policy outputs. Lee's (2010) analysis of the roles of CSOs in constructing the core global health policy regimes discovers a rough division of labor between Steward-

2. The other two organizations championing the Choices Story were chosen deliberately for the way they articulate this narrative.

Table 5 Distribution of Organizational Types across the Periphery, Center, and Core of the CSO Sample

	Core		Center		Periphery	
Types	No.	%	No.	%	No.	%
Therapy-based	1	7.14	2	2.22	18	2.42
Disease-based	3	21.43	12	13.33	73	9.83
Interest groups	1	7.14	9	10.00	79	10.63
Professional association	4	28.57	35	38.89	95	12.79
Single issue	3	21.43	24	26.67	276	37.15
Humanitarian	1	7.14	5	5.56	74	9.96
Environmental	0	0.00	0	0.00	20	2.69
Think tank	0	0.00	1	1.11	36	4.85
Global health partnerships	1	7.14	0	0.00	0	0.00
Government organizations	0	0.00	0	0.00	0	0.00
Blank	0	0.00	2	2.22	59	7.94

Source: Ney 2011

ship and Rights advocates.[3] In general, Lee finds that CSOs are predominantly active in the policy formation phase (problem definition, agenda setting). International governmental organizations (IGOs), in turn, are mostly responsible for decision making. Recently, specifically for the International Health Regulations (2005), implementation and monitoring are shared between CSOs and IGOs: here, Lee argues, CSOs play a "watchdog role," barking whenever the public or private sector transgresses. Corporations are conspicuous in their absence from these processes.[4]

Yet the implicit division of labor between the advocates of the Stewardship and Rights Stories also suggests that actors resolve tensions between the two in favor of the Stewardship Story. Scoones and Forster (2008) describe how the Rights Story gets sidelined and out-voiced in the policy response to highly pathogenic avian influenza (HPAI). Policy making, they argue, is dominated by the "outbreak narrative" that understands avian influenza as a biological, medical, and veterinary threat. Controlling this threat, so the argument goes, means diligent monitoring to rapidly detect and decisively quell any outbreak of HPAI (Scoones and Forster

3. International Code for the Marketing of Breastmilk Substitute, the revised International Health Regulations (2005), the Framework Convention for Tobacco Control, and the Codex Alimentarius.

4. And are only mentioned to highlight the pernicious influence of industry on global public health objectives, as for example for the overly lax Codex Alimentarius (Lee 2010).

2008). Not only does this call for the requisite medical and veterinary expertise, it also requires effective global coordination.

In the shadows of the "outbreak" narratives — essentially the Stewardship Story — Scoones and Forster make out alternative plausible accounts of HPAI. Here the avian influenza emerges as a result of socioeconomic conditions and cultural practices. More than a mere biological problem, HPAI results from complex socioecological interactions. Forster and Scoones contend that these alternative narratives point to (among other things) pervasive inequities and poverty as drivers of practices that promote zoonosis. Further, Scoones and Forster are careful to point out that the alternative framings are located within "the system" — predominantly the UN system including the WHO, UNSIC, UNICEF, and FAO. They argue that contending narratives "are presented, not as alternatives or challenges to the mainstream views, but as complements, additions or nuances. Often they are articulated together with the mainstream narratives but more as a polite add-on, a superficial dressing, or an acknowledgement of alternative views before proceeding to the main argument" (Scoones and Forster 2008: 38).

In sum, the narrative data, the sample, and the secondary literature suggest that a core group of professional organizations, IGOs, and CSOs successfully keep out the advocates of the Choices Story from puzzling over global health issues. What is more, the data and literature also suggest that the advocates of the Stewardship Story remain the dominant partner in this settlement.

Global Health Partnerships: Stewardship and Choices

Open-source anarchy has given rise to another form of transnational health policy making: the global public private partnerships (GPPPs) or the global health partnerships (Buse and Harmer 2007). GHPs are disease-focused, project-based, and problem-oriented forms of policy cooperation across sectoral and national boundaries. Here "public and for-profit private organisations have a voice in collective decision-making" (ibid.: 259). By tapping into the (stereo)typical strengths of the private sector and the reach of public health systems, GHPs are supposed to cut through organizational complexity and reduce coordination costs involved in solving global health problems. These newer forms of global health policy making compete with the classical public health consensus by exploiting the

synergies between the Choices and Stewardship Stories. Often, this also means excluding the Rights Story from the puzzling process.

Ideologically, many GHPs are based on the points of agreement between the Stewardship and Choices Stories. For these policy actors, the close relationship between economic growth and health is plain to see (World Bank 1993; WHO 2000; ILO 2007; GSK 2006a; Johnson and Johnson 2010b). Since rising health care costs threaten economic growth, both favor policies that control costs while preserving value (GSK 2005). "Steering more and rowing less" makes sense to both sets of actors, as does the contention that there is a role for the private sector in health systems (WHO 2000; Bundesärztekammer 2003; BMA 2004; ILO 2007). Both agree that the public sector should provide the suitable institutional conditions for high-quality health services (World Bank 1993; Wallace 2004; European Commission 2007; Union for International Cancer Control 2008; World Heart Federation 2005). This includes health education or a strong regulatory framework to protect intellectual property rights as well as patients' safety from dangerous counterfeit medicines (WHO 2000; Novartis 2005b; GSK 2010; Johnson and Johnson 2010b, 2010d). Given suitable conditions, then, the private sector can play to its innovative strengths. Since wealth begets health (and vice versa), proponents of the two stories take a rather dim view of the Rights Story's cavalier approach to economic reality. Demanding radically democratic primary health care facilities is utterly impractical, not to mention enormously costly (World Bank 1993; WHO 2000). Moreover, both coalitions would agree that offering everyone the same, invariably low-quality, health services is counterproductive (WHO 2000, 2008).

Although GHPs have mobilized an impressive number of organizations in a relatively short period of time, evidence suggests that CSOs and the Rights Story play a relatively marginal role (Buse and Harmer 2007; Forster and Scoones 2008). The exact number of GHPs is not known but ranges from 70 (ELDIS) to about 150 (IFPMA). In 2007 Buse and Harmer argued that only 23 qualified as public-private partnerships if the term implied shared decision making.

Data on participation in 17 of these 23 GHPs suggests that CSO organizations and the Rights Story are being excluded at both board and partner levels. In their overview of GHP evaluations, Buse and Harmer (2007: 262) point out that GHPs fail to "provide legitimate stakeholders a voice in decision making on governing bodies." Governments and other stakeholders from low- and middle-income countries, the researchers find, make up

Table 6 CSO Participation in Global Health Partnerships

CSO/GHP	Periphery	Center	Core	Total
Periphery	16	7	6	29
Center	10	2	2	14
Core	2	0	0	2
Total	28	9	8	45

Source: Ney 2011

an average of only 17 percent across all the governing boards of the 23 GHPs they sampled. Further, they show that NGOs make up an average of only 5 percent of the governing boards (Buse and Harmer 2007). This contrasts with 23 percent representation from the corporate sector and 13 percent representation from government (ibid.: 263).[5]

At the level of partners, comparing organizations from the CSO population and the GHP list of participants suggests that few CSOs take part in GHPs. Of the 1,075 or so organizations involved in 17 of the 23 GHPs (either as board members or as partners) analyzed by Buse and Harmer (2007),[6] 45 of the overall CSO population are listed as partners. This corresponds to just over 5 percent of the total population of 848 CSOs.[7]

A closer look at the pattern of overlap displayed in table 6 is revealing. More than half (29) of the organizations from the CSO population that participate in GHPs are located in the periphery of the CSO population. By the same token, of the 11 organizations in the core of the CSO population (more than two mentions on lists), two organizations — the Global Health Council and the World Heart Federation — participate in GHPs. Of these two organizations, Buse and Harmer (2007) count the Global Health Council as a GHP.[8] Not only do most CSOs from the sample population not take part in GHPs, the few that are included are predominantly located in the periphery of the sample population.

It also seems that the CSOs in the core of the GHP organizations are located in a marginal position within the CSO population. About 111

5. Regrettably, Buse and Harmer (2007) do not disaggregate the government figure into specific countries and regions. My simple network analysis showed that USAID, DfID, Irish Aid, and CIDA feature prominently in the core group of the 17 GHPs analyzed here. See table 7.

6. Buse and Harmer (2007) concentrate on 23 GHPs. For 5 of these GHPs, data on participating organizations were not readily available.

7. Incidentally, this list of 45 also includes 3 GHPs (the Global Health Council, the International AIDS Vaccine Alliance, and the International HIV/AIDS Alliance).

8. Many GHPs list other GHPs as their partners. This raises the interesting issue of whether GHPs are developing into policy actors in their own right.

organizations participate in more than one of the 17 GHPs identified for analysis. About 37 participate in more than 2 GHPs. Within this group, the density of participation varies considerably from the median 3 participations, with the top ten organizations participating in 6 to 12 GHPs each (see table 7). The composition of this core group differs considerably from the core CSO group. First, CSOs are a small minority compared with firms (8), research organizations (8), and government organizations (6).[9] Significantly, professional associations are conspicuous in their absence from this group. Moreover, 6 of the CSOs in the GHP core are "located" at the CSO population periphery.

There is little in the literature on GHPs comparable with Scoones and Forster's elegant narrative analysis of the avian influenza issue. Nonetheless, Richter's (2004) critical think piece points to the inherent pitfalls of the GHP policy paradigm. In particular, she takes issue with construction of GHPs as win-win-win solutions for global health without viable alternatives. Among other things, Richter contends, this not only devalues ideas of public health interests and global health rights but also helps "outvoice" public-sector alternatives to GHPs from the outset.

Buse and Harmer's (2007) analysis corroborates Richter's assessment. As the World Bank has become an increasingly important player in global health, they argue, the Stewardship Story has found itself besieged (Buse and Harmer 2007). They point out that many GHPs, influenced by the World Bank's virulent distrust of the public sector (cf. Ney 2009), are biased against public-sector health care provision. As a result, "the alternatives to, and implications of GHPs, were rarely seriously and systematically considered because of feelings of ill-will to WHO and the public sector more generally" (ibid.: 265). This, the researchers imply, may explain why IGOs, most notably the WHO, constitute only 7 percent of the GHP boards they examined.

Judging by the available data, CSOs and the Rights Story play a subordinate role in both decision-making and agenda-setting processes in GHPs. While the data reveal some overlap between the two groups of organizations, it is rather small. What is more, GHPs seem to attract CSOs from the periphery of the CSO sample and vice versa.

9. This reconfirms Buse and Harmer's (2007) conclusions for the board membership of GHPs. An interesting detail, however, is that if we look at participation beyond the board, we find that IGOs — specifically the WHO — are involved in almost as many GHPs as the Bill and Melinda Gates Foundation. This suggests that, as Buse and Harmer (2007) point out, while the WHO may be becoming less important as a decision maker, it would seem as if it may still be difficult to ignore the WHO as an agenda setter.

Table 7 The GHP Core Organizations

Organization	Type	Partnerships
Bill and Melinda Gates Foundation	Foundation	12
World Health Organization	IGO	10
United States Agency for International Development	GO	9
Centers for Disease Control and Prevention	GO	8
World Bank	IGO	7
London School of Hygiene and Tropical Medicine	Research	6
Helen Keller International	Humanitarian	6
Department for International Development	GO	6
Pfizer	Firm	5
Merck and Company	Firm	5
Irish Aid	GO	5
UNICEF	IGO	4
Sight Savers International	Disease-based	4
Johns Hopkins University	Research	4
GlaxoSmithKline	Firm	4
Canadian International Development Agency	GO	4
Academy for Educational Development	Humanitarian	4
University of Washington	Research	3
University of Texas Southwestern Medical Center	Research	3
University of Melbourne	Research	3
Swedish International Development Cooperation Agency	GO	3
Sanofi-Aventis	Firm	3
RTI International	Single issue	3
PATH	Single issue	3
Novartis	Firm	3
National Institute of Allergy and Infectious Diseases	Research	3
Mectizan Donation Program	GHP	3
Lymphatic Filariasis Support Center	Disease-based	3
Johnson and Johnson	Firm	3
Izumi Foundation	Foundation	3
Harvard School of Public Health	Research	3
Handicap International	Disease-based	3
Global Fund to Fight AIDS, Tuberculosis, and Malaria	GHP	3
Global Alliance for TB Drug Development	GHP	3
ExxonMobil	Firm	3
Eli Lilly and Company	Firm	3
Center for Neglected Tropical Diseases, Liverpool School of Tropical Medicine	Research	3

Source: Ney 2011

Social Entrepreneurship and Health: Choices and Rights

The triangular discursive space suggests a potential alliance between advocates of the Rights and Choices Stories. However, little in the data or the literature points to the kinds of institutional structures and policy practices that characterize the other two settlements.

Perhaps unsurprisingly, much of what Rights and Choices champions agree on takes place far away from the rarified heights of global politics. Rights and Choices Stories are both about patient rights (cf. ICN 2008a; WFOT 2006; GSK 2009; Novartis 2008). Centralization of power in the hands of bureaucrats and experts, both agree, has done little to provide equitable and efficient access to health care (Wallace 2004; Oxfam, VSO, and Save the Children 2002). On the contrary, such terms as *clinical needs* and *physician autonomy* conveniently hide massive infringements on our rights and liberties. Consequently, Rights and Choices advocates look to measures that empower and enable patients (World Bank 1993; PHM 2000). At the local level, particularly in South Asia, so-called social entrepreneurs combine private-sector practices with an egalitarian mission to provide the poor and underprivileged with access to affordable but high-quality health care. The model that underlies this practice is what Muhammad Yunus (2007), Nobel Laureate and erstwhile head of the Grameen Bank, calls a "social business." These ventures, so the argument goes, operate just like for-profit business except that they do not pay out returns to investors. Instead, the profits are reinvested into the business (ibid.).

Compared with the other two settlements, the data suggest that the Choices-Rights cooperation is not well developed, at least not at this time. As I have shown, the CSO sample reveals very little trace of a Rights-Choices settlement. Of the 47 organizations analyzed, 8 use arguments from the Choices and Rights discourse.

Nonetheless, the data on the 17 GHPs reveal some, albeit homeopathic, traces of the Rights-Choices settlement. First, the Global Health Council — a GHP with a wide set of partners — looks to combine elements of all policy stories in its outputs. Second, the Ashoka Foundation, an organization that has consistently promoted social entrepreneurship for thirty years (Bornstein 2004), is involved in the GAIN. Third, commentators view the Institute of One-World-Health — part of Buse and Harmer's (2007) sample of 23 GHPs — as a flagship for health social entrepreneurship at the global level. Indeed, Victoria Hale is a fellow of the Schwab Founda-

tion, which, next to Ashoka and the Skoll Foundations, is a driving force for global social entrepreneurship.

In sum, open-source anarchy is sufficiently open to prevent any single policy story from dominating all others. However, open-source anarchy is a polycentric system in which actors form "local" alliances that effectively exclude voices from puzzling within these policy communities. The narrative analysis suggests that open-source anarchy features two such settlements across the triangular policy space: the classical public health consensus and GHP. What is more, a simple network analysis suggests that these settlements are housed in separate organizational substrates. While there is some evidence of a settlement between Choices and Rights advocates, it is still at an early stage of development.

How do these alliances and settlements affect puzzling about global health issues?

Risks to Puzzling

Narrative analysis suggests that there are at least two risks associated with the patterns of exclusionary settlements discussed in the previous section. First, if the policy debate becomes polarized, puzzling may degenerate into an "intractable policy controversy" (Rein and Schön 1994). Here learning across narratives is unlikely. Second, excluding contending voices from puzzling risks policy failure brought about by unanticipated consequences.

Polarization and Policy Deadlock

Polarization between policy narratives poses a significant risk to effective puzzling. Conflict about the global health crisis is less likely to lead to policy-oriented learning across narratives and more likely to degenerate into a shouting match, the less contending policy actors are responsive to rival arguments (Sabatier and Jenkins-Smith 1993).

At present, the narrative analysis suggests that policy deliberation about global health is a relatively civilized affair. This is particularly true when compared with health care reform at the national level (particularly in the United States or, less so, in the United Kingdom) and to other global policy issues (such as, most prominently, global climate change). In general, different organizations articulate each story in a remarkably similar tone and approach across different advocacy coalitions. The CSO sample

presents the most variability in tone and approach.[10] In general, the closer to the center and core of the CSO sample, the more measured and conciliatory the narrative's articulation.

For both the Rights and Choices Stories, the real firebrands are located in the periphery of the CSO sample.[11] For the Rights Story, this includes Oxfam, Save the Children, HAI, and particularly the PHM. The peripheral organizations adopt an altogether more confrontational and accusatory tone. Similarly, the *Economist* and the Adam Smith Institute present the Choices Story more aggressively than most of the organizations in the market sample.[12] Despite being vociferous and outspoken, these organizations (still) make up a minority of the sample. What is more, little in the literature indicates that policy outputs from the classical public health consensus or the GHPs reflect the more radical articulations of the narratives.

That said, the narrative analysis also suggests that the degree of learning that occurs across different sectors is modest. While about three-quarters of the documents articulate a single narrative, about 25 percent of all documents analyzed incorporated ideas from at least one other narrative. About 6 percent of the documents contained ideas from all three narratives. This proportion is relatively stable across the different institutional sites: about 23 percent of documents from civil society actors and 27 percent of documents from market actors contain ideas from more than one narrative. So, while most published policy arguments fall into one or the other policy story, some organizations are responsive to arguments and ideas from more than one narrative.

A look at the institutional location of organizations suggests a shape to the polarization. With a single exception, market actors combine Stewardship and Choice arguments.[13] Similarly, of the twenty-one plural documents produced by CSOs, two documents combined Choices and Stewardship arguments, two documents fused Rights and Choices, and seventeen

10. Given the small number of organizations in the public- and private-sector samples compared with the CSO sector, this finding needs to be interpreted with considerable care.

11. The CSO periphery also houses organizations that fuse contending stories (such as Helen Keller International) as well as rather moderate articulations of single stories (such as the BMA). The obverse, however, is not true: the core and center of the CSO sample contain no firebrands.

12. With the possible exception of GSK, which adopts a rather confrontational tone on health system reform. This, however, could reflect its relatively marginal position in the British health reform debate.

13. The one exception, incidentally, was a position paper on the environmental aspects of the pharmaceutical industry.

Table 8 Distribution of "Plural" Policy Documents across Institutional Locations

	Stewardship-Rights	Stewardship-Choices	Rights-Choices	Total
State	1	1	0	2
CSO	17	2	2	21
Market	1	9	0	10
Total	19	12	2	33

Source: Ney 2011

documents included ideas from both the Stewardship and Rights narratives (see table 8).

The breakdown of all policy documents using ideas from a single narrative — what we may call a "pure" story — confirms this pattern. As table 9 shows, of eighty "pure" policy documents from CSOs, 39 percent (31) relied on the Stewardship narrative, 50 percent (40) used Rights ideas, and only 11 percent (9) championed Choices. By the same token, thirty-three of the thirty-four single-narrative documents of market actors argued in favor of Choices. In terms of published material, then, the camps in the global health debate are clearly defined but not hermetically sealed.

When polarization prevents learning, the puzzling processes and, as a consequence, the policy process often come to a grinding halt. For the global climate change debate, Depledge (2006) has called this process "ossification." The danger of ossification and the deadlock is that it creates incentives for powerful actors to abandon puzzling in favor of "powering." Here policy change becomes a function of "raw power" (Sabatier and Jenkins-Smith 1993). The wider global health governance literature suggests that this is both a conceptual possibility and an empirical reality. Smith (2010) warns that the broader pluralism of open-source anarchy will gradually replace rational rule through health expertise by economic power. For example, Brown (2010) has shown for the Global Fund to Fight AIDS, Tuberculosis, and Malaria that, despite explicit constitutional provisions for institutionalizing inclusion and participation, powerful state actors preferred to "power" rather than "puzzle": strategic behavior, such as coordinated block voting, effectively undermined any inclusive deliberation in the Global Fund's decision-making bodies (Brown 2010). In open-source anarchy — a space characterized by rapid electronic communication — all the powerless can do (or perceive they can do) is to shout louder and shriller. This, of course, contributes to polarization by further eroding responsiveness. Indeed, evidently feeling unheard, Daniel Vasella, CEO

Table 9 Distribution of "Pure" Policy Documents across Institutional Locations

	Choices	Rights	Stewardship	Total
State	0	1 (25%)	3 (75%)	4
CSO	9 (11%)	40 (50%)	31 (39%)	80
Market	33 (97%)	0	1 (3%)	34
Total	42	41	35	118

Source: Ney 2011

of Novartis in 2004, notes: "There is limited praise for pharmaceutical companies just now. Quite the contrary, rarely a day passes without blame: blame for selling products at high prices, for not being innovative enough, for stopping development, for developing a new product, and we are sure for side-effects of a drug at the same time that we face lawsuits for not being able to supply enough drugs" (Vasella 2004: 44).

Unanticipated Consequences and Policy Failure

The second risk to puzzling has to do with how policy actors use frames to make sense of the global health crisis. Narratives impose order on the complexities of health by selectively foregrounding some aspects and backgrounding others. This is why each policy story comes with built-in blind spots. These lead actors to place unwarranted trust in some institutions and capacities while disregarding others. It leads them to downplay certain risks and overemphasize others.

Inequality, Ineffectiveness, and GHPs

While acutely aware of inequities created by public health systems, proponents of the Choices Story seem oblivious to the inequality generated by markets. At the individual level, the Choices Story overestimates individuals' capabilities to exercise control over their health (BMA 2004; Blunden and Smith 2005; Bundesärztekammer 2003) as well as make rational choices about their health care (Hansen 2007; World Bank 1993). At the systemic level, the advocates of the Choice Story overlook that "efficiency" in commercial health care often bars people from access to health care. The danger here is that many health services — specifically for children, women, and the elderly — will fall by the wayside, exacerbating what is already a rather precarious situation for these groups (Benson 2001).

Critics of GHPs point out that this is precisely what is happening. Buse and Harmer (2007) point out that most GHPs are poorly aligned with the wider health needs of any particular country. GHPs' claims to produce fast results — or at least faster than the outputs of the classical public health policy regimes — mean that GHPs tend to focus on projects that generate high returns (to use the language of market). Since the private sector looks for the most return on an investment, GHPs often focus on specific diseases in specific regions. A vertical focus on diseases, however, may be at a tangent to the wider health system needs of a particular country (Buse and Harmer 2007; PHM, Medact, and GEGA 2005). It also means that more complex and less potentially lucrative health issues — such as visceral leishmaniasis, human African trypanosomiasis, and Chagas (Buse and Harmer 2007) — in less affluent regions are ignored. Similarly, Buse and Harmer (2007) suggest that GHPs suffer from poor management. In their overview of GHP evaluations, they point out that most GHPs suffer from poor governance, lack of coordination, and inadequate management of partners (Buse and Harmer 2007). Since these are classical competences of Stewardship advocates, we may suspect the poor management performance to be related to the out-voicing of the Stewardship Story in GHPs.

Expertise, Hierarchy, and GHG

Stewardship trusts the expertise and ethical fiber of health care professionals, on the one hand, and efficacy of top-down health systems, on the other (WHO 2000; WMA 2008). This leads Stewardship advocates actors to overestimate the moral force of expert knowledge while underestimating the motivational role of self-interest. Among other things, this leads advocates of Stewardship to dismiss the potential contribution of other health care professionals as well as for nonhierarchical forms of policy making.

Again, the global health governance literature provides some indication that the outputs of the classical public health consensus may suffer from some of the typical blind spots of the Stewardship approach. For one, there is the faith in international law as a regulative force. While global health regimes — such as the International Health Regulations 2005 or the Framework Convention on Tobacco Control — may be pathbreaking in their implications for international law and political symbolism (Fidler and Gostin 2006), they have been rather less impressive in terms of actual outcomes (*Lancet* Editors 2007; Lee 2010). Lee (2010) points out that many of the global health governance policy regimes she analyzes are

little more than "toothless" paper tigers. For example, the FCTC seems to be going much the same way as other framework conventions at the global level: policy makers are keen to sign up to the treaty but are far less enthusiastic when it comes to implementing real measures at the national level (*Lancet* Editors 2007).

Similarly, in their review of the HPAI issue, Scoones and Forster (2008) point out that much of the global influenza strategy based on the "outbreak" narrative is simply impractical. The success of existing HPAI response strategies depends on an unbroken chain of command from the global down to the local level (ibid.). The underlying assumption of the outbreak/Stewardship narrative is that each link in this chain has both the capacity and the willingness to do as it is told by the experts at the top of the chain. Yet Scoones and Forster show that there is little reason to assume either as given. Policy response mechanisms and pandemic preparedness plans developed by the WHO and other agencies were based on assumptions about health system capacities on the ground that were often simply inaccurate. Many national pandemic preparedness plans—"long, turgid documents developed from templates elsewhere" (Scoones and Forster 2008: 34)—often reflect policy aspirations rather than ways to coordinate existing capacity (Ney 2007). Indeed, Scoones and Forster (2008: 36) contend that most plans are unimplementable: "Without extreme and highly disciplined military force, restricting a population to a small area would be impossible. Few governments would be able to enforce such a strategy, even if it made sense from the epidemiological point of view." The same, they argue, goes for the pandemic influenza surveillance, a key element of the global response strategy. Effective surveillance is predicated on functioning local capacity and willingness to report outbreaks. Scoones and Forster (2008) show that neither are necessarily given, particularly in areas with endemic HPAI, such as Indonesia. Relying on nonexistent capacity as well as the ability of local policy makers to "see sense" (of the centralized, expert-driven kind) made the Indonesian government's refusal to share viral samples in 2007 all the more surprising to WHO functionaries (Scoones and Forster 2008).

Splendid Isolation

Rights proponents believe in the inherent virtue of people. For them, structures of power, that is, institutions, are irredeemably corrupt. This makes them discount the role of both medical expertise and self-interest. By blaming disease on the exploitative socioeconomic order and its ruling

elites, proponents erect a "wall of virtue" around the like-minded. Anyone beyond that wall is, at best, morally compromised. Likewise, the quest for purity and justice blinds proponents to the efficacy of some top-down or commercial therapies.

Global health governance features few policy outputs that bear the hallmarks of the Rights Story. Partly, this is due to the uncompromising position many Rights advocates adopt toward institutions of global health governance and the medical supplies industry. Their refusal to cooperate or enter strategic alliances with business in GHPs closes down a potential avenue for pursuing their vision of global health. But the more radical advocates of the Rights Story, such as Oxfam or the People's Health Movement, see in these partnerships little more than a cleverly packaged privatization of health care aimed to throw critical voices off the scent (PHM 2000; Oxfam, VSO, and Save the Children 2002). Oxfam International (2009) argues that there is little evidence of a true partnership in GHPs. On the contrary, powerful interests — most prominently the World Bank and medical suppliers — have used the GHP mechanism as a cover to press for private-sector solutions (Oxfam International 2009; PHM, Medact, and GEGA 2005). In addition, Rights protagonists see in GHPs a way to edge critical voices out of global health governance: rather than the WHO, these GHPs empower private foundations, most prominently the Bill and Melinda Gates Foundation (PHM, Medact, and GEGA 2005: 275). Not, however, that the WHO needed much prompting. Under Margaret Chan, the WHO seems to have "sold out" to these global forces of capital: the WHO is, claim PHM, Medact, and GEGA, "compromising on values and moral principles by entering into public-private partnerships with business interests whose activities it should be condemning rather than courting" (ibid.: 277; PHM 2000). Contamination with commercial health care through GHPs, the Rights advocates contend, undermines the WHO's ability to define and defend public interests in global health governance (PHM, Medact, and GEGA 2005; Oxfam International 2009). And so the Rights advocates are likely to remain in splendid isolation where they are morally pure but a practical irrelevance to global health governance.

Each of the three narratives, then, has inherent blind spots that generate specific vulnerabilities (see table 10). Some of these blind spots have already been institutionalized in global health governance policy outputs. If undiagnosed and left untreated, these blind spots may develop unanticipated consequences that cause policy to fail. But, as I have shown, the policy consequences of blind spots are unanticipated only for the advocates of a particular story. Contending storytellers readily pick up on these

Table 10 Sources of Unanticipated Consequences

	Choices	Rights	Stewardship
Trusts	Markets and competition	Malleability of social norms; inherent good of people	Authority and probity of health professionals
Downplays	Inherent market distortions in health	Self-interest of actors	Dangers of concentrating power
Vulnerable to	Increasing inequality	Free-riding and irrelevance	Bureaucratic inertia and corruption

Source: Ney 2011

vulnerabilities. So Stewardship advocates recognize the governance shortcomings, and Rights advocates clearly see injustices of GHPs. Likewise, Choices advocates see the impracticalities of global health governance regimes that impose prohibitive costs on people who can easily evade them, while Rights activists are justified in demanding that global health policy take local conditions and local knowledge into account. Stewardship advocates are right to point to the need for some expertise in health care, whereas proponents of the Choices Story do well to remind Rights advocates of the motivating force of self-interest.

Conclusion

In some senses, as I have shown, the global health issue is depressingly simple: globalization means that gross health disparities and inequities between rich and poor, formerly safely contained within national or at least regional boundaries, have now become everyone's problem. This, then, has led to the crystallization of a global public health interest: we can conceive of policy outcomes that, while possibly imposing costs on some, would greatly benefit global health. While most pundits can come to something vaguely resembling agreement on the existence of a global public health interest, how this interest is best served is the subject of considerable contention.

Part of the controversy is that globalization has transformed the institutional context for international health policy making. Today, global health policy making takes place in the unstructured and unregulated pluralism of open-source anarchy.

Many pundits are deeply suspicious of open-source anarchy. The unstructured and unregulated pluralism of open-source anarchy, they argue, undermines any attempt to put new resources to use for the global public health interest. What is more, the polycentric nature of open-source anarchy means that the locus of power is shifting away from states and IGOs toward private-sector actors. In short, critics conclude, open-source anarchy is as ineffective as it is unfair. If global health governance is to be successful, open-source anarchy will need to be brought to heel by strong institutions capable and willing to defend global public health interests.

Using narrative analysis, this article has looked closely at these claims. The analysis drew on about 170 policy documents from forty-five organizations from the public, private, and citizen sectors. The analysis found that the unstructured and unregulated pluralism of open-source anarchy gives rise to, or at least does not hinder, the emergence of a wide scope of policy conflict. The analysis of the policy documents revealed three contending policy narratives: a policy story about Health Choices that criticizes public inefficiency and champions markets, a narrative about Health Rights that deplores health inequities and emphasizes global social justice, and a tale about Health Stewardship that is suspicious of unregulated policy interaction and calls for strong governance institutions. Between them, these stories create a triangular policy space. This space is a rich reservoir of ideas and concepts for policy actors to tap into when they puzzle about global health issues.

However, the triangular policy space assumes, somewhat unrealistically, that each voice gets a fair hearing. Using the triangular policy space as a yardstick, the second section teased out different patterns of exclusion and out-voicing. The evidence from secondary literature as well as a simple network analysis suggests that pairwise alliances across the triangular policy space effectively exclude specific stories from deliberation. Of the three possible patterns, the analysis suggests two are dominant: the "classical public health consensus," an alliance of Stewardship and Rights advocates, and the "global health partnerships," a settlement across the Choices-Stewardship space. The data provide little evidence for the third possible alliance, a settlement between the Choices and Rights discourses. Nonetheless, there is some indication that social entrepreneurs are making inroads into global health governance. This settlement, then, may be an interesting focus for future research.

Within the two dominant settlements across the triangular policy space, the evidence suggests that some out-voicing and marginalization of one of the voices takes place. In the classical public health consensus, the

Stewardship Story tends to out-voice the Rights narrative, while in GHPs, Choices advocates trump Stewardship proponents.

The third section discussed two risks that these patterns of interaction pose for puzzling about global health issues. First, the narrative data suggest that the responsiveness between contenders in the debate is relatively low. An overview of policy documents shows that there is relatively little permeability of ideas across different sectors in the sample. While the narrative analysis suggests that some polarization between Rights and Choices discourses may be taking place, the most radical expressions of the Rights and Choices stories are confined to the periphery of global health governance policy communities.

Polarization risks policy deadlock. In turn, deadlock provides powerful actors with a convenient excuse to abandon "puzzling" and revert to "powering." In this sense, then, open-source anarchy may be "unfair" in that it favors powerful actors. This, then, suggests that global health governance will need to implement measures and structures to establish and maintain responsiveness between contending policy actors.

The second risk of exclusionary alliances is policy failure because of unanticipated consequences. By excluding and out-voicing policy narratives, actors import their built-in blind spots and perceptual biases into policy. The evidence from the wider global health governance literature suggests that policy outputs of both dominant settlements — the classical public health consensus and the GHPs — suffer from weaknesses and vulnerabilities because of discursive blind spots. However, these vulnerabilities and weaknesses are picked up by actors refracting health issues through the excluded narratives.

In this sense, then, open-source anarchy is effective in generating (or at least not hindering) a rich and variegated reservoir of concepts and ideas for puzzling. However, tapping into this reservoir may require some form of equalization strategy to enable that each voice gets a fair hearing. Buse and Harmer (2007) contend that both of the largest GHPs (the Global Fund and GAVI) are moving in this direction by becoming more accountable.

Global health governance, then, is not only about "harnessing, regulating, and coordinating" actors and resources. Significantly, global health governance will also have to be about creating and maintaining the institutional contexts for effective — that is, critical and conflictual — puzzling. This means promoting constructive policy conflict across the entire triangular policy space while avoiding polarization that may lead to the policy deadlock we observe at the national level. Effective puzzling

and learning will require institutional innovations at all levels to keep access to policy deliberation open both for the system as a whole and for specific policy communities, such as the GHPs.

Open-source anarchy features an unstructured and bewildering plurality of actors at all levels of governance and in almost all parts of the world. Commentators may be forgiven for perceiving the debate about the global health crisis as chaotic, overpopulated, and in urgent need of streamlining. However, the narrative analysis suggests that what at first sight may seem like an overwhelming "cacophony" of voices is, in fact, a lively, critical, and constructive policy debate. This debate — conflictual and messy as it may be — points to an emergent public sphere for health issues at the global level. Rather than lock this public sphere out of policy deliberation and policy making — as the Intergovernmental Panel on Climate Change and United Nations Framework Convention on Climate Change have done for climate change — effective global health governance must include, promote, and protect this public sphere.

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