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Abstract

Through an empirical case analysis of *Health is Global: A UK Government Strategy 2008-2013* and three background country case reviews this study seeks to fill the need for primary research to advance an understanding of global health diplomacy (GHD) practice and theory with a focus on the integration of health into foreign policy. To accomplish this objective it draws on a novel theoretical framework, which is the focus of this paper, that combines David Fidler's health and foreign policy conceptualizations – revolution, remediation and regression – and John W. Kingdon's Multiple Streams Model of Policymaking (MSM). Consistent with Fidler's arguments, it concludes that the primary reason why state actors strategically invest in global health is to advance their foreign policy priorities, traditionally defined. The application of Kingdon's model highlights the importance of policy communities and entrepreneurs at the state level of global health policymaking and the importance of creating and capitalizing on a window of opportunity to make policy change. Applying these theories may help practicing health diplomats understand the theory behind their practice and potentially be more effective GHD practitioners. The analysis also reveals that additional theoretical perspectives, such as institutional theory and political economy, could build on this theoretical framework to help expand and deepen understanding of GHD. Continuing to apply a combination of relevant theories to understand GHD will undoubtedly advance the sophistication and impact of both its theory and practice.

Introduction

Over the past decade or so, global health issues have become more prominent in foreign policies at the national level. The process to develop state level global health strategies is arguably a form of global health diplomacy (GHD) (Gagnon & Labonté, 2013), defined as "policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilise health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives" (Lee & Smith, 2011). Despite an increase in the volume of secondary research and analysis devoted to GHD and the integration of health into foreign policy, little primary research, particularly that which draws directly on the perspectives of those involved in these processes, has been conducted. This study seeks to fill this knowledge gap and, in particular, advance a theoretical understanding of GHD through an empirical case study of *Health is Global: A UK Government Strategy 2008-2013* (HM Government, 2008) and the application of a novel theoretical framework for analyzing the results. Briefer background case reviews of three nations that are leaders in GHD – Brazil, Norway and Switzerland, were also conducted to inform the analysis of the UK case. To build understanding about how and why health is integrated into foreign policy and to derive lessons of its potential relevance to other nations interested in developing whole-of-government global health strategies, the study draws on a unique theoretical framework that incorporates the Multiple Streams Model of Policymaking (MSM) (Kingdon, 2003) and David Fidler's health and foreign policy conceptualizations – revolution, remediation and regression (Fidler, 2009; Fidler, 2005).

Methods

Literature review, document analysis and semi-structured interviews were used to conduct the UK case, as well as the three background case reviews. To structure data for subsequent analysis and interpretation using the theoretical frameworks, an adapted version of Walt and Gilson's policy analysis triangle (Walt & Gilson, 1994; Walt et al., 2008) served as an heuristic device to gather and organize a comprehensive and relevant set of data in five areas: 1) the policy context within which the policy was developed; 2) the policy processes; 3) the policy content; and 4) the actors involved (Walt et al., 2008; Walt & Gilson, 1994). A fifth important category, indications of impact, was added to capture data that focused on potential and actual effects of the policy (Gagnon & Labonté, 2013).

The methodology encompassed the identification and examination of a case within each of the four countries for focused description and analysis. Table 1 provides a brief descriptive summary of the focus of the main country case study and the three background country case reviews. Since both the UK and Switzerland had developed global health strategies these were the respective focus of those two countries. At the time this study was carried out, Norway did not yet have a whole-of-government global health strategy (though it has since launched one in 2012) so the Oslo Ministerial Declaration launched in 2007 was chosen as the focus of the Norway case review given Norway's significant leadership in the process to develop the declaration. Brazil does not have a global health strategy *per se,* therefore, the focus of the Brazil case review was on its role as a leader in a number of important global health issues and processes over the last decade or more, as well as its

focus on health as a human right and global solidarity on global health and international development.

Table 1: Summary of focus of each country case

Country and Case	Description
United Kingdom: ***Health is Global: A UK Government Strategy 2008-2013***	• A whole-of-government strategy to guide and coordinate a coherent approach to the UK's investment in global health and demonstrate global leadership in global health and development • Sets out five main priorities: 1) Better global health security; 2) Stronger, fairer and safer systems to deliver health; 3) More effective international health organizations; 4) Stronger, freer and fairer trade for better health; and 5) Strengthening the way the UK develops and uses evidence to improve policy and practice • Developed using a cross government and cross sector process with non-state actors over two years led by the Department of Health, and in particular by an individual policy entrepreneur in the bureaucracy • Revamped as *Health is Global: An Outcomes Framework for Global Health 2011-2015* in 2011
Switzerland: ***Swiss Health Foreign Policy, 2006-2012***	• An internal agreement to improve policy coherence and coordination between the Federal Department of Home Affairs (FDHA) and the Federal Department of Foreign Affairs (FDFA) approved by the Swiss Federal Council in 2006 following an 18 month negotiation process; the first formal agreement designed to integrate health into foreign policy issued by any country • Sets five main interests the Swiss government will pursue over a five-year period: 1) Protect the health interests of the Swiss population; 2) Harmonize national and international heath policies; 3) Improve the effectiveness of international collaboration in the area of health; 4) Improve the global health situation; and 5) Safeguard Switzerland's role as host country to international organizations and a base for major companies working in the health sector • Developed between relevant departments (health, foreign affairs and development) with foreign affairs acting as the broker and through leadership from a key bureaucrat • Renewed in 2012
Norway: ***Oslo Ministerial Declaration, 2007***	• Led by Norway's Foreign Minister launched in 2007 by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand to support and advocate for the integration of health into foreign policy; renewed in 2010 by this same group. • Outlines an agenda for action based on three themes 1) Capacity for global health security, 2) Facing threats to global health security, and 3) Making globalization work for all • Developed by these foreign ministers without substantive input from health leaders • Norway launched its own whole-of-government global health strategy in 2012

Brazil: **Global solidarity and health as a human right**	• In Brazil health is a key strategic interest in its foreign policy and the country has demonstrated leadership on a number of global health issues primarily by using a "soft power" approach • Health was entrenched as a human right in Brazil's constitution in 1988 which is the foundation of Brazil's current policy focus on global health solidarity • The bulk of international cooperation is carried out through the leadership of the 110 year old Fundação Oswaldo Cruz (FIOCRUZ) attached to the Brazilian Ministry of Health

Purposive sampling was used to identify and recruit interviewees for semi-structured interviews. State and non-state actors who had been directly involved in health and foreign policy integration in each of the four countries were targeted for interviews. Overall, access to interviewees was not an issue; however repeated attempts to recruit politicians who had been involved in the endorsement and approval of the UK strategy for an interview were not successful.

A total of twenty interviews were conducted, fourteen for the UK case (seven each with state and non-state actors) and two for each of the background case reviews. (See Table 2) Interviews took place between August 27, 2009 and March 24, 2010. Informed consent was obtained before the interview began. Interviews were audiotaped and then transcribed verbatim. Ethics approval was obtained from the University of Ottawa.

Table 2: Summary description of sample

Country	Description of sample of interviewees
UK	• Seven participants who worked within Her Majesty's Government (HMG) including the Department of Health (DH), the Foreign and Commonwealth Office (FCO), the Department for International Development (DFID), the Ministry of Defense, the Health Protection Agency and the UK Collaborative on Development Sciences • One participant from the journal publishing sector • Three participants from academia • Two participants from research and policy think tanks • One participant from an NGO (Medact)
Switzerland	• One participant from academia and private consulting • One participant from the Swiss Division of International Affairs, Federal Office of Public Health
Norway	• One participant from academia • One participant from the Secretariat for Foreign Policy and Global Health Initiative, Ministry of Foreign Affairs
Brazil	• Developed Two participants from FIOCRUZ Centre for Global Health, Brazilian Ministry of Health

A general inductive approach guided the analysis of the interview data using manual coding. Both the research objectives and questions (deductive) and multiple readings and interpretations of the raw data (inductive) guided data analysis (Thomas, 2003). Data analysis encompassed three concurrent and iterative flows of activities: 1) data reduction; 2) data display; and 3) conclusion drawing/verification (Patten, 2002; Miles & Huberman, 1994).

Theoretical Frameworks

Fidler's health and foreign policy conceptualizations (the term that Fidler uses to describe them) and Kingdon's MSM underpin this research. Fidler's framework primarily helps to build understanding in regards to *why* states incorporate global health into their foreign policy agendas and global health's rise in foreign policy prominence (i.e. the motivations and rationale behind this policy direction), while Kingdon's provides significant insight into the policy making process itself and *how* through issue framing, timing and the influence of various actors some issues attract the attention of policymakers while others do not. Taken together, these frameworks provide a complementary and useful mechanism for analyzing and interpreting the study findings and arriving at conclusions to elucidate how and why health is integrated into foreign policy.

Fidler's conceptualizations

Of the literature reviewed for this study, Fidler provides the most extensive and in-depth discussion of the conceptual and theoretical underpinnings of GHD and the relationship between health and foreign policy. This is the main reason why this framework was adopted as part of the theoretical framework for this study. Fidler's work is grounded in international relations theory and posits three arguments for why health has risen as a foreign policy issue – revolution, remediation and regression (Table 3). The usefulness of these conceptualizations as analytical and explanatory devices is reflected in their recent application by scholars writing on GHD and the integration of health and foreign policy. In two papers published in 2010, Feldbaum and colleagues used Fidler's three concepts to help elucidate why states incorporate global health into their foreign policy agendas and the relationship between global health and foreign policy (Feldbaum et al., 2010; Feldbaum & Michaud, 2010). Similarly, Labonté and Gagnon refer to the three conceptualizations to help clarify global health's rise in foreign policy prominence (Labonté & Gagnon, 2010).

An understanding of the functions of foreign policy is fundamental to these arguments. Foreign policy involves a variety of government departments with direct interest in global policy and frames how a nation will interact with other nations and non-state actors in the global community. The four basic functions of foreign policy are generally defined as: 1) to ensure national security; 2) to contribute to economic power and prosperity by promoting international trade and investment; 3) to support order and stability in countries and regions important to a nation's security and economic interests; and 3) to promote and protect human dignity (human rights and humanitarian assistance) (Fidler, 2005; Smith et al., 2010). According to Fidler, experts in foreign policy and international relations frequently discuss these functions within a hierarchy of objectives for foreign policy from high politics to low politics. Traditionally health has been categorized as low politics because health activities were perceived as technical, scientific, non-political and

humanitarian endeavours not connected to the high politics of foreign policy. The foreign policy community perceived health as gravitating toward normative values concerned with human dignity, and having less relevance to the state's pursuit of its material interests, power and security (Fidler, 2005).

Overall, health's new prominence in foreign policy, as demonstrated in the UK strategy and that of other countries, reflects the movement of health from the margins of low politics into a situation in which health features significantly in all four foreign policy functions. The discursive framing of global health (i.e. health as security, development, human right, commodity and global public good, described later), and other bodies of literature that analyze health's relation to national security, globalization and the protection and promotion of human dignity, support the claim that health is figuring more prominently across foreign policy priority areas (Labonté & Gagnon, 2010; Schrecker et al., 2008). These developments signify the movement of health from low to high politics, but understanding what this means for health and foreign policy, and how health is positioned and understood within foreign policy, remains unclear. Fidler's three conceptualizations aim to clarify and explain this phenomenon further and as such are used in this study.

The first conceptualization is 'revolution.' This perspective argues that health's increasing role in foreign policy is transformative of the health-foreign policy nexus. Health collapses the traditional distinction between high and low politics and provides new political space in which health is an overriding normative value and the ultimate goal of foreign policy (Kickbusch, 2011; Fidler, 2005b). Health is broadly perceived as more than the absence of disease, encompassing as well the social determinants of health (Fidler, 2005). The scope of foreign policy is argued to extend beyond traditional preoccupations with military and economic power. Health and health equity become pre-eminent political values for the 21st century. This theory is consistent with health discourses that focus on health as a human right and the 'health for all' ideal (Robinson, 2007; Labonté, 2008; Scott-Samuel & O'Keefe, 2007).

The second conceptualization 'remediation' asserts that health's rise as a foreign policy issue reflects the continued persistence of the traditional hierarchy of foreign policy functions (Fidler, 2005a). Health has become another issue that needs to be addressed through traditional approaches to foreign policy, or as a strategic vehicle through which traditional foreign policy 'high politics' goals can be achieved. As Fidler notes, foreign policy's attention on health actions is highly elastic, focused when disease crises appear and fading when crises drop from the political spotlight. Such elasticity makes health-centred issues highly vulnerable to subordination or marginalization by other non-health problems or crises that flare up (Fidler, 2009). Within this context, health is not a factor that transforms thinking and is not an overriding norm that states believe in and desire to adhere to. It has risen as a foreign policy issue because it impacts on the high politics of foreign policy and threatens the material interests and capabilities of the state. Health is only about communicable diseases and attention paid to it is primarily crisis driven. As Fidler notes, "but for the global ravages of HIV/AIDS, the fear produced by SARS (severe acute respiratory syndrome), the framing of tobacco-and obesity-related diseases as pandemics, and the panic associated with the emergence of pandemic influenza, health

would not have its present foreign policy prominence" (Fidler, 2008). When improving health or health systems in foreign countries is an intended consequence of foreign policy action, the strategic objective is usually something other than health in keeping with the traditionally narrow view of foreign policy. The remediation perspective may acknowledge health's 'escape' from the domain of low politics but interprets this as health becoming another issue like others that foreign policymakers need to grapple with (Fidler, 2005a). The continued application of the traditional framework for foreign policy remedies the mistaken notion that health has a special place in international relations (Fidler, 2005a). This conceptualization appears to resonate with health discourses that focus on health as security, the dominant global health discourse of the past decade, and health as a commodity, which focuses on the potential economic impacts of investments in health products and services. It is also consistent with the realist theory of international relations in which states necessarily act in their own self-interest in the international arena in keeping with the traditional functions of foreign policy. Of the three models it has been argued that remediation provides the strongest explanation for why health has risen as a foreign policy issue (Labonté & Gagnon, 2010; Feldbaum & Michaud, 2010).

'Regression' is the third of Fidler's models. This model views health's integration into foreign policy as a regressive development; in other words, as an indicator that health problems are getting worse. The increasing attention paid to health across the functions of foreign policy signifies the failure of public health efforts and 'regression.' Connecting health to high politics threatens to tarnish long-standing associations of health with normative values (Fidler, 2005a). So public health's wish for health to become more politically prominent may have come true but in a way that threatens what was special about health in international relations in the first place. For example, while the inclusion of health across several of the Millennium Development Goals (MDGs) vindicates the rise of health in the development agenda, a failure to meet these health equity goals could signify the failure of the effective integration of health into foreign policy or another sign of regression.

An important issue that Fidler raises is the role of science and epidemiological evidence in GHD. Regardless of political and economic considerations and which of his three conceptualizations resonates best in reality, foreign policy decision makers are also often confronted with scientific evidence about health threats when making policy decisions, which may require public acceptance, rejection or avoidance of engaging with such evidence, and the potential political risks this might entail. As Feldbaum et al. write, an emphasis on health scientific evidence in global health policymaking does not discount that state interest drives foreign policy, but it does recognize that the influence can run both ways (Feldbaum & Michaud, 2010). The role of science in the development of policy related to global health means that the disparate worlds of policy and science need to interact, understand each other and speak the same language, which is a key challenge underpinning the development of evidence-based policy (or what is now more aptly called evidence-informed) (Fafard, 2008; Lavie, 2006; Pielke, 2007).

Table 3: Summary of Fidler's Health and Foreign Policy Conceptualizations (Fidler 2005a; Fidler, 2005b)

Conceptualization	Description
Revolution	• Health's increasing role in foreign policy is transformative of the health-foreign policy nexus • Health collapses the traditional distinction between high and low politics and creates a new political space in which health is an overriding normative value and the ultimate goal of foreign policy • Health is broadly conceived and encompasses the social determinants of health • Is consistent with health discourses that focus on health as a human right and the "health for all" ideal
Remediation	• Health's rise as foreign policy issue reflects the continued persistence of the traditional hierarchy of foreign policy functions • Health has become another issue that needs to be addressed through traditional approaches to foreign policy, or as a strategic vehicle through which traditional foreign policy goals can be achieved • Foreign policy attention on health is focused when disease crises appear and fades when crises drop off the political spotlight • Provides the strongest explanation for why health has risen as a foreign policy issue
Regression	• Health's integration into foreign policy is a regressive development – an indicator that health problems are getting worse • The increasing attention paid to health across the functions of foreign policy signifies the failure of public health efforts • Connecting health with the high politics of foreign policy threatens to tarnish long-standing associations of health with normative values • Public health's wish for health to become more politically prominent may have come true but in a way that threatens what was special about health in the first place

Multiple streams model of policymaking

Kingdon's model of the policymaking process is a highly reputable, evidence-based model that focuses on understanding why some topics become prominent on the policy agenda and others do not, and why certain policy alternatives are seriously considered while others are neglected (see Figure 1). While there is no shortage of theories of the policy process that can help explain how and why health might rise on the policy agenda at any given time, Kingdon's MSM was used to analyze this phenomenon, for a number of reasons. First, this is an evidence-informed model grounded in hundreds of interviews conducted over several years with both state and non-state actors involved in policymaking in the United States (US). Second, the model focuses on understanding why and how some topics become prominent on the policy agenda and others do not, and why and how some alternatives for choice are seriously considered while others are neglected (i.e. on the agenda setting and policy formulation stages of the policy process that are the foci of this

study). Third, with a focus on actors, process, policy content and contextual factors, the model coheres well with Fidler's framework, which has been applied in empirical studies similar to the one undertaken for this study. Fourth, the model provides a framework within which theories, frameworks and concepts related to the importance of the framing of issues in policy discourse and the role of influential actors in the process can be incorporated, in particular, as elements within the model's policy stream. Finally, Tomlin, Hillmer and Hampson have adopted Kingdon's model for their analysis of Canada's international policies because it is more comprehensive than others (e.g. advocacy coalition and punctuated equilibrium models)[1] and subsumes the concepts of these other two models in its theoretical structure (Tomlin et al., 2008).

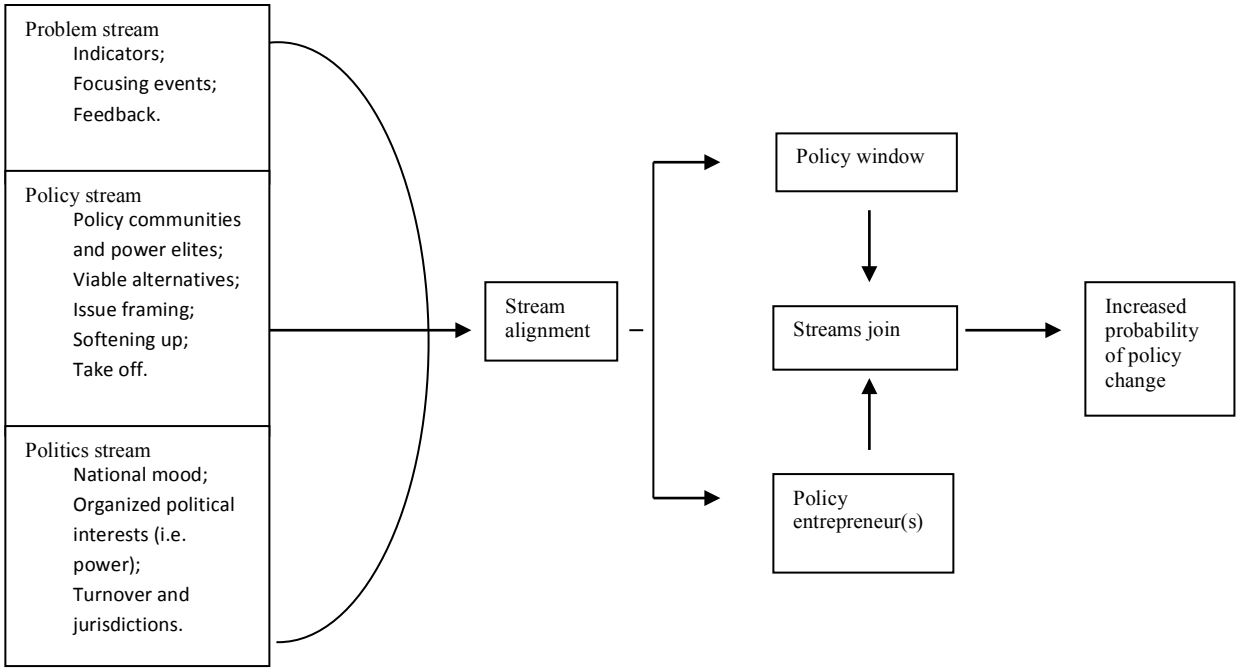
According to Kingdon the policy selection process resembles biological natural selection (Tomlin et al., 2008). Ideas float around in policy communities, are softened up and may be combined with others in various ways. The 'soup' of ideas changes through the appearance of wholly new elements and also by the recombination of existing elements (Tomlin et al., 2008). While ideas float around, systematic indicators (e.g. surveillance data about the growing incidence and prevalence of a disease in a population), 'focusing events' such as crises and disasters and/or feedback pertaining to the implementation of current government programs, allow some to attract the attention of policy and decision makers (Kingdon, 2003). In this 'evolutionary' process, completely new ideas do not suddenly appear and get adopted; rather ideas float freely and are debated and framed by the community of specialists (i.e. policy community) who attempt to persuade one another while advocates of particular solutions act as policy entrepreneurs, attempting to soften up who needs to be persuaded (Tomlin et al., 2008). Policy entrepreneurs are not necessarily found in any one location in a policy community. They could be inside or outside of government, in elected or appointed positions, in interest groups or research organizations. But, like business entrepreneurs their one defining characteristic is that they are willing to invest their resources - time, energy, and reputation - in the hope for a future return, such as a policy that they support. Kingdon describes them as central figures in the policy process with three sets of qualities: 1) some 'claim to a hearing' such as expertise or an authoritative decision-making position; 2) is known for his/her political connection or negotiating skill; and 3) is tenacious and persistent (Kingdon, 2003).

Through the efforts and influence of policy communities and entrepreneurs, when a particular idea catches on, a tipping point is reached, the idea takes off and a bandwagon effect secures its adoption (Tomlin et al., 2008). This process is conceived of consisting of three separate streams of activity – problem identification or recognition (i.e. the problem

[1] In the advocacy coalition model, actors in policy subsystems join together in advocacy coalitions based on their shared knowledge of a problem and their common interest in pursuing certain solutions. In Kingdon's model, such coalitions would be examples of policy entrepreneurs. The punctuated equilibrium model of agenda change is based on the premise that rather than changing gradually over time substantive policy shifts occur rapidly from one stable point to another. Many policy ideas circulate in policy subsystems competing for attention but once an idea gets attention, policy change is rapid. This occurs more frequently in response to external events that disturb the equilibrium of the political system. This idea of rapid change fits within Kingdon's model as a part of the explanation behind rapid change that can occur when streams align and policy windows open (Tomlin et al., 2008).

stream), policy alternatives generation (i.e. the policy stream), and politics (i.e. the politics stream that includes swings in national mood, administration or legislative turnover, interest group pressure etc.) - that flow through and around decision structures, largely independent of one another (Kingdon, 2003; Tomlin et al., 2008). At a certain time the three streams come together and at that juncture major policy change can occur. At these points policy windows (defined as opportunities for policy entrepreneurs to advocate for particular proposals or conceptions of problems) are opened either by the appearance of compelling problems or because of political will (e.g. strong and organized political interests all pointing in the same direction) (Tomlin et al., 2008). The importance of time and timing in the policymaking process are critically important elements of Kingdon's model. 'Who pays attention to what and when' (Zahariadis, 1999) and how time is managed is fundamental to the policymaking process and underpins the model.

Figure 1: A Multiple Streams Model of Policymaking (adapted from Tomlin, Hillmer & Osler Hampson, 2008)



Results and Discussion

Based on their analysis, Gagnon and Labonté concluded that the primary reason that the countries examined have decided to focus more on global health is self-interest - to protect national and international security and their economic interests (Gagnon & Labonté, 2013). Investing in global health was also seen as a way to enhance a state's international reputation. In terms of self-interest, Brazil was an outlier, however. International solidarity and health as a human right have been the driving forces behind its long-term investment in development cooperation to date (Gagnon & Labonté, 2013). Investing in health for normative reasons was also a prevalent through weaker theme in the UK, Swiss and Norwegian cases. The study highlighted the critical role that policy entrepreneurs who

cross the domains of international relations and health play in the global health policymaking process. In regards to advancing a conceptual understanding of GHD, the findings proposed that the whole-of-government global health policymaking process is a form of global health diplomacy. These results are analyzed and discussed further in the following section using the Multiple Streams Model and Fidler's conceptualizations.

The importance of policy communities and policy entrepreneurs

The influence of a policy community

While *Health is Global* was launched in 2008, the policy community had been actively influencing its eventual development for at least a decade earlier. The Nuffield Trust, in particular, played a major role in attracting and sustaining focus and analytical scrutiny on the link between globalization and health and, with partners, in connecting the various players in the policy community (e.g. government, academia, think tanks) (The Nuffield Trust, 2005; The Nuffield Trust, 2006). This leading and connecting role is critical to preventing the fragmentation of the community and the policy alternatives it espouses, which can significantly weaken such a community's clout as influencers in the process (Kingdon JW, 2003). A more closely knit policy community can generate consistent ways of thinking, common language and issue framing, all of which are important to softening up a policy space and stabilizing a policy system to influence change. That *Health is Global* was framed according to recommendations stemming from the Nuffield Trust led processes indicates that this policy community had an impact.

Government actors are part of policy communities and in the UK case the most prominent of these were the Foreign and Commonwealth Office, Department for International Development and the Department of Health. Whether actors from these three sectors considered themselves to be part of the same policy community during the policy development process is not known, although given the significant consensus building that was required to arrive at an agreed upon strategy, likely they did not (Gagnon & Labonté, 2013). Instead, as several interviewees described, the policy development process itself brought departments with disparate views closer together creating somewhat of a closer knit policy community in government (Gagnon & Labonté, 2013).

Researchers are another important part of policy communities. An interesting observation stemming from the interview data pertains to the somewhat tense interactions that academics involved in the *Health is Global* policy process had with government policymakers. On the one hand, academics thought that there needed to be a greater focus on gathering and scrutinizing evidence to inform the policy, while on the other, the policymakers were focused on being pragmatic and moving forward with whatever evidence they had on hand. This tension is not surprising and is supported by ample literature about the challenges associated with the evidence-informed policy and decision making processes (Lomas, 1997; Pielke, 2007; 2009; Davies, 2004; Contandriopoulos et al., 2010).

It appears, then, that while members of the academic community participated in the *Health is Global* process this does not necessarily go hand in hand with the conclusion that research evidence played a central role in influencing policy decisions. Drawing on

conclusions derived from the application of Kingdon's model, policy is primarily the result of politics, policy entrepreneurs and the convergence of the three streams and not the result of research evidence *per se.* The interview data corroborates this conclusion. To repeat one particularly relevant comment, "my personal take is that there's kind of a political rationale that's important in understanding why this has happened rather than being evidence based. To the extent that it is evidence-based, it's evidence of emerging infectious diseases." This comment resonates with Labonté's argument and Fidler's assertion that technical evidence, especially about risk and pandemic preparedness, may have traction in global health policymaking as it aligns with the health security focus, but rarely is there a full consensus on evidence with respect to other global health areas such as aid and development, leading to a significant amount of political interpretation (Labonté, 2009).

Leadership from policy entrepreneurs

According to Kingdon's model, policy change cannot take place without leadership from tenacious policy entrepreneurs (Kingdon, 2003). In the UK case and all background case reviews, a policy entrepreneur played the key leadership role in advancing policy directions. While such entrepreneurs do not necessarily need to be politicians or public servants, based on the findings from this study leaders in GHD processes appear to possess at least two special attributes. First, they are either politicians or senior public servants, and second, they encompass both health and international relations expertise through formal training and/or education or a combination of the two. Three of the four leaders in the case studies were medical doctors who could call upon their status as the elite profession within health, as needed. Despite their authority and influence, however, policy entrepreneurs cannot be successful unless they have backing of those from the highest level of political power. In the UK case, Prime Minister Brown was personally committed to *Health is Global*. Support from "number 10" was viewed as essential for the process to succeed. Similar political support and policy leadership from the very top was seen as necessary for the policy directions taken in the background cases. According to Kingdon, both policy communities and policy entrepreneurs play the key role in 'softening up' the system and linking the problem, policy and politics streams through influential activities such as generating evidence informed policy alternatives and developing relationships with key decision makers (Kingdon, 2003).

The importance of timing and stream alignment

Timing and the alignment of the problem, policy and politics streams found in Kingdon's model were critical to the eventual development and government-wide agreement on *Health is Global.* The growing awareness of global health and the potentially important relationship between health and foreign policy (part of the policy stream) had been brewing for several years in the UK policy community before the SARS crisis hit as the 'wake-up call' for the government to take concrete action. While SARS was what Kingdon would call the 'focusing event,' (a component of the problem stream) there also appeared to be political motivation - to improve the UK's global reputation post Iraq (Lunn et al., 2008; Horton, 2006; Horton, 2007; Norton-Taylor, 2011). Investing in global health was arguably one potential way to do this. The UK's commitment at the time to helping to achieve the Millennium Development Goals (MDGs) (another aspect of the problem stream)

was also a strong motivating factor for focusing on global health. Within this mix of policy, problems and politics, leaders within the bureaucracy (policy entrepreneurs) had set the stage over a number of years for catalyzing stream alignment when the policy window opened with the SARS crisis. A bandwagon effect occurred at that point in time that created incentives for the various government actors with non-state actor participation to arrive at an agreement on whole-of-government global health policy: the *Health is Global* strategy.

Revolution? Remediation? Regression?

Of Fidler's three conceptualizations, 'remediation' helps to describe the rise of health as a foreign policy issue in the UK case and background case reviews. In this concept, diplomacy is an instrument in pursuit of power, survival and self-interest. On the other hand, 'revolution' helps to describe the prominent position of global health in foreign policy in Brazil. In Brazil, improving global health has become an overriding norm and, as such, is a goal of foreign policy (Calcagnotto, 2007; Alcazar, 2008; Lee & Gomez, 2011; Bliss, 2010). Brazil's ground-up, inclusive approach, in which state and non-state actors construct a normative model of reality from which they seek to derive global health strategies, appears to be based on cooperation and not competition. What foreign policy attends to, how and why is a product of multi-stakeholder engagements leading to more or less consensual agreements on policy directions. Global health diplomacy is the mechanism through which a normative model of reality can emerge resulting in collective strategies and approaches to advancing global health at both the state level and the global level. To a certain extent, the UK process also aimed to arrive at a collectively derived global health strategy and that goal was largely achieved (Gagnon & Labonté, 2013). Unlike Brazil, however, the principle reality that emerged was not that health is a human right but rather that investing in global health is a strategic way to improve national and international security and the economic interests of the state.

In all four country cases, the World Health Organization (WHO), although needing significant reform, emerged as an important and central actor (Gagnon & Labonté, 2013). The four countries studied were highly supportive of the WHO and argued that its leadership and convening role should be strengthened to help them and other actors make sense of the increasingly complex global health context characterized by a multiplicity of actors and agendas. This finding highlights that multilateralism is consistent with Fidler's remediation theory; in other words, with a system of international relations in which self-interest dominates. As the Brazil background case showed, however, it is also consistent with 'revolution.' Additional research focused on the WHO and other international institutions in GHD is clearly needed to better understand their role in this process and how states perceive of and interact with such institutions to achieve their goals.

While self-interest manifested through the global health security framing and explained through the 'remediation' concept may resonate with foreign policymakers, some argue that such positioning is potentially fraught with risk for global health and can lead to global health 'regression' (Labonté & Gagnon, 2010a; Aldis, 2008). Health may have risen as a foreign policy concern but in a way that tarnishes it's normative underpinning or what made health special in the first place leaving it at the margins of traditional foreign policy and vulnerable to shifting foreign policy attention.

Conclusions

This study provided significant insight into why and how health is integrated in foreign policy, which has helped to better define and crystallize GHD at the state level. Together, Fidler's conceptualizations and Kingdon's multiple streams model were extremely useful as a theoretical framework to help interpret and explain the findings and advance an understanding of how and why health is integrated into foreign policy. Applying these theories to shed light on this empirical GHD study may help practicing health diplomats understand the theory behind their practice and potentially be more effective GHD practitioners. The analysis also reveals that additional theoretical perspectives may deepen an understanding of GHD beyond what was learned in this study. For example, as Sandberg and Andresen allude to in their 2010 article that traces the Norwegian case of the formation of health into foreign policy, institutional theory could help further elucidate the role of institutional actors in the process (Sandberg & Andresen, 2010). A central tenet of new institutionalism is that institutions shape action and as such can play a significant role in influencing political processes and policy directions (Lecour, 2005). Understanding the influence of institutional actors on the actions and motivation of individual policy entrepreneurs and policy communities could provide additional richness and understanding to the analysis of GHD. Understanding how power, and politics influence the process could also benefit from a political economy perspective that helps elucidate the impact of political and economic forces in setting policy agendas. For example, understanding the role of networks that link state and non-state actors, such as 'flex-nets' that operate at the interstices of public and private power and are particularly adept at supplanting official processes and information, seems potentially relevant to the examination of GHD (Wedel, 2010). While Fidler and Kingdon's models shed significant light on this study's findings, continuing to apply a combination of relevant theoretical frameworks to understand GHD will undoubtedly advance both its theory and practice.

Disclaimer of interest

The author declares that she has no competing interests.

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