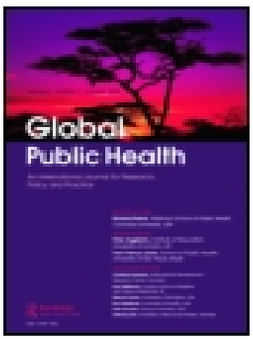

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Global Health Diplomacy (GHD) and the integration of health into foreign policy: Towards a conceptual approach

Arne Ruckert[a], Celia Almeida[b], Jorge Ramírez[c], German Guerra[d], V Nelly Salgado de Snyder[d], Emanuel Orozco[d], Alexandre Andrade Alvarenga[b], André Nassim de Saboya[b], Rosiane Martins dos Santos[b], Dino Sepúlveda[c], Elena del Carmen Rivera Vivian[c], Marilia Da Silva Santos[c], Kara Doriani[c] and Ronald Labonté [a]

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ABSTRACT

Since the end of the Cold War, health has gone from a peripheral concern in foreign policy negotiations to a prominent place on the global political agenda. While the rise of health onto the foreign policy agenda is by now old news, the driving forces behind its expansion into new political spheres remain understudied and undertheorized. This article builds on empirical findings from a four-country study of the integration of health into foreign policy, and proposes a conceptual approach to GHD to improve understanding of the conditions under which health is successfully positioned on the foreign policy agenda. Our approach consists of three dimensions: features of institutions and the interest various actors represent in GHD; the ideational environment in which GHD operates; and issue characteristics of the specific health concern entering foreign policy. Within each dimension, we identify specific variables that, in combination, make up the explanatory power of the proposed approach. The proposed approach does not relate to, or build upon, a single social sciences, public health, or international relations (IR) theory, but can be seen as a heuristic device to identify dimensions and variables that may shape why certain health issues rise onto the foreign policy agenda.

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Global Health Diplomacy; conceptual approach; exploratory study; health in foreign policy

Introduction

Since the end of the Cold War, health has gone from a peripheral concern in foreign policy negotiations to a prominent place on the global political agenda. Such developments have recently been intensified by the arrival of the COVID-19 pandemic. While the rise of health onto the foreign policy agenda is by now old news, the driving forces behind its expansion into new political spheres remain understudied and undertheorized. Despite the rapid growth of academic work in this area, no sound conceptual or theoretical basis for the rise of health in foreign policy has been suggested. Global health diplomacy (GHD), a relatively new and still contested concept (Almeida, 2020; Thaiprayoon & Smith, 2015), has been employed to capture the multi-stakeholder negotiation processes and dynamics at the nexus of health and foreign policy (Ruckert et al., 2016). There has been little theoretical development surrounding the notion of GHD, with most attempts to theorise

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it drawing selectively (and often implicitly) on international relations (IR) theories, in particular realism (Fidler, 2011; Ruger, 2008), constructivism (Davies et al., 2015; Shiffman, 2009), and cosmopolitanism (Lencucha, 2013).

This article builds on empirical findings from a four-country exploratory study of the integration of health into foreign policy, and proposes a conceptual approach to GHD to improve understanding of the conditions under which health is successfully, or not, positioned on the foreign policy agenda. Our findings and conceptual approach overlap significantly with a widely used framework in social research in health, the 3i framework, which reflects on the role that ideas, institutions, and interests play in the policy-making process (Gauvin, 2014). Our approach consists of three dimensions: features of institutions and the interest various actors represent in GHD; the ideational environment in which GHD operates; and issue characteristics of the specific health concern entering foreign policy. Within each dimension, we identify specific variables that, in combination, make up the explanatory power of the proposed approach. The proposed approach does not relate to, or build upon, a single social sciences, public health, or international relations (IR) theory, but can be seen as a heuristic device to identify dimensions and variables that may shape why certain health issues rise onto the foreign policy agenda. In the discussion section we then relate our conceptual approach to existing theoretical and conceptual explanations that have been invoked to account for the rise of health onto the foreign policy agenda.

Methodological and conceptual considerations

We derived the information for our conceptual approach from a four-country exploratory study, funded by the Canadian Institutes for Health Research (Operating Grant #136927), combining two sets of qualitative data and analyses in each of the four case countries (Brazil, Canada, Chile, and Mexico): document analysis ($n = 1745$) and key informant interviews ($n = 88$) (see Table 1 for more details). Our analysis further builds on a previously published literature review of GHD (Ruckert et al., 2016). Key informants (KIs) were purposively selected to represent key members from the government, civil society, and private sectors most relevant to GHD practices, and the document analysis was used to inform the initial selection of KIs, with snowball sampling used in a second step. The document analysis covered the period from 2000 to 2016, while interview data was collected between 2016 and 2019.

Rigour in explanatory case study research is partly dependent on variability in the selection of the cases; thus, our countries represent a theoretical sample with contrasting contexts. Brazil has strong GHD commitments (since the 1990s), some documented experiences and a special training programme for health diplomats. Chile has the region's most open economy with extensive global economic connections, some interest in GHD within its diplomatic training academy but to date little presence of health in trade or other foreign policy negotiations. Mexico, one of Canada's most important trading partners, has yet to embark on building a strong health and foreign policy platform, although there is interest within its diplomatic training academy to do so. Canada, with a reputation for multilateralism, has a largely undocumented history of efforts in GHD apart from annual evaluations of its G8 and G20 commitments undertaken by the Centre for G8/G20 Research at the University of Toronto. All four countries are multi-party democracies, providing political, institutional and ideological diversity across the sample.

Table 1. Sources of information for qualitative analysis.

	Systematic review of academic literature	Document analysis	In-depth interviews
Brazil	138	656	24
Canada	114	544	34
Chile	32	528	20
Mexico	52	17	10

For comparative purposes, the research was designed to focus on a limited number of key topics then prominent in global health discourse: trade/investment, intellectual property rights, non-communicable diseases, health worker migration, and sustainable development goals. It was also flexible to allow countries to elect which of these five topics (or sub-sets therein) to pursue, and for new country-specific topics to emerge. All relevant information from each of the three data sets was entered into NVivo10 for coding and analysed thematically by each country's research team. Unique country-specific research reports were developed and used for a second-level analysis, in which findings from all four research sites were compared and contrasted in an iterative process involving all four research teams, developing a GHD evidence map and a summary table of findings. Analytical themes originated deductively from the existing GHD literature and its engagement with international relations (IR) theories and the wider 3i-framework, and were enriched inductively through the second-level thematic analysis. All four studies received ethics approval from their respective university review boards.

While we aimed to develop a conceptual approach that can be applied widely, we are cognizant that governmental, cultural and institutional context matters, and that the specific process of how health enters foreign policy differs greatly from country to country. This speaks to the limitations of any conceptual approach in terms of its ability to widely generalise about GHD. In addition, GHD is a highly political sphere, and the literature may fail to document information that is sensitive in negotiations, and this may also affect what some key informants (KIs) are willing to share during interviews. Other limitations of our study include the time frame of analysis (2000–2016) which reflects a period of rising importance of health diplomacy in each of the four countries, and the exclusive use of qualitative research methods; however, we used triangulation of data by combining findings from the document analysis and interview stage of the research project in all four countries.

Our conceptual approach consists of three dimensions, with each subsuming a number of explanatory variables (see Figure 1). The first dimension describes institutions which can broadly be

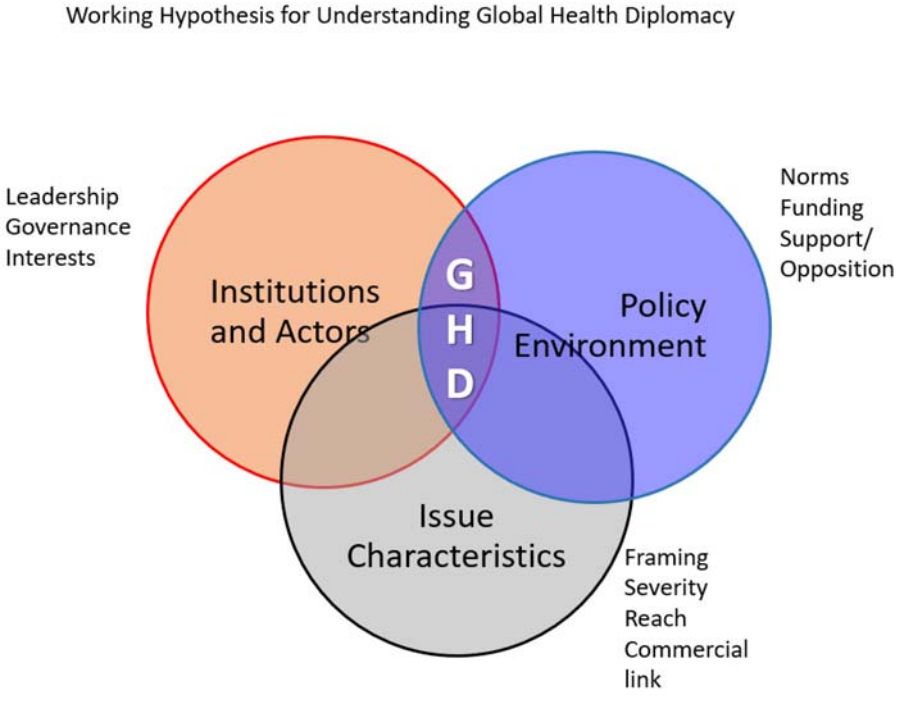

Figure 1. Conceptual approach.

defined as the 'rules of the game' that structure policymaking, incorporating government structures (organisational systems), policy legacies (path dependency), and policy think tanks (Abimbola et al., 2017). Key variables under this dimension are: the role of institutional leadership; the way in which institutions are designed to govern global health diplomacy practices; and organisational and other interests driving GHD practices. The institutional design and location of responsibility for GHD differed widely between our case countries, with important implications for understanding how GHD operates in different bureaucratic contexts and settings. Institutional leadership for specific health concerns represents an important factor accounting for why certain health issues become a foreign policy concern or receive attention in GHD (Burkle, 2015). Such leadership is informed by bureaucratic and other interests, as reflected in the common assumption that policy developments and choices are driven by the real or perceived interests of policy stakeholders (Gauvin, 2014).

Institutions active in GHD operate within a normative environment, the second dimension, which influences how specific ideas are received. Certain health issues are more likely to enter the foreign policy agenda if they are well-aligned with the wider normative preferences of domestic and international policy communities, and receive wide-spread support from a variety of actors in the political system (Shiffman et al., 2016). At the same time, GHD efforts that aim to regulate corporate behaviour, such as tobacco control might experience opposition if there are powerful actors within the policy environment opposing such policies (Bump & Reich, 2013). The final dimension refers to the issue characteristic, or nature of the specific health issue, to be addressed through GHD. Issue characteristic matters for a number of reasons. For example, framing can impact the perception of severity, or the extent to which a health issue represents a real or perceived threat to the whole community (McInnes & Lee, 2012). Similarly, health concerns that have strong socio-economic implications are dealt with differently (and more centrally) in foreign policy than those that do not reach beyond the health sector, with the unravelling COVID-19 pandemic being a prime example for this. Finally, none of the dimensions proposed as part of our approach are standalone; rather, they interact and are dynamic, with dimensions shaping each other both politically and pragmatically.

Findings

The role of institutions and their design

Institutional design and related governance practices within domestic or specialised bureaucracies central to GHD play an important role in how GHD operates, and influence to what extent health or other 'soft' foreign policy concerns rise onto the foreign policy agenda. In all of our four cases, health ministries share the responsibility for engaging in GHD with foreign affairs ministries, but foreign affairs ministries tend to lead in actual diplomatic negotiations while relying on health sector expertise mostly for technical consideration. In all four countries, a dedicated office for international affairs within the health sector coordinates the integration of health and foreign policy issues. But this office does not necessarily lead in global health negotiations or the intersectoral coordination of health with other foreign policy goals. In Mexico. the foreign affairs ministry takes the lead in international negotiation and intersectoral coordination of global health issues (Interview with government representative from health sector, Mexico). Who leads in global health negotiations is important, with the Mexican case suggesting that a foreign affairs lead in intersectoral coordination can skew GHD policy dynamics towards prioritising economic and security interests over health goals. Directly related to this is the role of coordination mechanisms in GHD. Health issues seem to rise more easily onto the foreign policy agenda if intersectoral communication is able to minimise distrust and to identify co-benefits from collaboration to advance GHD (Interviews with representatives from health and foreign policy sectors, Brazil). Brazil, however, was alone among the four countries in having a formalised mechanism in place for

intersectoral health/foreign policy coordination, particularly during the Lula de Silva administration (2003–2010), and even afterwards, despite increasing political turmoil (Interviews with representatives from health and foreign policy sectors, and civil society organisations, Brazil). This might partly explain why Brazil was comparatively more successful at positioning health issues in its foreign policy apparatus, especially during the Lula era, but also in succeeding administrations. All other research sites reported mostly informal or ad-hoc use of intersectoral coordination mechanisms, despite acknowledging such intersectoralism as fundamental to GHD.

Given the absence of institutionalised intersectoralism, the role of informal connections and networks, across government agencies, and with civil society actors operating in the GHD space was a frequently referenced factor for successful policy coordination. Such informal connections and networks can facilitate the flow of ideas and bring health issues to the attention of senior-level managers within the bureaucracy. In Brazil, civil society organisations in discussion with government institutions were important in creating that country's National Program to Fight HIV/AIDS and its international advocacy for generic drug production and treatment of virus-infected individuals (Interviews with representatives from civil society organisations, international organisations, and academia, Brazil). Similarly, informal connections between five Canadian non-governmental organisations (NGOs) and the chief of staff of Canada's then Prime Minister, Stephen Harper, led to positioning maternal, newborn, and child health high on Canada's foreign policy agenda during the negotiation of the Sustainable Development Goals (Interview with NGO representative, Canada). Other countries also experienced similar instances of informal GHD activities cutting across government sectors and reaching into civil society. Such informality extends to agenda-setting, as in the case of Chile where GHD agenda setting was seen mostly as a response to external health threats (SARS, Influenza H1N1, and Ebola), and many of the diplomatic processes associated with global health have been driven by informal negotiations amongst global stakeholders (Interviews with government representatives from health and diplomatic sector, Chile). Agenda-setting is more formalised and hierarchically organised in the other three countries, ranging from very hierarchical in Mexico, through the Foreign Affairs Ministry, leading to the exclusion of many important actors, to a mix of formal (use of Memoranda of Understanding) and informal organisation principles (ad hoc intersectoral committees, public consultations) in the case of Brazil and Canada.

Another important aspect of institutional design is the extent to which countries train their own professionals in the fields of diplomacy and health to ensure health expertise amongst their foreign policy and diplomatic cadres (Katz et al., 2011). One of the health sector's central GHD challenge is finding the right partner in foreign policy departments with an open interest in health. Training diplomats within the foreign affairs apparatus on public health concerns, and health professionals in the practice of GHD with an emphasis on diplomacy, can facilitate uptake of health issues within diplomatic circles (Kevany, 2015). Brazil represents a good example for this as Brazil has a specific institution (Rio Branco Institute–RBI) to train its diplomats. During the second Lula administration, a specific course on social issues, including health, was included in the curriculum, in close collaboration between health and diplomacy, exerting influence on how foreign policy negotiations occur and strengthening the place for health within diplomatic enterprises (Interview with diplomatic representative, Brazil). In addition, other Brazilian institutions also train professionals from the health and social policy field at the post-graduate level to act in the field of global health and health diplomacy (e.g. Fiocruz with a Specialization Course and a Professional Master's Degree Course; and a PhD course through the Public Health Faculty, University of São Paulo).

In Canada the opposite occurred, with the loss of health expertise and limited access to global health training for diplomats inside the foreign affairs department identified as barriers to promoting health issues within foreign policy (Interview with Global Affairs Canada representative) (see also Runnels et al., 2014). Similarly, in the case of Chile, not a single health attaché has been appointed to its Geneva field mission since 2010 which, some have suggested, is mostly related to the country's lack of training for health diplomacy (Interviews with Ministry of Health

representative and diplomatic personnel, Chile). In contrast, since the 1990s, Brazil's Permanent Delegation in Geneva has actively participated in health-related discussions at the UN, such as negotiations concerning the TRIPS Agreement and the Doha Declaration and those that led to the approval of the Framework Convention on Tobacco Control, while providing support to Brazilian health ministry delegates in international fora, such as the World Health Assembly of the WHO (Interviews with government representatives from health sector, and a representative from international organisations and academia) (see also Lima, 2017). During Lula's government this joint effort intensified, but has since become practically extinct under the Bolsonaro government, with important UN health-related meetings being attended only by the Brazilian representative in Geneva with no participation of professionals from the Ministry of Health (Interviews with a representative from health and foreign policy sectors, Brazil). In Mexico, training in GHD for diplomats is still in early stages, with some isolated efforts between the official institution for Foreign Service training, the Matías Romero Institute, and the National Institute of Public Health and other health training institutions to integrate health as a relevant topic in the professional curriculum (Interview with diplomatic personnel, Mexico). Finally, policy leadership by well-connected individuals inside the bureaucracy was highlighted in all four countries as an important ingredient for the successful integration of health issues into foreign policy. Such actors are often able to identify opportune moments in the political system ('policy windows') and use political capital to promote uptake of specific health ideas within the foreign policy establishment (Guldbrandsson & Fossum, 2009).

This leads us into the role played by competing interests within institutions and amongst various actors participating in GHD. We start by emphasising the role of (at times competing or opposed) organisational interests within the different government sectors involved in GHD in the formulation of health-related foreign policy positions (e.g. Foreign Affairs, Finance, Development, Health). To put it differently, an organisational interest perspective acknowledges that there is no such thing as a homogenous state with a unified set of interests, but a multiplicity of ministries/agencies with often competing priorities (Krasner, 1972). In practice, this means that there can be big differences in policy positions on the same issue between actors from different ministries or departments, and different government branches. In the case of Canada, Global Affairs Canada (the foreign affairs department) tends to prioritise health issues in GHD that have security implications, perceiving health as a means towards an end of enhancing the security landscape for Canadians (Interview with Global Affairs Canada representative, see also Ruckert et al., 2019). In contrast, the Public Health Agency of Canada positions health as a goal in itself with limited concerns for fiscal repercussions of global health programming (Interview with Public Health Agency of Canada representative). Fiscal impacts, in turn, are a central concern for Finance Canada, which focuses on limiting additional expenditure related to global health commitments (Proulx et al., 2017). Similar policy tensions and goal conflicts between departments could be observed in other cases. In Chile, diplomats from MINREL (the Ministry of Foreign Affairs which takes the lead in all foreign policy negotiations) do not always fully recognise the importance of health and often prioritise commercial interests in most international negotiations. At the same time, limited understandings amongst the Chilean foreign policy cadre of health as involving only health care, and not broader policy concerns, is explained, in part, by a lack of engagement with the social determinants of health concept (Interview with NGO representative and various academics, Chile).

Brazil has faced similar trouble related to different political stances from the Executive and Legislative about specific health issues, and to the absence of specific regulations for certain international activities that involve the disbursement of additional economic resources or that require approval from the Legislative (Interviews with government representative from health and foreign policy sectors, Brazil). One such example was the case of equipment donation in the technology transfer process for the production of generic drugs in Mozambique. As Brazil was already producing generic medicines for HIV/AIDS (on the basis of expired patents), this caught the attention of other countries and became the subject of demand for technical cooperation (Lima, 2017). The lack

of specific legislation, for example, for donations of equipment as in case of technology transfers; and the restrictive nature of government regulations means that such technical cooperation requires permission from the Brazilian Legislative. However, this support has not always been forthcoming, especially among some legislative members that allege waste of resources in technical cooperation related to GHD (Interviews with a representative from health and foreign policy sectors, Brazil; see also Almeida et al., 2010; Buss & Ferreira, 2010).

The preponderance of private sector interests is also a crucial limiting force in GHD, most often taking the form of corporate lobbying against domestic health measures arising from international/intergovernmental commitments and treaties. This was mentioned in the case of Brazil where pressures were mostly exerted from industry groups and institutions with vested interests, which lobbied ministries, Parliament, different institutions, and the diplomatic service on certain issues related, for instance, to tobacco, alcohol, and front-of-package (FOP) food labelling regulations (Interviews with a representative from health and foreign policy sectors, and civil society organisations, Brazil). Although regulatory measures under consideration were designed to address non-communicable diseases, industry groups argued that they could negatively impact trade, commercial links, and the profitability of firms manufacturing or trading in such unhealthy commodities (Lencucha & Thow, 2019). In these instances, NGO representatives and academic groups in Brazil have had a very active role, denouncing and fighting against industry lobbying, as in the case of tobacco industries, while proposing new FOP food labelling. In Mexico and Chile, corporate lobbying is understood to be particularly widespread when international agreements are translated into national policy, with real or perceived negative impacts on the profitability of key industries. A case in point is the strong opposition by corporate food and beverages industries to FOP in Mexico that required a Supreme Court intervention in 2020, which supported the new FOP labelling policy (Interview with NGO representative, Mexico). In Canada, opinions were more split on the role of corporate lobbying, with government officials suggesting that, with the exception of trade issues, there is little corporate involvement in global health and health-relevant policy negotiations (Interview with Global Affairs Canada representative). NGO representatives, however, thought otherwise, emphasising the role of corporations in shaping certain Canadian policy positions in GHD, for example, the influence of pharmaceutical companies on Canadian policy positions regarding intellectual property rights in trade and investment agreements (Interview with NGO representative, Canada). In Mexico, NGO activist have even gone further in pointing to an 'informal partnership' between some industries (such as tobacco or sweetened beverages) and federal-level decision-makers inside ministries that hinder the implementation of public health measures against those harmful goods (Interview with NGO representative, Mexico).

The role of the policy environment

The ideational environment describes the norms and ideas that infuse both the domestic and global policy-making process. In the domestic context, governments are more likely to support health issues in foreign policy that align with national political priorities and values. This was seen in the case of Canada, where health is considered an important policy issue with universal access to healthcare regarded as a defining element of the Canadian state (Interview with Public Health Agency of Canada representative). This strong grounding of health in national identity can explain why Canada has been a champion of a number of global health issues, especially as evidenced in its support for the Muskoka Initiative on Maternal, Newborn, and Child Health (Proulx et al., 2017). Health similarly has a unique place in the domestic policy environment of Brazil, where access to medicines in the context of the HIV/AIDS crisis was a domestic priority before the country promoted it globally through targeted GHD activities, as it also did with tobacco control initiatives (interviews with representatives from health and foreign policy sectors, and civil society organisations, Brazil) (see also, Portes et al., 2018). There is also an element of normative policy alignment with GHD activities at the global level that can facilitate uptake of health issues, as was experienced in Chile's successful

promotion of front-of-package (FOP) food labelling. Chile was the first country to implement it, with several countries following the Chilean model, reflecting a normative appetite for such a system in the wider global policy environment (Interview with NGO representative, Chile). In a similar vein, Brazil also implemented strong policies for the prohibition of baby food propaganda and hard advice on cigar packaging labelling linked both to strong policy leadership in these issues, despite some food and tobacco industry opposition (Interviews with representatives from civil society organisations and academia, Brazil; see also, Johns, 2012, 2014; Iglesias, 2018).

At the same time, health can also function as an entry point to promote normative consideration in foreign policy, and as such shape the global ideational environment. This was apparent in the case of Canada where health is often linked to gender and human rights concerns in its GHD (Interview with Canadian NGO representative). Similarly, GHD can be used to promote greater visibility of countries in the international system. This was referenced in the case of Brazil, which exported its domestic health values in international fora through defending health as a human right, promoting access to medicines and other health supplies in relation to the HIV/AIDS epidemic, and continuing with its internationally-noted defense of strong public and universal health systems against neoliberal health sector reforms (Riggirozzi, 2014). At the same time, Brazil promotes international health cooperation which can be seen as a subset of global health diplomacy, and a more narrowly focused form of direct nation to nation cooperation, more limited in reach than GHD which integrates a wider host of public and private actors. Through this South-South cooperation, Brazil is fostering better relationships with other countries, mainly in the geopolitical South and within specific regional and global blocks (Herrero & Tussie, 2015), to develop joint GHD positions in international fora (Interviews with representatives from health and foreign policy sectors, Brazil). In Canada, Chile, and Mexico, health similarly functions as a foreign policy reputation builder by promoting a caring image and, through international health cooperation, fostering better relationships with other countries. This reputation building is often seen as a form of soft power in international relations, defined as exercising influence through non-material capabilities such as reputation, culture, and normative appeal that can aid the attainment of a state's policy objectives (Almeida, 2020; Viotti & Kauppi, 2019). In Chile, this can be seen through its leadership role in the WHO Commission on the Social Determinants of Health (Interview with government representative from health sector, Chile). In the case of Mexico, this was articulated through the notion of Mexico being a 'hinge country': due to its role as technical articulator of specific strategic alliances between global actors, and its dual role as both donor and recipient of international aid and cooperation. As such, Mexico is seen by some as capable of fostering health dialogue, transferring capacities, and formulating health priorities within the region (Gonzales et al., 2015).

A second element of the policy environment relates to the existence of potential opponents or supporters of specific health issues as they rise onto the foreign policy agenda. This ideational element was raised in all four countries, with particular reference to the role of non-state actors either providing support for, or opposing specific global health policies. If there are many groups active in a policy space whose values align with specific global health issues, such issues are more likely to find a way onto the foreign policy agenda due to lobbying efforts (Shiffman et al., 2016). Of particular importance is whether such groups are able to coordinate their behaviour to amplify their impacts. This was seen in the cases of Mexico and Canada, where findings affirmed the importance of coalition building among NGOs to advance health issues onto the foreign policy agenda (Interviews with NGO representatives in Canada and Mexico). Conversely, countries are less likely domestically to implement policies negotiated in international fora through GHD if there are powerful opponents to them in the domestic policy environment. Corporate sector lobbying against tobacco control policy and regulation of pharmaceuticals and drug prices were mentioned in the case of Chile as barriers to that country's implementation of intergovernmental health agreements, such as the Framework Convention for Tobacco Control (Interview with NGO and government representative from health sector, Chile). The same can be said in the case of Brazil concerning

strong lobbies against regulation of drug prices and generic drug production (Interviews with representatives from health and foreign policy sectors and academia, Brazil).

The role of issue characteristics

The final category, the characteristics of specific health issues, is more fluid and relates to the other two categories. It reflects the reality that the (perceived) nature of health issues affects how they are dealt with in foreign policy negotiations. Some health issues might impact a wide range of sectors, making it inherently more difficult for them to rise on the foreign policy agenda due to potential push back from several sectors. One finding across all country sites is that framing plays an important role in how a specific health issue is perceived, thereby creating particular pathways of response which in turn affect the potential for, and nature of, GHD. Another finding common to three of our case countries (Canada, Mexico, Chile) stands out: that framing health issues as a security threat enhances the chances of their uptake in GHD. Each country also has a set of unique frames that influence its GHD. In Canada, respondents emphasised that results-based framing is increasingly common in GHD efforts, for example, through highlighting how Canadian health cooperation is contributing to reach clearly quantifiable health goals (Interview with Global Affairs and Finance Canada representative). In Mexico, GHD is predominantly framed as a development and security concern, and often seen as a technical (and not political) enterprise (Interview with government representatives from health sector, Mexico). In Chile, economic framings that emphasise the role of trade in GHD alongside traditional security concerns dominate GHD policy discussions, whereas an ethical framing, such as ensuring affordable access to drugs, is commonly invoked at the international level (Interviews with government representatives from health sector and diplomatic personnel, Chile). In Brazil, GHD framings explicitly highlight the political nature of diplomacy, with GHD often seen as a way to challenge neoliberal hegemony in the international system (at least until 2016, before president Roussef's impeachment) (Interviews with representatives from health and foreign policy sectors, Brazil). With the 2019 arrival of the ultraconservative administration of Bolsonaro, the political nature of the Brazilian diplomacy was confirmed, but in an opposite, arguably irresponsible, controversial, and incompetent way, one that is subservient to the US and dangerous for Brazilian's international trade and diplomatic relations (Ortega & Orsini, 2020). No matter the frame, framing strategies are crucial to presenting health concerns in a light that is reflective of the ideational or even mandated policy norms of a specific audience, for example, security versus economic versus development actors in GHD; and as such framing strategies are widely seen as central to getting health onto foreign policy agendas.

The severity of a health issues is directly related to framing. The more severe the real or perceived health concern, the more likely it will become securitised in foreign policy discourse. Severity, in turn, is connected to reach, the extent to which health issues affect society and leave a trail of victims. This was noted in the case of antimicrobial resistance (AMR) in Canada which, due to the lack of AMR victims and their advocates, has had a difficult time to find a responsive foreign policy environment (Interview with Public Health Agency of Canada representative). On the other hand, in Brazil the trail of HIV/AIDS victims and the social movement advocates that highlighted their fate led to Brazil's championing of 'access to medicines' in GHD. Finally, the commercial link of a health issues speaks to the fact that health issues are more likely to rise onto the foreign policy agenda if they do not threaten the interests of powerful economic actors. This was especially noted in the cases of Brazil, Chile, and Mexico, were economic forces have been found to push back against implementing policies negotiated through GHD that have implications for how economic actors operate domestically.

Discussion

Our conceptual approach, presented in Figure 1, draws from several existing theoretical accounts invoked in earlier GHD scholarship, notably those from policy (3i framework) and international

relations theories; however, it also incorporates new elements that emerged from our four country study and our cross-case analysis. Below we reflect on how our conceptual approach offers a novel account of some of the driving forces for the integration of health into foreign policy.

Institutions, one of the three dimensions of our conceptual approach, are at the heart of our empirical findings. There is a rich literature that documents the importance of institutional set-up and legacy in public policy (Hall, 1997; Hall & Lamont, 2009), including the foreign policy theory of bureaucratic politics which highlights how the nature of institutional set-up impacts foreign policy dynamics (Krasner, 1972). This theoretical approach initially became popular in foreign policy because it emphasised the competing interests between different parts of the same bureaucracy. As such it moved away from the notion of a homogenous state interest at the national level, as assumed by systemic theories of international relations, such as realism and constructivism. Instead, it emphasises the role of path dependency wherein the institutional design leaves a clear imprint on how policy negotiations proceed, and focuses on how different parts of the bureaucracy might have competing and conflictual priorities (Bevan & Robinson, 2005). The traditionally economic explanation of how path dependency occurs is potentially applicable to GHD, through the steps of lock in, positive feedback, increasing returns, and self-reinforcement of policy choices (Greener, 2005). In all four countries, we found that previous policy choices and institutional set-up left a legacy that entrenched certain health issues as dominant within the foreign policy establishment. In addition, the role of the institutional design was a major factor in how GHD operates in practice. In particular, countries with health ministries in the lead in international negotiations have been able to bring a broader (social determinants of health informed) perspective to the table (Brazil and Canada), while countries where foreign affairs departments are in the lead display a narrower (and largely security focused) understanding of health issues (Chile and Mexico). Intersectoral coordination mechanisms are another central aspect of institutional design, with health issues more easily promoted as a foreign policy concern in environments with established and institutionalised intersectoral mechanisms, such as standing committees or working groups in areas relevant to GHD. Finally, diplomatic training represents an important element of institutional set-up, as GHD initiatives are less likely to succeed in the absence of formal training of health experts on broader political and international responsibilities and diplomatic strategies (Kevany, 2015).

The role of interests of various policy stakeholders speaks to key issues associated with the three leading theoretical paradigms in international relations (IR) theory often invoked to explain the driving forces of GHD. Consider, first, the role that national (and specifically security) interests play as driving forces in GHD. Most existing theoretical engagements with GHD focus on national security interests, often highlighting how health can function as a tool to pursue wider foreign policy goals related to defence and economic interests (Ruger, 2008). As Ooms and colleagues (2011) point out, the 'health of all people' is rarely 'an end of foreign policy in itself' but serves, instead, to advance other policy goals. Others have similarly argued that development assistance (for health) is often provided by richer countries to advance their own strategic interests, security goals, and political values rather than to promote better health in the Global South as an end in itself (Fidler, 2005; Fidler, 2009; McInnes & Rushton, 2014). A good example for this is the problematic misalignment between global health needs, as measured in global disease burdens, and donor priorities expressed in development assistance for health flows (Khazatzadeh-Mahani et al., 2020). Since the 1990s, the burden of disease in many Low and Middle-Income Countries (LMICs) began to shift from infectious to non-communicable diseases (NCDs), albeit often with high concurrent rates of both types of disease. Despite the rising importance of control of NCDs in LMICs, most development assistance remains focused on infectious diseases, which some have argued reflects a strategy to contain such diseases at source before they might spread to developed (donor) countries (Khazatzadeh-Mahani et al., 2020). While the importance of this strategy has been reinforced by the COVID-19 pandemic, in practice the emergence of vaccine nationalism demonstrates still weak perception of collective interests and protection in a pandemic (Labonte et al., 2020).

Security-centric understandings of GHD are best embodied by realist IR theories which pose that the first priority of all governments in the world is to enhance security in an anarchical international system (Paxton & Youde, 2019). Other research, however, also argues that international attention and praise for a nation's ability to engage in, and lead, international negotiations surrounding global health issues may motivate governments' interests in GHD, with the objective of sustaining and furthering their international reputation and influence (Gomez, 2012). Such an understanding crosses over from the realm of interest into that of norms and ideas as driving forces of GHD (our second conceptual dimension) since, as constructivist theorists would argue, interests are themselves the expression of a specific normative understanding of the world (Wendt, 1992). In this vein, some scholars, contend that states provide bilateral foreign aid in health with the goal of increasing their international reputation and image, in turn contributing to their 'soft power' influence (Feldbaum & Michaud, 2010; Lee & Smith, 2011). The theme of how the promotion of internationally recognised health issues can be used as an instrument to further a nation's international influence and reputation was widely acknowledged in all four countries, with Brazil's response to HIV/AIDS and tobacco control as the most prominent examples. In this context, some scholars have argued that the combination of hard and soft power into 'smart power' is increasingly common in GHD, such that countries strategically combine material and normative incentives and resources to achieve specific goals (Almeida, 2020; Kevany, 2014).

Generally, the role of norms and ideas has received less attention in GHD scholarship, where explanations of the integration of health into foreign policy have tended to focus on hard (security) interests, although the existence of non-state actors opposing or supporting GHD initiatives has been widely studied from a constructivist perspective (Balcius & Novotny, 2011; Koivusalo & Mackintosh, 2011). Such studies draw on a theoretical apparatus steeped in a social science tradition, and focus on how, through expert and advocacy networks based on shared values and norms, state behaviour can be influenced within the international system (Ruckert et al., 2016). Key aspects of this process include information mobilisation and issue framing that are used instrumentally to not only influence policy outcomes, but to transform the nature and terms of policy debates surrounding GHD (Keck & Sikkink, 1999). The importance of such actors in the positioning and framing of health issues in foreign policy was seen in all of our case studies: maternal/child health (Canada), HIV/AIDS and generic antiretrovirals (Brazil), FOP nutrition labelling (Chile), and special taxation on sugar-sweetened beverages (Mexico).

The last dimension, issue characteristics, can help identify what theoretical approach might be the best fit in different policy contexts. Health issues that inherently go beyond the narrow confines of the health sector, and that have strong implications for private industry (or commercial link), are more likely to experience push-back from the private sector, and to generate opposition within the ideational policy environment (such as FOP nutrition labelling in Chile, and international property rights and production of generics drugs in Brazil). Political economy theories that capture the role of lobbying in policy formulation would be a good starting point to reflect on who is driving the policy process under such circumstances (Bump & Reich, 2013). Health issues with a direct security dimension (e.g. infectious diseases and their governance) might best be understood through the lens of realism, with its focus on how the lack of central authority in the international system is forcing countries to maximise security through self-help. On the other hand, in areas where countries have heavily invested a lot of political capital and certain parts of the bureaucracy have become strong supporters of specific policies (as in the case of Global Affairs Canada and maternal newborn and child health), institutional theories with their focus on path dependency might be best suited as a starting point for any theoretical explanation of GHD.

Conclusion

Our conceptual approach highlights that no single factor or variable can explain why specific heath issues enter onto the foreign policy agenda (while others do not). It is a combination of variables

related to institutional set-up and legacy, interest-driven lobbying, ideational environment and issue characteristics of health issues and their framing that in each country combine and interact to create the preconditions for uptake of health issues in foreign policy in unique ways. However, our findings do have clear implications for global health practise and offer a number of entry points for improving GHD. First, improving the institutional set-up of GHD is crucial, including through establishing formal intersectoral collaboration mechanisms and entrenching global health knowledge through diplomatic training within the foreign policy process. Second, GHD practitioners should be aware of the potential pushback they might experience once global health agreements or treaties are translated into national-level policy commitments and implemented through domestic regulations and laws. This highlights the importance of building domestic policy coalitions in support of GHD initiatives. Third, the on-going COVID-19 pandemic, and the return of health nationalisms, as for example expressed in advance vaccine purchase agreements, will likely make it more difficult to achieve cooperation in global health. At the same time, the global health community requires cooperation more than ever to achieve its goals. At the most recent World Health Assembly, there were resoundingly clear calls and recommendations for a united, collaborative, global effort to address the COVID-19 pandemic – to leave no one behind. But to achieve effective global health cooperation will not only require more political will but also a better understanding of the institutions, interests, and ideational environments that can either facilitate or hamper GHD efforts.

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References

Abimbola, S., Negin, J., Martiniuk, A. L., & Jan, S. (2017). Institutional analysis of health system governance. *Health Policy and Planning*, *32*(9), 1337–1344. https://doi.org/10.1093/heapol/czx083

Almeida, C. (2020). *Global health diplomacy: A theoretical and analytical review*. Oxford Encyclopedia of Public Health. Oxford Press. https://doi.org/10.1093/acrefore/9780190632366.013.25.

Almeida, C. M., Campos, R. P., Buss, P. M., & Ferreira, J. R. (2010). Brazil's conception of South-South "structural cooperation" in health. *RECIIS – Rev. Eletr. de Com. Inf. Inov. Saúde. Rio de Janeiro*, *4*(1), 23–32. https://doi.org/10.3395/reciis.v4i1.343en.

Balcius, J., & Novotny, T. E. (2011). New approaches to global health governance: The evolution to public-private partnerships. *Journal of Commercial Biotechnology*, *17*(3), 233–240. https://doi.org/10.1057/jcb.2011.14

Bevan, G., & Robinson, R. (2005). The interplay between economic and political logics: Path dependency in health care in England. *Journal of Health Politics, Policy and Law*, *30*(1–2), 53–78. https://doi.org/10.1215/03616878-30-1-2-53

Bump, J. B., & Reich, M. R. (2013). Political economy analysis for tobacco control in low- and middle-income countries. *Health Policy and Planning*, *28*(2), 123–133. https://doi.org/10.1093/heapol/czs049

Burkle Jr, F. M. (2015). Global health security demands a strong international health regulations treaty and leadership from a highly resourced World Health organization. *Disaster Medicine and Public Health Preparedness*, *9*(5), 568–580. https://doi.org/10.1017/dmp.2015.26

Buss, P., & Ferreira, J. R. (2010). Health diplomacy and South-South cooperation: The experiences of UNASUR Salud and CPLP's strategic plan for cooperation in health. *RECIIS – Rev. Eletr. de Com. Inf. Inov. Saúde. Rio de Janeiro*, *4* (1), 99–110. https://doi.org/10.3395/reciis.v4i1.351en.

Davies, S. E., Kamradt-Scott, A., & Rushton, S. (2015). *Disease diplomacy: International norms and global health security*. JHU Press.

Feldbaum, H., & Michaud, J. (2010). Health diplomacy and the enduring relevance of foreign policy interests. *Plos Medicine*, *7*(4), e1000226. https://doi.org/10.1371/journal.pmed.1000226

Fidler, D. P. (2005). *Health and foreign policy: A conceptual overview*. Nuffield Trust London. http://www.nuffieldtrust.org.uk/sites/files/nuffield/event/Health%20And%20Foreign%20Policy%20A%20Conceptual%20Overview.pdf.

Fidler, D. P. (2009). *After the revolution: Global health politics in a time of economic crisis and threatening future trends*. 2 Global Health Governance (2008/09), 21.

Fidler, D. P. (2011). Health in foreign policy: An analytical overview. *Canadian Foreign Policy Journal*, *15*(3), 11–29. https://doi.org/10.1080/11926422.2009.9673489

Gauvin, F. (2014). *Understanding policy developments and choices through the "3-i" framework: Interests, ideas and institutions*. National Collaborating Centre for Healthy Public Policy. http://www.ncchpp.ca/165/publications.ccnpps?id_article=1077.

Gomez, E. (2012). Understanding Brazilian global health diplomacy: Social health movements, institutional infiltration, and the geopolitics of accessing HIV/AIDS medication. *Global Health Govern*, *6*(1).

Gonzales, G., Pellicer, O., & Saltalmaccia, N. (2015). *Mexico and the multilateralism of the XXI century*. ITAM.

Greener, I. (2005). The potential of path dependence in political studies. *Politics*, *25*(1), 62–72. https://doi.org/10.1111/j.1467-9256.2005.00230.x

Guldbrandsson, K., & Fossum, B. (2009). An exploration of the theoretical concepts policy windows and policy entrepreneurs at the Swedish public health arena. *Health Promotion International*, *24*(4), 434–444. https://doi.org/10.1093/heapro/dap033

Hall, P. A. (1997). The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. *Comparative Politics: Rationality, Culture, and Structure*, 174–207.

Hall, P. A., & Lamont, M. (2009). *Successful societies: How institutions and culture affect health*. Cambridge University Press.

Herrero, M. B., & Tussie, D. (2015). Unasur Health: A quiet revolution in health diplomacy in South America. *Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development*, *15*(3), 261–277. https://doi.org/10.1177/1468018115599818

Iglesias, R. M. (2018). *Brasil é o principal fornecedor do complexo produtivo do cigarro paraguaio*. Published interview on 28/08/2017. Informe Ensp, 21/06/2018. http://www.ensp.fiocruz.br/portal-ensp/informe/site/materia/detalhe/42438.

Johns, P. (2012). *Industria do tabaco: o agricultor é o elo mais fraco da cadeia produtiva*. Published interview on 15/09/2012. http://www.ihu.unisinos.br/entrevistas/513558-industria-do-tabaco-o-agricultor-e-o-elo-mais-fraco-da-cadeia-produtiva-entrevista-especial-com-paula-johns.

Johns, P. (2014). *As desigualdades em torno do hábito de fumar: problema de saúde pública que atinge principalmente os pobres*. Published interview on 10/02/2014. http://dssbr.org/site/entrevistas/as-desigualdades-em-torno-do-habito-de-fumar-problema-de-saude-publica-que-atinge-principalmente-os-pobres.

Katz, R., Kornblet, S., Arnold, G., Lief, E., & Fischer, J. E. (2011). Defining health diplomacy: Changing demands in the era of globalization. *Milbank Quarterly*, *89*(3), 503–523. https://doi.org/10.1111/j.1468-0009.2011.00637.x

Keck, M. E., & Sikkink, K. (1999). Transnational advocacy networks in international and regional politics. *International Social Science Journal*, *51*(159), 89–101. https://doi.org/10.1111/1468-2451.00179

Kevany, S. (2014). Global health diplomacy, "smart power", and the new world order. *Global Public Health*, *9*(7), 787–807. https://doi.org/10.1080/17441692.2014.921219

Kevany, S. (2015). Diplomatic advantages and threats in global health program selection, design, delivery and implementation: Development and application of the Kevany Riposte. *Globalization and Health*, *11*(1), 22. https://doi.org/10.1186/s12992-015-0108-x

Khazatzadeh-Mahani, A., Ruckert, A., & Labonté, R. (2020, March 19). *Global health diplomacy*. The Oxford Handbook of Global Health Politics. https://doi.org/10.1093/oxfordhb/9780190456818.013.7.

Koivusalo, M., & Mackintosh, M. (2011). Commercial influence and global nongovernmental public action in health and pharmaceutical policies. *International Journal of Health Services*, *41*(3), 539–563. https://doi.org/10.2190/HS.41.3.h

Krasner, S. D. (1972). Are bureaucracies important? (or Allison Wonderland). *Foreign Policy*, *7*(7), 159–179. https://doi.org/10.2307/1147761

Labonte, R., Plamondon, K., Johri, M., & Murthy, S. (2020). *Canada's "me first" COVID-19 vaccine strategy may come at the cost of global health*. https://theconversation.com/canadas-me-first-covid-19-vaccine-strategy-may-come-at-the-cost-of-global-health-146908.

Lee, K., & Smith, R. (2011). *What is 'Global Health Diplomacy'? A conceptual review*.

Lencucha, R. (2013). Cosmopolitanism and foreign policy for health: Ethics for and beyond the state. *Bmc International Health and Human Rights*, *13*(1), 29. https://doi.org/10.1186/1472-698X-13-29

Lencucha, R., & Thow, A. M. (2019). How neoliberalism is shaping the supply of unhealthy commodities and what this means for NCD prevention. *International Journal of Health Policy and Management*, *8*(9), 514–520. https://doi.org/10.15171/ijhpm.2019.56

Lima, J. H. d. S. (2017). Saúde global e política externa brasileira: Negociações referentes à inovação e propriedade intelectual. *Ciência & Saúde Coletiva*, *22*(7), 2213–2221. https://doi.org/10.1590/1413-81232017227.02652017

McInnes, C., & Lee, K. (2012). Framing and global health governance: Key findings. *Global Public Health*, *7*(sup2), S191–S198. https://doi.org/10.1080/17441692.2012.733950

McInnes, C., & Rushton, S. (2014). Health for health's sake, winning for God's sake: US Global Health Diplomacy and smart power in Iraq and Afghanistan. *Review of International Studies*, *40*(05), 835–857. https://doi.org/10.1017/S026021051400031X

Ooms, G., Hammonds, R., Decoster, K., & Van Damme, W. (2011). *Global Health: What it has been so far, what it should be, and what it could become*.

Ortega, F., & Orsini, M. (2020). Governing COVID-19 without government in Brazil: Ignorance, neoliberal authoritarianism, and the collapse of public health leadership. *Global Public Health*, *15*(9), 1257–1277. https://doi.org/10.1080/17441692.2020.1795223

Paxton, N., & Youde, J. (2019). Engagement or dismissiveness? Intersecting international theory and global health. *Global Public Health*, *14*(4), 503–514. https://doi.org/10.1080/17441692.2018.1500621

Portes, L. H., Machado, C. V., Turci, R. B., Figueiredo, V. C., Cavalcante, T. M., & Costa e Silva, V. L. (2018). A política de controle do tabaco no brasil: Um balanço de 30 anos. *Ciência & Saúde Coletiva*, *23*(6), 1837–1848. https://doi.org/10.1590/1413-81232018236.05202018

Proulx, K. R., Ruckert, A., & Labonté, R. (2017). Canada's flagship development priority: Maternal, newborn and child health (MNCH) and the Sustainable Development Goals (SDGs). *Canadian Journal of Development Studies / Revue Canadienne D'études du Développement*, *38*(1), 39–53. https://doi.org/10.1080/02255189.2016.1202103

Riggirozzi, P. (2014). Regionalism through social policy: Collective action and health diplomacy in South America. *Economy and Society*, *43*(3), 432–454. https://doi.org/10.1080/03085147.2014.881598

Ruckert, A., Labonté, R., & Lencucha, R. (2019). Health in Canadian foreign policy: The role of norms and security interests. *Canadian Foreign Policy Journal*, *25*(3), 325–341. https://doi.org/10.1080/11926422.2019.1642216

Ruckert, A., Labonté, R., Lencucha, R., Runnels, V., & Gagnon, M. (2016). Global health diplomacy: A critical review of the literature. *Social Science & Medicine (1982)*, *155*, 61–72. https://doi.org/10.1016/j.socscimed.2016.03.004

Ruger, J. P. (2008). Normative foundations of global health law. *The Georgetown Law Journal*, *96*(2), 423.

Runnels, V., Labonté, R., & Ruckert, A. (2014). Global health diplomacy: Barriers to inserting health into Canadian foreign policy. *Global Public Health*. 1080–1092. doi:10.1080/17441692.2014.928740

Shiffman, J. (2009). A social explanation for the rise and fall of global health issues. *Bulletin of the World Health Organization*, *87*(8), 608–613. https://doi.org/10.2471/BLT.08.060749

Shiffman, J., Quissell, K., Schmitz, H. P., Pelletier, D. L., Smith, S. L., Berlan, D., Gneiting, U., Van Slyke, D., Mergel, I., Rodriguez, M., & Walt, G. (2016). A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning*, *31*(Suppl 1), i3–i16. https://doi.org/10.1093/heapol/czu046

Thaiprayoon, S., & Smith, R. (2015). Capacity building for global health diplomacy: Thailand's experience of trade and health. *Health Policy and Planning*, *30*(9), 1118–1128. https://doi.org/10.1093/heapol/czu117

Viotti, P. R., & Kauppi, M. V. (2019). *International relations theory*. Rowman & Littlefield.

Wendt, A. (1992). Anarchy is what states make of it: The social construction of power politics. *International Organization*, *46*(2), 391–425. https://doi.org/10.1017/S0020818300027764