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‘Health in All Policies’ at EU Level: A Critical Analysis

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Thesis abstract

The politics of non-communicable diseases (NCDs) has been the focus of a growing body of research. Political, social and macroeconomic determinants of NCDs are increasingly well understood. Consequently, 'Health in All Policies' (HiAP) was introduced to the EU in 2006. HiAP is an approach to policymaking which seeks to prioritise and mainstream health across policy areas. This thesis offers a critical analysis of HiAP at EU level, in relation to broadly defined health promotion. While HiAP has been looked at from a technical angle, this thesis uses discursive institutionalism to engage with the ideational dimensions of HiAP in the EU. This normatively-oriented research agenda builds on the work highlighting links between neoliberalism and ill-health. It explores the tensions between neoliberalism as a determinant of ill-health, and HiAP. The empirical analysis of HiAP in the EU is divided into three sections: first, the *institutional context* offers insights into how the EU institutional architecture, with its ingrained neoliberal bias, limits the space for HiAP. Secondly, the thesis goes beyond institutional power and zooms into the EU *background ideational structures*. This section sheds light on how neoliberalism underpins paradigms and frames around health and knowledge, and how that affects the scope for HiAP. The third empirical section looks at *foreground discursive abilities*, the agential space to define HiAP. It draws on the concept of 'chameleonic ideas' to argue that, on one hand, this space for agency is used to co-opt and water down HiAP. On the other hand however, this space for agency can also be used to reshape and adapt HiAP. This is seen in the shift from HiAP towards the 'economy of wellbeing'. Finally, the thesis offers reflections on the potential synergies between chameleonic HiAP, and radical degrowth discourses to push for endogenous institutional change.

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List of abbreviations

AMR	Anti-microbial resistance
AVMSD	Audio-Visual Media Services Directive
CAP	Common Agricultural Policy
CDA	Critical discourse analysis
CF	Cohesion Fund
CHAFEA	Consumer, Health, Agriculture and Food Executive Agency
CJEU	Court of Justice of the European Union
CSR	Country-specific recommendation
DG	Directorate General
DG ECFIN	DG for Economic and Financial Affairs
DG GROW	DG for Internal Market, Industry, Entrepreneurship and SMEs
DG SANTE	DG for Health and Food Safety
DI	Discursive institutionalism
DNA	Deoxyribonucleic acid
EC	European Commission
ECDC	European Centre for Disease Control
ECHI	European Core Health Indicators
EFTA	European Free Trade Association
EIB	European Investment Bank
EMA	European Medicines Agency
EMU	European Monetary Union
EP	European Parliament
ERDF	European Regional Development Fund
ESF	European Social Fund
ESIF	European Structural and Investment Fund
EU	European Union
FDI	Foreign direct investment
GDP	Gross domestic product
HIA	Health Impact Assessment
HiAP	Health in All Policies
HLG	High Level Group on Nutrition and Physical Activity
HP	Health Programme

IA	Impact Assessment
IMF	International Monetary Fund
ISG	Interservice group
JRC	Joint Research Centre
LMIC	Low- and middle income country
MEP	Member of the European Parliament
MFF	Multiannual Financial Framework
NCD	Non-communicable disease
NGO	Non-governmental organisation
NMG	New modes of governance
OECD	Organisation for Economic Co-operation and Development
OMC	Open Method of Coordination
REFIT	Regulatory Fitness and Performance Programme
SDH	Social determinants of health
SGP	Stability and Growth Pact
SGPP	Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SME	Small and medium-sized enterprises
SPS	Sanitary and phytosanitary
TEC	Treaty of the European Community
TEU	Treaty of the European Union
TFEU	Treaty on the Functioning of the European Union
TTIP	Transatlantic Trade and Investment Partnership
UK	United Kingdom
UNESDA	Union of EU soft drinks associations
WHO	World Health Organisation

INTRODUCTION

It is commonly assumed that European Union (EU) affairs have little to do with health promotion. And while the health-related competencies of the EU are often acknowledged, they are rarely seen as an important part of what the EU is about (Lamping, 2005; Schimmelfennig and Rittberger, 2006). With health promotion being very clearly a member state competence, why would anyone speak about 'EU health promotion'? At most, one can think of the EU and health promotion in relation to food safety, making sure the products available in the Single Market are safe for consumers. But beyond that, can the EU do anything more than encourage member states to promote health within their own national borders? In the Treaty on the Functioning of the European Union (TFEU), article 168 clearly states that

> [a] high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. (European Union, 2012, Art. 168) (see Box 2.1., pp.66-67)

What this suggests, is that the EU does have a responsibility to protect public health and to make sure its activities positively affect public health. Arguably, this paragraph of the treaty may sound like a vague, aspirational mention, with little practical relevance, given the EU operates mainly in policy areas unrelated to public health. This logic, I argue in this thesis, is dependent upon how one defines 'health promotion'.

What exactly is health promotion? This thesis posits that the term health promotion is discursively and socially constructed, that it does not have one 'accurate', pre-existing meaning. Instead, what health promotion means depends on normative assumptions, which matter for how the EU's public health responsibility outlined in article 168 is understood: is health promotion merely about encouraging healthy behaviours and guaranteeing the absence of biological, physical or chemical contamination of products? As Chapter One will explain, there are good reasons to reject this minimalist definition. Instead, mounting research shows that public health, i.e. the health of populations (as opposed to health of individuals), is affected by political decisions taken in areas that have 'apparently nothing to do' with health: housing policies, welfare systems, urban policies, labour market policies, fiscal governance,

the agricultural and food system, even broader and more fundamentally than that: the overarching, macroeconomic system and its propensity to widen or reduce societal inequities. These are the 'distal' determinants of public health, the so-called 'causes of causes' (Huynen et al., 2005). In terms of macroeconomic model and political ideology, neoliberalism is worth singling out for its current dominance and its detrimental effects on societal inequities. Chapter Two will justify in more detail why this thesis chooses to focus on identifying neoliberal rationality as a distal determinant of health which widens inequities.

If these are the factors that shape the health status of populations, considering them seriously has implications for what could or should count as health promotion. Viewed in this light, health promotion suddenly becomes very broad, and suddenly the political, normative nature of health promotion becomes impossible to ignore. If the opening lines of article 168 TFEU are reassessed in light of this understanding of public health determinants, then the relevance of EU activities to public health and health promotion starts to make more sense: encouraging healthy behaviour is merely the tiny tip of the health promotion iceberg. Underneath the surface lie all those other policy areas and their normative underpinnings that constitute the 'distal determinants of health', many of which are EU competencies (see: European Union, 2016). This is why a case can undoubtedly be made for a 'Health in All policies' (HiAP) approach at EU level: an approach to policymaking which is supposed to recognise that all policy areas, in particular those that are not 'directly health policy', have an impact on population health, because the activities in those areas constitute and/or shape distal determinants of health. HiAP is not about extending EU competencies into healthcare systems, but it is about recognising these distal – and normative – determinants of health, and respecting article 168.

In this thesis, I will analyse how normative barriers to HiAP at EU level manifest. This however, represents a particularly complicated task: it requires an unorthodox approach to EU studies, given that the EU and health promotion are not commonly associated. It also requires a radical approach to health promotion; one that focuses on those distal determinants of health and does not shy away from their normative nature. With respect to engaging with the political and normative essence of public health, the EU represents a particularly worthwhile case to study; as Chapter Two will explain, the EU has often been theorised as having a particularly ingrained neoliberal institutional bias. The task in this thesis is to investigate how this bias manifests through various kinds of power: institutional power, and forms of ideational power (see Chapter Three). Additionally, the thesis also aims to better

understand the opportunities for HiAP, critically assessing the possibilities for a malleable idea like HiAP to be continuously redefined in ways that seek to challenge and contest neoliberal orthodoxy.

Ultimately, this thesis looks at how the various pathways of neoliberal reproduction in the EU undermine the scope for HiAP, as well as how HiAP itself offers a space for agency to challenge the neoliberal orthodoxy. Through this thesis, I make three main points: Directed to EU studies, I wish to draw more serious attention to the relevance of the EU to health promotion. Downplaying the relevance of the EU to health is in itself political, insofar as it actively obscures distal determinants of health. This recognition goes hand in hand with rethinking what health promotion should be considered to be about. Directed to public health studies, I wish to emphasise the limits of the all too common reluctance in the field to properly engage with normative and political questions – even though I recognise and reflect upon why this tends to be the case. Finally, I emphasise the importance of critical approaches to enrich the insights into studies of power. This point also speaks to discursive institutionalist (DI) scholars, who tend to focus more strongly on the discursive-agency aspect of DI, whereas this thesis proposes an application of DI which is closer to the ideational-structure aspect of DI (see Chapter Three).

Starting point and aim of the thesis

The purpose of this research project is to explore HiAP in the EU institutional, ideational, and discursive context. 'Institutional' and 'ideational' context, here, refers to two (co-constitutive) types of structures which shape what is doable and thinkable. Analysing the obstacles to HiAP within the EU 'institutional context' refers to analysing how the so-called EU 'constitutional asymmetry' prevents a HiAP uptake at EU level (see Chapter Four). Constitutional asymmetry is a term used to describe the EU institutional architecture as shaped in a way that systematically favours market integration over social protection (see Chapter Two, p.63). Analysing the obstacles to HiAP within the EU 'ideational context' refers to analysing how certain frames and paradigms dominant in the EU and pertaining to how health and knowledge is made sense of, are reproduced in ways which undermine a HiAP uptake (see Chapter Five). Finally, the 'discursive context' refers to the agential space in which EU actors can actively define and re-define HiAP, either in ways that fit the

dominant structures, or in ways that seek to promote endogenous institutional change (see Chapter Six).

This project distinguishes itself from the majority of literature on HiAP, in that it is not concerned with analysing technical methods of implementation of HiAP. In other words, it does not focus on particular policies and how to concretely insert public health considerations within them. Rather, this thesis is about looking at how ideological power dynamics play out in relation to HiAP in the EU context. The purpose is thus to move away from a technical approach to health mainstreaming, and to embrace the normative essence of HiAP, analysing how it plays out in the EU. In line with embracing the normative nature of a health mainstreaming project, the thesis is thus also about broadening the definition and scope of what should be considered 'health promotion'.

As will be detailed in Chapter Two, economic systems, particularly through their propensity to exacerbate or reduce societal inequities, are determinants of (ill-) health. The first premise guiding the research project, is that neoliberalism should be considered a determinant of population ill-health. This means that a *meaningful* HiAP project is incompatible with- and needs to challenge neoliberal orthodoxy. The second premise, is that the EU institutional context is particularly (yet not monolithically) neoliberal. Both these premises are explained and justified in the second chapter. The purpose of the thesis is thus to understand how neoliberal rationality manifests in the EU context, not only institutionally (in a conventional sense), but also ideationally and discursively, in a way that undermines the possibility for a meaningful HiAP – the 'neoliberal obstacles' to HiAP. At the same time, this thesis also aims to better understand how HiAP 'made it' to the EU space in the first place. Given the apparent normative incompatibility, this represents a success in and of itself, and it points to aspects of agency, to the idea that institutions and ideational structures are not immutable, but can be actively challenged and gradually changed. Overall, this thesis is thus concerned with the following puzzle: why was HiAP successfully introduced into the EU space, but yet has not led to a fundamental transformation and a meaningful recognition of distal determinants of health? The set of research questions guiding this thesis can then be articulated as follows:

Overarching research question:
What are the possibilities and limitations of HiAP in the EU context?

Sub-questions:

1. How does the EU institutional architecture, particularly its neoliberal bias, limit the possibility for a meaningful HiAP uptake?
2. How do neoliberal background ideational structures in the EU limit the possibility for a meaningful HiAP uptake?
3. What are the various discursive power struggles at EU level around the meaning of HiAP, and how do active redefinitions of HiAP promote institutional change?

The argument

The central argument of this thesis, is that a radical HiAP shift is unlikely to happen in the EU context, because HiAP is normatively at odds with the dominant neoliberal rationality prevailing at EU level. This is most visible in the asymmetrical EU institutional architecture that systematically privileges market goals over social goals. Addressing the first sub-question, I argue that the EU governance areas that affect distal determinants of health tend to be those areas with the most constraining forms governance. However, they also have the least *perceived* relevance to health. In contrast, those areas with the most perceived relevance to health promotion pertain largely to proximal determinants of health and tend to be governed in a softer, less binding way (see table 4.1., p.120).

However, I suggest that enabling HiAP is not solely a matter of redressing this constitutional asymmetry. In other words, enabling HiAP is not solely a matter of changing the EU institutional architecture in a way that no longer systematically privileges markets over people. Instead, it is necessary to also consider the ideational and meaning making context that prevails at the EU. Here, I argue for the need to look at how paradigms of health and knowledge shape the framing of NCDs and evidence respectively, and how this system of meanings has an impact on the possibility to take up HiAP. More specifically, I look at the framing of NCDs as a problem mostly related to ageing populations, the embeddedness of this frame in economic, security, and biomedical paradigms of health, and the neoliberal 'deep core' that underpins these frames and paradigms. Similarly, I look at the framing of evidence as 'SMART' (Specific, Measurable, Achievable, Relevant, and Time-bound), its embeddedness in a positivist knowledge paradigm, and how the neoliberal underpinning of these frames and paradigms undermine the possibility to take up HiAP. Importantly, I argue

that, while ideational and institutional structures reinforce each other, neoliberal reproduction occurring through these paradigms and frames are *more* than merely path-dependent consequences of institutional configuration and need to be analysed and challenged 'in their own right'.

Yet finally, the fact that HiAP as a concept reached the EU space in the first place suggests that space for contestation and gradual change exists, even though it points to incremental, evolutionary change processes rather than revolutionary, radical ones. This is explored in the final part of the thesis where I draw on Smith's (2013a) categorisation of ideas to argue that HiAP successfully reached the EU space because it is a so-called 'chameleonic' idea: its normativity is strategically toned down, there remains an intentional level of vagueness, and it has been made to fit the EU language. The consequence of a chameleonic idea is that, as a space for agency, its meaning is an important site of discursive power struggle. In line with neoliberal rationality, HiAP can be made to fit the prevailing institutional orthodoxy. But a 'neoliberal HiAP co-option' is not the end of the story, either. The last sections argue that HiAP is being continuously re-adapted and 'recycled' in response to risks of co-option. This is illustrated for example in the move from using the term 'health' to using 'wellbeing', the shift from HiAP to 'economy of wellbeing'. I suggest that there could be potential for discursive synergy between chameleonic ideas like HiAP, and more radical discourses like degrowth. While the latter remains marginal, it is not entirely absent even from the EU institutions.

Ultimately, I argue that the pervasiveness of neoliberalism goes beyond EU institutional power dynamics, and has also to do with ideational paradigms that provide the frames to make sense of the world, as well as active discursive ability. At the same time, these structures are not pre-determined and forever fixed – they can be strategically challenged, and they do evolve. This is where the advantage of using DI as a theoretical framework lies: it allows researchers to strike a balance between structure and agency, a balance determined to an extent by the researchers themselves and their own ontological positioning, and that allows for both structure and agency to be considered. This is possible because DI conceptualises power as operating in various different, non-mutually exclusive ways: consequently, it can draw attention to power dynamics that would have otherwise been left unchallenged, while avoiding totalising claims.

Methods and methodological reflections

Before presenting the methods used in this research project, it is necessary to reflect upon how the theoretical position in this thesis informs the methodological standpoint and, in turn, contributes to determining which methods are appropriate to collect and make sense of data. The thesis aims to avoid conflating ontology with epistemology and rejects the reduction of all social reality to the product of enquiry about social reality (Parsons, 2010). It does, however, recognise the relative co-constitutive extent of epistemology and ontology, and the inevitably normative underpinning of knowledge. In the same vein, the position adopted throughout this thesis rejects the notion of a social world objectively pre-existing out there, and in turn also rejects the idea that researchers can be neutral observers (of an objective reality). The most precise ontological, epistemological and methodological situation of this thesis, as far as one can attempt to fully determine such categories, would be a form of 'post-modern constructivism', located between modern, 'traditional' constructivism and post-structuralist constructivism as described by Parsons (2010)[1]. According to him, both types of constructivism (modern and post-modern) argue that social reality is socially constructed, but post-modern ones do not consider research as somehow capable of escaping social construction, and thus do not claim to be able to provide a 'truer' picture of reality. They do not attempt to convince that their argument is necessarily more accurate, rather, they are more concerned with unpicking the underlying normative bases of social constructions, while remaining reflexive about their own normative assumptions. Arguably, this type of position is closer to the ideational turn in constructivism (see: Hay, 2010; Marsh, 2010) than is often acknowledged, which again contributes to making the boundaries between constructivism and post-structuralism more blurred.

The term 'critical' in the thesis title, thus refers to a broadly defined group of theories which are not situated in the positivist research paradigm. Instead, their ontology and epistemology is premised on the idea that social phenomena analysed do not exist independently of society, nor independently of how humans make sense of them. In order to understand how this type of research can provide useful insights and explanations of social phenomena, it is worth referring to Wendt's analysis of constitution and causation in international relations, as well as Parsons' case for the legitimacy of ideational explanations in social science (Parsons, 2007; Wendt, 1998). Wendt argues that there are broadly two ways to approach international

[1] Parsons (2010) considers post-structuralism a particular and singular variation within the broad family of constructivism

relations. One is to seek causal explanations, and to identify social laws that are generalisable. This one is normally associated with a positivist ontology. The other approach is concerned with constitutive explanations, which seek understanding of meanings that lead agents to act in the way they did. Constitutive theories do not seek to explain a causal mechanism (A causes B), but 'account for the properties of things by reference to the structures in virtue of which they exist' (Wendt, 1998, p.105). Drawing on Wendt, Parsons argues for the inclusion of ideational elements as a legitimate explanatory factor in political sciences, alongside structural, institutional and psychological explanations (for more detail: see Parsons, 2007). Ideational explanations, Parsons claims, are inherently particularistic, which means that their causal segments are not 'inevitable', pre-determined by external factors which would then be a generalisable explanation. Instead, they explain the result of contingent, 'man-made' causes that are not pre-determined and inevitable.

In Chapters Five and Six, the thesis focuses on a conceptualisation of power as present in language, discourse, meaning-making, and knowledge production. Specifically, Chapter Five is concerned with power *in* ideas, and Chapter Six analyses power *through* and *over* ideas (Carstensen and Schmidt, 2016) (see Chapter Three, pp.98-99). Chapter Four, on the other hand, takes into consideration the insights from institutional power. While the discursive and ideational analyses of HiAP and neoliberalism at the EU (Chapters Five and Six) are an obvious fit with the ontological and epistemological positioning outlined above, I argue that even the analysis of institutions (Chapter Four) is not incompatible with it. Indeed, this depends how 'institutions' are defined. In this thesis, I follow Schmidt's definition of institutions as socially and discursively constructed entities, rather than structures pre-existing independently of what society and its actors make of it (see Chapter Three). Additionally, focusing on ideational and discursive power does not mean negating all material reality. Rather, one can seek to understand it in relation to discourse and ideas, and shed light on the co-constitutive nature of institution, discourse and ideas.

Semi-structured elite interviews

One method of data collection employed in this research project was semi-structured elite interviews. In line with the considerations above, the purpose of the interviews, to cite the metaphor employed by Kvale (1996, p.3), was not to excavate bits of factual truth. Rather, it was more in line with conceptualising 'the interviewer as a traveller on a journey that leads to

a tale to be told upon returning home' (p.4). The purpose of the interviews was to dialogically bring about understandings of meanings and discourses (Kvale, 1996, pp. 38-46). Interviews have steered my focus and have led me to re-theorise and re-conceptualise my research. They allowed me to better understand meanings and discourses, how they matter, and what their effects are – in a way that would not have been possible to decipher from texts alone. As such, interviews allowed me to seek triangulation. Triangulation here, is not meant in a positivist way of seeking the truth by applying several different methods onto the 'same phenomenon'. Rather, triangulation is used in a sense that combining document analysis and interview data allowed me to make better sense of the relevance of some ideas and some concepts as opposed to others, it allowed me to interpret 'what matters', for the purpose of my research. As put by Fielding and Fielding (1986, cited in Flick, 2018, p. 781): 'We should combine theories and methods carefully and purposefully with the intention of adding breadth or depth to our analysis but not for the purpose of pursuing "objective" truth'.

In total, I interviewed 35 participants over the course of 32 interviews and one email exchange (see list of interviewees, p.249). The identification and contacting of participants started based on the list of EU Platform for action on diet, physical activity and health (EU Diet Platform) members (see Chapter Four, p.121), and an online search for European Commission (EC) officials working on NCD prevention and health promotion using the EU 'Who is Who' search engine. After that initial reach-out, the list of interviewees expanded considerably based on reputational snowballing (Farquarson, 2005), and I was able to identify and interview members of the High-Level Group for Nutrition and Physical Activity (HLG) (see p.125), in addition to EU officials, civil society and private sector stakeholders. The interviews were undertaken in two rounds: in the first round, between March and July 2018, I conducted 28 semi-structured elite interviews with 29 participants. Interview participants were eight officials of EU health advocacy groups, seven officials of the EC Directorate General for Health and Food Safety (DG SANTE) (six current and one former official), one official of the EC Joint Research Centre (JRC), three officials of the European Parliament (EP) (one member of the European Parliament (MEP), one MEP assistant and one former MEP assistant), five representatives of health ministries of EU member states, four associations representing the interests of the food and retail industry, and one representative of a research and evaluation company. The interviews were conducted by myself, face-to-face (24), over Skype (2), by telephone (1) and via email (1).

As suggested above, interviews have guided the development of this research project. While the initial research idea was more narrowly focused on the EU Diet Platform, the project moved towards the broader concept of HiAP as a result of the interviewing process and the interpretation of interview data. The semi-structured nature of the interviews provided flexibility to develop broader topics, including the evolution of DG SANTE, the EC's involvement in public health promotion, the role of the EP and latest policy developments in the area. This created a picture in which 'sensitising concepts' (Faircloth, 2012, p.272) appeared as more important than the original focus, caught my attention and guided the evolution of the research. These concepts were investigated in increasing depth (in two cases, interviewees were contacted a second time to elaborate on the new foci): First, the challenges to implementing HiAP, and 'the politics of defining HiAP' in relation to health promotion and NCD prevention. Secondly, the role of evidence and knowledge in public health promotion: how to process and review it, how to devise effective assessment methods and identify best practices. Interviewees were split between a majority who firmly adhered to the dogma of evidence-based health policymaking, and a few public health policymakers and advocates who took a critical stance vis-à-vis evidence-based policymaking.

The evolution of the research topic and the refinement of the research questions developed as a result of what can be referred to as 'grounded conceptualisation' (Belfrage and Hauf, 2017). More generally, this refers to a 'double hermeneutic cycle' whereby a discursively constructed reality is interpreted by interviewees, and then again by the researcher herself (Furlong and Marsh, 2010, p.185). That means the research process departed from an initial provisional conceptualisation of an issue (which focused on the EU Diet Platform) and was modified and re-theorised as a result of fieldwork (ending up focusing on HiAP). This process brought to the forefront the ontological dilemma in public health between aspiring to produce 'normatively neutral' knowledge, and recognising that the political and social dimensions of public health elude objectivity. This dilemma appeared to be salient in the attempts to implement HiAP, because HiAP refers to both a normative vision and a technical process. The EU context illustrates these tensions particularly well because of both its 'technocratic' nature and its institutional neoliberal bias.

As a result of the fieldwork in Brussels and Luxembourg, I conducted a second round of interviews in Finland (Helsinki and Tampere, in April 2019), during which I spoke to seven participants in four interviews. I chose Finland because, besides having a long history with HiAP, Finland is the member state which has introduced HiAP at EU level most prominently

during the its EU Presidency in 2006 (see Chapter One p.49). The aim of these interviews were largely twofold: to better understand the process of introducing HiAP at EU level, as well as the HiAP idea in Finland, nowadays and back when this kind of idea first emerged. The interviewees were three former Finnish health ministry officials who worked on the 'Health for All' agenda in the 1970s and 80s (see Chapter One, p.43); two current Finnish health ministry officials (one of whom was already interviewed once in the first round of interviews), one public health researcher, and one Finnish health advocate from a non-governmental organisation (NGO).

Depending on the consent given, I either recorded or took notes during the interviews. In the case where interviewees felt that they could talk more openly if not recorded, I privileged making the interviewee comfortable, getting more interesting insights and taking notes, even if that meant not being able to quote those interviewees directly (Lilleker, 2003; Harvey, 2015). Recorded interviews were transcribed. The content of both notes and transcripts was then organised in a grid in which I regrouped similar ideas on different topic categories, also colour-coding which interviewee(s) (and which kind of interviewee, from which sector) had put forward the idea. For example, one topic commonly discussed in the interviews was 'the future of DG SANTE', and I regrouped the interviewees who argued that the new multiannual financial framework (MFF) entailed a risk of watering down public health involvement of the EC (see Chapter Six, p.183). This categorisation is in no way meant as a formal 'code book', rather, it provided an overview of the kinds of ideas put forward on different topics, by the different interviewees.

Discourse analysis

In addition to interviews, I gathered and analysed a number of official EU documents. Around 280 documents were downloaded from the respective websites (mostly the website of the EC, some documents were also collected from the EP website and from the EUR-Lex repository), out of which a total of 106 documents (including websites) were subsequently included in the analysis. Given the breadth of the research topic, I collected documents on a variety of topics, which I categorised in the following way (with overlap): DG SANTE Health Programmes and Strategies; chronic diseases/NCDs; HiAP; social determinants of health and health inequalities; alcohol policy; the Audio-visual Media Services Directive (AVMSD); Better Regulation and EC working methods; the Common Agricultural Policy

(CAP); the European Core Health Indicators (ECHI); the European Structural and Investment Fund (ESIF); EU Health Policy Forum; the European Semester; the 2006 Finnish presidency; Horizon 2020; EU health knowledge cycles; nutrition and physical activity; occupational health; the Steering Group for health promotion, disease prevention and management of non-communicable diseases (SGPP); EU Social Pillar; tobacco policy; JRC publications; the 2019 Finnish presidency documents.

The selection and inclusion of documents was done following a logic of purposeful and emergent sampling (Emmel, 2014). Purposeful, as the selection of texts was done using pragmatic judgment about what is relevant to this thesis. Emergent, as the inclusion and selection of documents resulted from the input of interviewees during fieldwork. In line with my theoretical stance, the way I approached the documents and interview texts was with a focus on discourse – a discourse analysis: 'To understand an object or action, political scientists have to interpret it in the wider discourse of which it is part' (Foucault, cited in Bevir and Rhodes, 2003, p.23). The purpose of the analysis was then to identify 'regularities in meanings' (Taylor, 2001, p. 9), and understand the dominant discourse(s), how they are shaped, reproduced but also contradicted, and how they structure meanings. Concretely, this translated into particular attention to how health and NCDs are talked about, how these concepts are defined, and importantly, how (and in relation to what) they are contextualised. Another focus of the discourse analysis pertained to the meaning of knowledge and evidence: what does the way EU documents talk about evidence say about the assumptions underlying what constitutes reasonable knowledge? What counts as useful and useable knowledge? How are certain kinds of evidence legitimised through discourse and in the texts? While discourses are underpinned by normative struggles, they are not merely a vehicle that reflects existing power dynamics. Instead, they should be seen as producing these normative struggles, reinforcing the 'status quo' but also potentially challenging it: in the case of this thesis, this means investigating how neoliberal discourse is reproduced, how it can structure the meanings of HiAP, but also how HiAP can be used to actively challenge dominant discourses.

As Bacchi (2005) explains, there is a structure/agency tension at the heart of the theoretical conceptualisation of discourse analysis. While I do not wish to dwell on it in a paralysing way, it is still necessary to render that tension explicit and to bear it in mind. It relates to 'whether we ought to think of subjects primarily as *discourse users* or as *constituted in discourse*.' (Bacchi, 2005, p.200 [emphasis in original]). This tension is seen in the difference

between, on one hand, the critical discourse analysis (CDA) tradition, which tends to be inspired by (neo-)Marxism and neo-Gramscianism and is more concerned with exposing how hegemonic power operates in discourses (see: Wodak, 2001; Fairclough, 2003, 2015). This type of analysis is more concerned with the use of rhetoric and linguistic techniques to intentionally maintain power dynamics in a way that benefits the elite (Jorgensen and Phillips, 2002). Implicitly, this approach puts more emphasis on discursive agency to maintain oppressive structures in place. On the other hand, those who tend to consider subjects as 'constituted in discourse' represent the more Foucault-inspired, post-structuralist tradition of discourse analysis. Here, the emphasis is less on the agency of subjects, and more on how discourses produce subjects and produce reality. However even in this approach to discourse analysis, there is still space for agency, insofar as people can be aware of discourses while enacting them or contesting them. While it is important to bear this distinction in mind, I would argue that it should not be taken as a clear dichotomy, and instead it is useful to negotiate both elements of discursive agency and structure. DI, I suggest, allows us to take into account the simultaneous co-existence of both elements, which is one of the main reasons why this thesis uses DI as a theoretical framework (see Chapter Three). While it is important to be clear about these different aspects, I think it is useful to move beyond purely theoretical considerations and instead see how these concepts can be usefully applied in practice. Notably, one might consider the co-constitutive nature of both elements, as together forming statements, discourses and episteme (see below) which are socially constructed *and* produce reality. Consequently, the discourse analysis in this thesis is not excessively concerned with trying to prove whether discourses are reproduced *intentionally* or *structurally*. It assumes that both play a role, and an overlapping, somewhat inevitably artificial differentiation between them forms the basis of the empirical division between Chapter Five and Six. The extent to which discourses are both intentional and structural at the same time is a question that arises mostly in the section that looks at strategic discursive adaptation to fit HiAP to prevailing neoliberal orthodoxy (see section 6.2., p.180). It is not possible to know the extent of intentionality versus structure that is taking place in this process, but it might be reasonable to assume that the co-option process is driven by a blend of both institutional and ideational structures, and agential discursive practice. As Bacchi (2005) concludes:

> In clarifying the distinction between these two analytical projects the goal is not to suggest that they should be kept separate, but that understanding them as two analytical perspectives is a first step to considering how they can be combined. (Bacchi, 2005, p. 208)

To understand what discourse analysis consists of concretely, and in the theoretical context of this thesis, it is useful to briefly consider the relationship between episteme, statements and discourses (Mills, 1997, pp. 48-76). An episteme represents what is considered at a particular time as counting as knowledge. This is not about what discourse/ideology dominates at a particular time, but rather, much more broadly, what kind of 'knowledge era' we are situated in. A statement can be understood as an 'act of communication' (which can include utterances, behaviours, visuals, symbols, texts, practices…) in its particular meaning context (the same utterance can represent different statements when occurring in different contexts: for example, the Swastika symbol does not represent the same statement in India and in Germany). Sets of statements constitute discourses, and a multiplicity of discourses make up the contemporary episteme.

The purpose of discourse analysis is to make sense of the relationship between statements, discourses and episteme, in a way that seeks to reveal the normative underpinnings of the various elements, how these relate to each other, as well as their contingent nature (which relates to considering excluded, marginalised forms of knowledges). Throughout the empirical chapters of this thesis, my aim is thus to explore these relationships in multiple ways: I explore how *framings* of things (i.e. the representation of things) are embedded within broader *paradigms* which provide the background cognitive landscape for making sense of those things in relation to others. A concrete example can be how the framing of NCDs is embedded in an economic paradigm of health (see section 5.1.1., p.147). At an even deeper level than paradigms lie the ideological normative assumptions, the 'deep core' that permeate in paradigms and frames (Rushton and Williams, 2012). I also look at the malleability of ideas, and how discourse can be mobilised to shape their meanings. What these perspectives have in common is the different ways in which they appeal to normative neutrality, to inevitability and obviousness. This is what I am particularly interested in identifying and questioning and which is a common thread in all three empirical chapters. That appeal to normative neutrality, and the way it grants authority and legitimacy to certain knowledge, is also explored in the analysis of dominant meanings of evidence, and I suggest that it can be seen as a link between discourses and parts of the contemporary episteme.

Chapter outline

The critical analysis of HiAP at EU level undertaken in this thesis is divided into six chapters, followed by a conclusion. In Chapter One, I start by presenting HiAP: first of all, that requires familiarisation with the 'complexity turn' in public health promotion and NCD research, i.e. the increasing body of research that looks at the social, macroeconomic, and political determinants of health – which I refer to as 'distal determinants of health'. I then present the HiAP idea within this complexity turn: as an attempt to translate the awareness of distal determinants of health into a policy agenda. HiAP is by no means the only such attempt to 'bridge research and policy', however it is the concept that was adopted in the EU, which is the institutional case study of the analysis. Nor is HiAP only about health promotion and NCD prevention. However, for the purpose of narrowing down an already vast study subject, this thesis focuses on considering health promotion and action on the distal determinants of NCDs. To understand HiAP, Chapter One also explains the roots of the concept, which date back to around the time of the Alma-Ata declaration and the WHO Health for All agenda (WHO, 1978, 1981) (at least this is a remarkably important moment in the history of HiAP, however the idea itself predates even the 1970s). To provide context to the introduction of HiAP at EU level, this chapter also first briefly introduces HiAP in Finland. Indeed, it was the 2006 Finnish presidency that most emblematically raised HiAP onto the EU agenda, and looking at their own national journey with HiAP is useful context to understand the EU case study. The final part of this chapter engages with the challenges of researching HiAP, and the shortcomings of an approach focused solely on technical implementation. I conclude the first chapter by arguing for the need to study HiAP from a critical social scientific perspective, and what is more, from a critical political science perspective.

Chapter Two reviews the various literatures relevant to this thesis: first it presents the literature on the EU and health, explaining how the EU is increasingly involved in public health. The way this has been theorised by some scholars, is by using the notion of 'constitutional asymmetry'. This chapter presents the literature that argues that the EU institutions, by virtue of how they developed over time, now present an ingrained bias in favour of economic integration as opposed to social integration. This literature argues that the EU is more of a market-creating endeavour, rather than a market-correcting one. As such, critical researchers who have looked at the increasing involvement of the EU in health have tended to focus on explaining it as market rationality spreading into social areas (like health). However, they limit their analysis to the notion that EU involvement in health is the result of

illegitimate 'spill over' in an constitutionally asymmetrical context. Put simply, they argue that EU health policy is not genuinely about health, but instead its development happened as a 'knock-on' effect and following a market rationality. This thesis, on the other hand, seeks to understand why EU (non-health) policies struggle to be about health. To justify this thesis' angle, the second section of the second chapter reviews the vast literature that links neoliberalism to ill-health. It starts by defining neoliberalism, as a political rationality which favours a free market economy with minimal government intervention, and which seeks to shape the population into resilient, entrepreneurial individuals who can navigate that market responsibly (see section 2.2.1, p.73). It then looks at the impacts of neoliberalism on health, starting from the macro-, meso-, and then micro-level. The macro-level analysis of the relationship between health and neoliberalism looks at global neoliberal processes like free trade, the nutrition transition, and global inequities. The meso-level sheds light onto the domestic neoliberal policies and their effects on health, in particular the large amount of research on austerity policies and health. Finally, the micro-level pertains to the literature that critiques the negative effects of neoliberal framings of health promotion, in particular the 'individual responsibility' frame. In light of the review of the literature on health and neoliberalism, I then make the case for a radically broad conceptualisation of health promotion, in which neoliberalism is considered a determinant of ill-health. One implication of such a broad (and to an extent vague) definition of health promotion applied to health promotion mainstreaming, is the need to focus on meanings and discourses, rather than attempt an exhaustive list of policies and processes. Another implication of looking at health promotion mainstreaming in a broad case study such as the EU, is the need for a (simplified) model of governance types and governance areas. The final section of Chapter Two then offers a map of the EU governance types. Here, I present the difference between soft, hard and meta-governance, and provide corresponding examples of governance areas.

Chapter Three presents the overarching theoretical framework of the thesis: discursive institutionalism (DI) (Schmidt, 2008, 2015). I begin by introducing, contextualising, and defining DI. DI is really an umbrella term for multiple frameworks – the basic tenets being a focus on ideational power to explain institutional change and continuity. DI takes a conceptualisation of institutions as fluid, as both constraining actors as well as the product of them, and identifies three elements that need to be analysed in order to make sense of endogenous institutional change: institutional context, background ideas, and 'foreground discursive abilities'. In this chapter, I clarify what is meant with these three elements. I also provide clarifications regarding what is meant by 'discourse', by 'ideational power', and

where this thesis is situated vis-à-vis these definitions. I then move on to justify why DI is an appropriate framework to be used for this thesis, but equally, I explain how the use of DI here will differ from most of the existing empirical applications of DI, by shifting the balance between structure and agency. The last section of the theoretical chapter explicitly outlines how DI will be applied in each empirical chapter. Each part of the whole analysis (i.e. each empirical chapter) requires the use of an additional concept, which are all introduced in the last section: Chapter Four focuses on the 'institutional context' element of DI and draws on the concept of constitutional asymmetry (Scharpf, 2006). Chapter Five zooms into the 'background ideational structures' element of DI and, to do so, uses a framework for analysing global health policy-making (Rushton and Williams, 2012). Chapter Six is concerned with the 'foreground discursive abilities' element of DI, and uses the concept of 'chameleonic ideas' to analyse the malleability of the meanings of HiAP (Smith, 2013a).

The fourth chapter, and first empirical chapter, is concerned with analysing the space for HiAP within the EU *institutional* context. In order to approach this vast task in a concise and 'overarching' way, I draw on the institutional elements already explained in Chapter Two: a categorisation of soft-, hard-, and meta-regulatory governance. For each of those categories, I provide examples in relation to which I reflect upon the space for HiAP: in the soft governance category, I look at both the EU Diet Platform, and the 'Open Method of Coordination (OMC)-*like*' High-Level Group on Nutrition and Physical Activity (HLG). In the first example, I argue that the EU Diet Platform is not compatible with HiAP because the Platform rationale leads to the 'lifestyle drift' phenomenon (see pp.123-124), whereby policies intended to promote health remain limited to behavioural interventions, despite an initial acknowledgment of distal determinants of health. In term of the HLG, the group is not subject to the same economic disciplining features as a full-blown OMC, however that is perhaps precisely because its scope of action remains fairly restricted to proximal determinants of health. I then move onto the hard governance category, where I consider three types of examples: i) the EU Single Market and HiAP, for which the example is the AVMSD; ii) the CAP and HiAP, for which the example pertains to the post-2020 reforms, and; iii) the EU fiscal governance and HiAP, for which the example chosen is the European Semester and the EU investment in health. The three examples emphasise the limited space for HiAP, and the subordination of social goals to economic growth, as the notion of constitutional asymmetry would lead us to expect. Finally, in the third, meta-regulatory governance category, I draw on existing literature on Better Regulation and the tobacco industry to critically consider the (lack of) space for HiAP in meta-regulation. Finally, the

constitutional asymmetry is again illustrated through the concept of collegiality, as shown in the Directorate General (DG) for Health and Food safety (DG SANTE) strategic plan for 2016-2020. Ultimately what this chapter argues is that the EU institutional context is not favourable to HiAP. This, in and of itself, is neither novel, nor surprising. However based on its broad conceptualisation of health promotion, and on considering neoliberalism a determinant of health, this chapter provides a new picture of how the constitutional asymmetry operates in a way that undermines a normatively meaningful HiAP: indeed, it contrasts how softer governance areas have more perceived relevance to health, but also remain limited to *proximal* determinants of health, while harder (and meta-regulatory) governance areas – which are actually the areas that impact *distal* determinants of health – remain perceived as not being relevant to health.

Leading on to the next element of DI, I ague that, even though constitutional asymmetry is clearly an important way in which neoliberal rationality is reproduced and which undermines a normatively meaningful HiAP shift, leaving the analysis there would fail to capture numerous other dynamics, and whole other parts of the story. Indeed, the ideational landscape, the 'background ideational structures' need to be taken into consideration, and the ideational reproduction of neoliberalism needs to be analysed in its own right, as *more* than merely the consequence of institutional configuration. In Chapter Five, my aim is to explore the ideational reproduction of neoliberal rationality in the EU through various paradigms and frames. The benefit of this enquiry is to draw attention to otherwise neglected sites that shape meaning making around health and NCDs, and that prevent HiAP from being meaningfully adopted. I focus on the 'economic paradigm of health'[2] as a health paradigm particularly dominant in the EU grey literature analysed. According to the economic paradigm of health, investing in health makes sense financially (first face: health to prevent an economic burden), and health should be seen as a market full of profitable opportunities (second face: health to generate economic growth). I start by illustrating the pervasiveness of this paradigm. I then delve into unpicking how that paradigm interacts with other health paradigms, to shape the framing of NCDs as 'the inevitable consequence of an ageing population'. I highlight how this frame mobilises the first face of the economic paradigm of health in conjunction with the security paradigm of health, in appealing to an imminent threat to the sustainability of health and pensions systems, which then justifies austerity measures such as budget cuts. The ageing population frame of NCDs however also evokes the second face of the economic paradigm of

[2] See Rushton and Williams (2012), although the authors use the term 'economic paradigm' slightly differently.

health, in conjunction with the biomedical paradigm of health. This is visible through the push towards personalised medicine as a solution to the NCD 'crisis'. In the second half of the chapter, I move on to explore the framing of evidence and the knowledge paradigm within which it is situated. Specifically, I analyse the dominant meaning attributed to the notion of evidence, and how its dominant conceptualisation as 'SMART' stifles the possibility to consider the normativity and complexity of HiAP. Overall in Chapter Five, I reflect upon the implication for HiAP of both health, and knowledge paradigms and frames dominating at EU level. I conclude by arguing that the asymmetrical dynamics at EU level favouring neoliberal rationality are not only reflected in the institutional architecture, but also in the EU's background ideational architecture.

The sixth and final chapter is concerned with DI's third element, the 'foreground discursive abilities'. This element is concerned with looking at space for agency, and endogenous institutional change. Instead of thinking of institutional and ideational structures as completely rigid, pre-determined, and only ever changing as a result of exogenous shocks, foreground discursive abilities are the spaces in which agents from within the institutions can articulate discourses that are critical of their own institution. Rather than only focusing on critical discourses, I look at various manifestations of discursive agency in relation to HiAP – discourses which seek to establish a HiAP for institutional continuity (i.e. a 'co-opted', watered down HiAP), and discourses that put forward a HiAP for change. The chapter starts by presenting Smith's (2013a) categorisation of ideas, and argues that HiAP is a chameleonic idea. I argue that this is the reason it was successful in reaching and becoming accepted in the EU space: chameleonic ideas are strategically packaged to fit into the space which they aim to change. That means the language is adapted to the EU context, and the normative essence of the idea is toned down. The chameleonic nature of HiAP allows its co-option to fit the prevailing neoliberal rationality. This is visible, the chapter suggests, in the discursive construction of HiAP as 'inherently about multistakehoder engagement', even though HiAP according to Finnish advocates was not supposed to engage the private sector. The threat of discursively shaping HiAP for continuity is also visible in the use of HiAP-like language to justify eliminating the stand-alone health programme of the EC, which has been perceived as a risk of watering down health concerns in the EC[3]. However, I argue that HiAP proponents are far from unaware of these threats, and that they, too, continuously adapt and negotiate the meaning of HiAP in response to these pitfalls. In the same way that HiAP is an adaptation of

[3] Due to the current pandemic, the future of the Health Programme is now under re-consideration (European Commission, 2002c)

the Health for All agenda (see section 1.2.1, p.43), I argue that the 'economy of wellbeing' theme of the 2019 Finnish presidency represents an attempt to revive, in a strategically modified manner, what is essentially HiAP. Without being naïvely optimistic about the change that this new 'economy of wellbeing' concept can bring about, I illustrate how some of its characteristics can be seen as adaptations to challenges faced by HiAP. Finally, I explore the idea of 'degrowth', and how it relates to the economy of wellbeing and HiAP. The difference between these various ideas, I argue, is that degrowth is a radical idea, rather than a chameleonic one. Nevertheless, spaces in which the degrowth idea is present do exist, even in an institution like the EU, mainly in the JRC and the EP. At the end of the chapter, I reflect upon the possible synergy between contesting discourses, and whether constantly re-defined chameleonic ideas, together with radical ideas might lead to gradual, endogenous change.

CHAPTER 1: From the NCD complexity turn to 'Health in All Policies'

This chapter starts by explaining the importance of the 'complexity turn' in public health, particularly in relation to NCDs-related health promotion. It then explains how experts and researchers have come up with ways to translate that complexity turn into policy recommendations, focusing specifically on HiAP. The purpose of this chapter is to understand the context and nature of HiAP as an idea that has evolved over the past decades, and that has travelled to different policymaking spheres, including from Finland to the EU. The chapter's main argument is to highlight the need to study HiAP from a political angle, in a way that deals with power and ideology from a post-positivist ontology, rather than remaining with the most common approach of studying HiAP from a technical perspective.

The chapter is divided in three main sections. Section one consists of a literature review explaining the 'complexity turn' in NCDs. It first briefly introduces what NCDs are, and their relevance in terms of burden of disease. The section then goes on to explain the biomedical and behavioural paradigms of public health, before delving into the common critiques of those paradigms. This leads to explaining the 'complexity turn' in NCDs, the research on social determinants of health, and why it is important to make sense of health promotion much more broadly than the biomedical and behavioural paradigms allow. This section also clarifies how certain terms will be used throughout the thesis. One important first clarification is what is meant by 'health promotion'. In this thesis, 'health promotion' is not a proxy for 'health education' or other policies targeted at modifying the consumer's behaviour. 'Health promotion' in this thesis is understood much more broadly and includes any measure that seeks to reduce inequities in health and promote general mental, physical, social, environmental and spiritual wellbeing of the population. Following this definition of health promotion, policies and actions count as promoting health even when they indirectly promote health, for example policies to reduce gender, racial and/or socioeconomic inequities, or improving environmental sustainability. The term 'radically broad conceptualisation of health promotion' will be used in this thesis to emphasise this where needed, and to differentiate it from narrowly understood health promotion as equating to education campaigns and nudging policies. Overall, the first section provides the context to understand the purpose of (and need for) HiAP.

Section two of the chapter talks about the HiAP concept itself. First it introduces what this idea refers to, as well as other similar concepts that are often used interchangeably (even though they do differ in how they have been interpreted). It also explicitly clarifies why this thesis focuses on HiAP specifically in relation to health promotion and NCD prevention, and what this focus entails. It then draws on interviews undertaken in Helsinki with participants who have been involved in advocating for this type of approach since the 1970s, and tells the story of how this kind of thinking about health and policy emerged in Finland, in collaboration with the WHO through the 'Health for All' agenda. This subsection aims to really bring to the forefront the importance of values and politics when thinking about HiAP, as was very much emphasised by the HiAP advocates interviewed. This part also looks at the structures and processes that are/were present in Finland to facilitate HiAP, and how these have been changing over time. Finally, this section also introduces the 2006 Finnish presidency of the EU, which officially raised HiAP on the EU agenda.

The third section of this first chapter looks at how HiAP has been predominantly researched in academia, and echoes the point made by Kokkinen et al (2017) that HiAP has been researched mostly from a technical angle, whereas research agendas that focus on political dynamics around HiAP have so far been neglected (Kokkinen et al., 2017). This is despite the virtually unanimous recognition that HiAP is underpinned by norms and values, and that considering these is important. It provides an overview of the struggles within the public health literature to deal with the challenge of complexity, and evokes the growing suspicion of some of these scholars, that a traditional positivist, hypothetico-deductive model might not be fit to fully understand what stands in the way of HiAP, or in the way of a more holistic 'salutogenic' approach (see pp.41-42) to health promotion generally.

1.1. <u>The NCD complexity turn</u>

NCDs are responsible for the biggest burden of deaths, diseases and disability worldwide, including in the European Region. They are sometimes also referred to as 'chronic diseases' and include mostly cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases (even though some also include mental illnesses in the classification). According to the WHO (2018a) NCDs are responsible for 41 million deaths each year (71% of all deaths globally), 15 million of which qualify as 'premature deaths' (occurring between the ages of 30 and 69). The largest proportion of premature deaths from NCDs occur in low and middle income

countries (LMIC) (WHO, 2018a). Nevertheless, in the EU in 2016, an estimated 790,000 people died prematurely due to smoking, alcohol consumption, unhealthy diets and/or physical inactivity (European Commission, 2017a). It is fair to say that NCDs are one of the most important contemporary public health issues. They are also a particularly interesting thing to study from a critical social scientific perspective, because individual cases are determined by what has often been argued to be 'modifiable risk factors'. This means that, while there are risk factors that cannot be modified (such as age, sex and other genetic predispositions), researchers argue that to a very large extent, NCDs are preventable, and determined by 'lifestyle' dimensions, such as smoking, diet, and physical activity. This is precisely why HiAP is particularly and strikingly relevant in the context of NCDs. Even though public health messages promoting 'healthy lifestyles' have been around for decades, NCDs are still on the rise, and it is now understood that tackling NCDs will require political commitment, rather than merely health education campaigns and incentives to change individual behaviours. These political commitments need to be taken overarchingly, and reflected in all policy areas, hence the need for HiAP.

The Lancet NCD action group was launched to study the global burden of NCDs, and to include policy recommendations and strategies to embed NCDs in High Level agenda, such as the post 2015 development agenda (Horton, 2013). The 2011 UN High-level meeting on chronic diseases was seen as the opportunity to put NCDs on the global agenda and prompted a series of papers providing recommendations and evidence for how to tackle this public health issue (Beaglehole and Horton, 2011). Those trying to better understand risk factors of avoidable NCDs often identify a knowledge gap and call for more evidence-based approaches to tackle preventable risk factor exposure (Horton, 2013; Sacco et al., 2013). The Lancet Group identifies the following priorities:

> […] equitable early childhood development programmes and education; removal of barriers to secure employment in disadvantaged groups; comprehensive strategies for tobacco and alcohol control and for dietary salt reduction that target low socioeconomic status groups; universal, financially and physically accessible, high-quality primary care for delivery of preventive interventions and for early detection and treatment of NCDs; and universal insurance and other mechanisms to remove financial barriers to health care (Di Cesare et al., 2013, p.585).

At a more theoretical level, some researchers have looked into the different paradigmatic framings of health and how they manifest in the context of NCDs. Labonté (1998) argues that there are broadly three levels of health paradigms, that is, three different ways of thinking

about health in relation to the proximity or distality to the individual[4]. The first one is the biomedical paradigm, which sees health from the perspective of the body and its pathophysiology. The second one is the behavioural paradigm, which makes sense of health as determined by risks stemming from the way individuals behave. Finally, the third paradigm is the social one, which thinks of health as determined much more broadly, i.e. as related to the social conditions of life (Labonté, 1998). To give a simple example, diarrhoea seen from a biomedical perspective will be concerned with the toxicological mechanisms induced by the pathogen in the body. The behavioural lens might focus on hand hygiene to prevent diarrhoea. The social paradigm will look at the social roots of lack of access to water and sanitation infrastructures, such as poverty and social exclusion as a 'social determinant of diarrhoea'. Some researchers have argued that health budgets are driven disproportionately by the biomedical paradigm of health, which focuses on curing disease, i.e. a focus on healthcare, rather than preventing disease through public health and health promotion (Stuckler et al, 2010). One suggested explanation for this disproportionate weight is that the biomedical paradigm presents more obviously lucrative opportunities, mostly for the pharmaceutical and medical device industry, compared to socially-driven health promotion (Schrecker and Bambra, 2015). In the field of NCDs, the biomedical paradigm is very much present (despite fears of 'unaffordability' of the healthcare system), notably in the shape of innovative agenda for personalised medicine, e-Health and m-Health (see section 5.1.2.2., p.155). The biomedical response to the NCD burden has been criticised mostly for failing to address, and sometimes even for worsening, inequities in health (Frankford, 1994; Glasgow and Schrecker, 2016). Indeed, as will be developed in more depth in the subsections below, the NCD burden has much to do with health inequities and their determinants. Biomedical responses to NCDs can exacerbate those inequities by targeting high quality, highly personalised treatments preferentially at those who can afford them.

The second paradigm of health is the behavioural one. Throughout the last decades, this one has also been vehemently hammered into NCD governance. It typically includes health education on one hand (teaching the individual how to adopt a healthy lifestyle) as well as nudging policies on the other hand. Nudging policies are little incentives put in place to subconsciously nudge the individual towards a healthy lifestyle. For example, nudging policies for healthy diet promotion can include putting fruit and vegetables at the entrance of the supermarket while 'hiding' junk foods at the back. The idea is to send subliminal

[4] Chapter Five will look at some additional paradigms of health. Labonté's categorisation is useful to think about health in terms of micro/meso/macro levels.

messages to invite the consumer to choose the healthy option (Alemanno and Garde, 2015). A disproportionately strong focus on behavioural paradigms has been criticised for putting the blame on individuals while ignoring structural factors that lead to these behaviours. The suggestion that health inequities are the result of poor behaviour, and poor choice by poor people who cannot be trusted, is misleading and stigmatizing (Glaze and Richardson, 2017; McCartney et al, 2013). It is now a widely held position in the public health field that behavioural, nudging interventions are not only inefficient, but can often be actively harmful (see section 2.2.4., p.78). One nuanced exception is Van Den Broucke (2014), who argues that behavioural paradigms have been misused and that, when combined with action on the social determinants of health and when used properly, they may still have a lot to offer. He argues for example that behavioural research should not be applied only to citizens, but also to policymakers and politicians to better understand the way they act upon health promotion (Van den Broucke, 2014).

In summary, both biomedical and behavioural paradigms of health have been strongly criticised by public health scholars who have argued that the NCD 'crisis' is a political, socioeconomic one, and that biomedical and behavioural 'solutions' represent merely a superficial plaster on a much bigger problem, which may actively deter policymakers from looking at the root causes of the population's illnesses (Glasgow, 2005; Ottersen et al., 2014). Chapter Five will look in more depth at the relationship between health paradigms and ideology (see section 5.1., p.146). The next sections look at the work done by some of those critics who investigate the social, economic and political determinants of health, including NCDs.

1.1.1. Social determinants of health and health equity

The idea that health is determined by social and living conditions emerged as early as the 19th century, with public health scientists like Rudolph Virchow (Mackenbach, 2009). In the UK in 1980, this idea could have regained political attention, when the Black Report was published by the UK Department for Health and Social Security, in an attempt to explain inequalities in health and their structural causes (Townsend et al, 1992). The report showed that men from a working class background were twice as likely – and women two and a half times more likely – to self-report long-standing illnesses (Townsend et al, 1992, p.198). It also stressed that, even though infant mortality had decreased in each social class between the

60s and the 70s, the inequality in infant mortality between social classes had grown during that period of time (p.198). As a possible explanation, the authors of the report stated that '*in our view much of the evidence on social inequalities in health can be adequately understood in terms of specific features of the socio-economic environment* [emphasis in original text]' (p.199). Acknowledging specific areas worth improving, like ante-natal care, they claimed that 'there is undoubtedly much that cannot be understood in terms of the impact of so specific factors [like ante-natal care], but only in terms of more diffuse consequences of the class structure: poverty, working conditions, and deprivation in its various forms.' (p.199). Unfortunately and unsurprisingly, the recommendations of the report were not given much weight under Thatcher's premiership. It did however spark a powerful debate and much awareness of the link between poor health and poverty, as well as the link between poor health and inequalities. A second report, the 'Health Divide', was published with updated information about health inequalities in the UK (Townsend et al, 1992). A growing amount of research sought to document the state of health inequalities and the impact of social inequalities on health (Kickbusch, 2003; Marmot, 2005; Whitehead, 1991). This debate led to the adoption of the term 'social determinants of health' (SDH), which refers to social inequalities (related for example to employment and housing conditions) at the root of health inequalities (Marmot, 2015). It explains why people with lower socioeconomic status tend to have worse health conditions than wealthier people with better living and working conditions. In 2005, the WHO launched a Commission on Social determinants of health, led by Michael Marmot (WHO, 2008).

In line with the notion that inequalities in SDH lead to *unfair and avoidable* health inequalities, i.e. health inequities (as opposed to individual genetic variations), and that health is a human right and a goal in itself, those researching SDH are calling for more health equity (Lawn et al., 2008; Marmot, 2018). The terms inequity and inequality are generally used in the literature in the same way as Evan et al. (2001): 'Inequalities in health describe the differences in health between groups independent of any assessment of their fairness. Inequities refer to a subset of inequalities that are deemed unfair' (Evans T. et al., 2001, p.4). The Pan American Health Organization, for example, has recently launched an equity commission tasked with acting upon health inequities and structural determinants of health (PAHO, 2019).

While more vulnerable and poorer groups have worse health outcomes compared to wealthier population groups, it is crucial to stress that inequity itself is harmful for the whole of society,

not merely for the poor (Wilkinson and Pickett, 2010; 2018). Wilkinson and Pickett (2010, 2018) show how inequity in societies leads to worse mental health throughout all social classes, for example via increased 'class anxiety' (the pressure to display an image of belonging to a high social class). Furthermore, unequal societies have more markedly differential dominance behaviour system responses, whereby a stark gap between 'dominant individuals' and 'submissive individuals' is associated with narcissism and maniac behaviour for the former, and anxiety and depression for the latter (Wilkinson and Pickett, 2018). The point to remember here is that the negative health effects of inequalities should not be conflated with the negative effects of poverty on health (Smith, 2013a).

SDH awareness and the zooming out of the biomedical/behavioural paradigm of health to look at how society, the economy and politics affect health, can be understood as a kind of complexity turn in public health and health promotion. Those factors that indirectly influence health and are perceived as somehow far removed from the individual (i.e. macroeconomic, social and political factors) have been termed *distal* determinants of health (Huynen et al., 2005).

1.1.2. Towards 'complex' understandings of health promotion

As already suggested above, a considerable number of public health experts focusing on NCDs agree that in order to make true progress in improving population health, it is necessary to shift a greater focus onto the *social* paradigm of health. This paradigm, many argue, is better suited to addressing the root causes of contemporary public health issues. Evans and Stoddart explain the concept of SDH with a thermostat analogy (Evans R.G. and Stoddart, 1990 cited in Schrecker and Bambra, 2015, p.7). They explain how one way to react to chilly temperature inside a house is to turn up the thermostat and spend more on heating. Similarly, governments that focus too narrowly on the medical paradigm of health will respond to population's health issues by increasing the healthcare budget, up to a point where they consider it 'unaffordable'. Instead, Evans and Stoddart point out that to keep the house warm, one can also invest in well-insulated walls and double-glazed windows, after which there is no need to increase the heating anymore. Applied to the case of health, this would mean investing in health promotion and mental, physical, social, environmental and spiritual wellbeing more broadly, by improving the living and working conditions of the population. This kind of agenda promotes health equity, and considers socioeconomic

conditions as the root determinants of health, but also emphasises the link between environmental sustainability and health equity (Evans T. et al., 2001).

This kind of agenda also leads to a 'complex' understanding of health promotion, as it zooms in on the multiple, interrelated, indirect root causes of poor public health. 'Complexity' here, refers first and foremost to the recognition that health is shaped to a large extent indirectly, and that various aspects of the world and society, such as inequity, the environment, and globalisation, intersect. The section above introduced some of the research that looks at the complex relationship between social inequities and health. Research in the field of political science of health, or the sociology of health, has looked at the complex interlinkages between public health and other societal dimensions: globalisation, international political economy and health (Koivusalo, 2014; Labonté et al, 2011), patriarchy and health (Daykin and Naidoo, 1995; Hammarström and Ripper, 1999; Rogers, 2006), racism, post-colonial theory, and health (Douglas J., 1995; Paradies, 2016), intersectionality theory and health (Hankivsky and Christoffersen, 2008; Lapalme et al, 2019), or the relationship between environmental and human health (Watts et al, 2018; Zinsstag et al, 2011). Thinking about health promotion merely in terms of individual behaviour incentives, then, reflects a lack of understanding of complexity. If public health is shaped by so many complex and interacting political, economic, and social factors, then health promotion should be much more than incentivising healthy individual behaviour. This is the essence of the 'complexity turn' in NCDs and health promotion. A complex understanding of health promotion, in turn, recognises the intersection between environmental, animal and human health, and importantly, the relationship between these facets of planetary health and oppressive political systems. The complexity turn, as will be looked at throughout the thesis, also goes hand in hand with a recognition of normativity and political nature of health promotion and NCD prevention. Indeed, if contemporary public health issues are very complex, then solving them through a purely technical approach will not be possible. Instead one needs to recognise and embrace the fact that public health is political (see section 2.2., p.72).

1.2. Introducing 'Health in All Policies'

As seen above, the complexity of health determinants is not something newly discovered. Along with explaining the distal determinants of health, researchers have also come up with suggestions and recommendations on how this knowledge could be applied to policymaking.

One approach that is being advocated for by an increasing number of public health researchers and experts is 'Health in All Policies' (HiAP). It is the approach that has been put forward at EU level under the Finnish presidency in 2006 and which is still referred to now in the EC. This chapter section will explain what HiAP is, the story of how it emerged in Finland and how researchers have studied it so far. The section ends by explaining how it was put on the EU agenda in 2006.

As a result of growing understanding of the SDH and the ultimately social and political causes of public health burdens such as NCDs, 'broad' public health approaches and broad health promotion (also called 'systemic' or 'comprehensive') have regained attention and are now increasingly advocated for. Such approaches are not new, but arguably they are becoming more and more mainstream and increasingly accepted including within the policymaking sphere. Concepts like 'healthy public policies', 'intersectoral action for health', 'whole-of-government approach' and HiAP are all efforts to move beyond narrow individual behaviour framings of health promotion and instead take into account indirect determinants of health. 'One Health' is another, related concept that takes into account animal welfare, environmental wellbeing as well as human health as part of one and the same interconnected whole (Zinsstag et al., 2011). A striking example of the need to take on a 'One Health', holistic view of planetary health, is the threat posed by anti-microbial resistance (AMR): AMR clearly demonstrates the relationship between animal health, environmental sustainability, human health, medicine, and politics. While there are variations between these approaches, broadly one of their main common messages is the call for a holistic, integrative vision that takes into account the health impact of *other* policy areas, and a call for a mainstreaming and prioritising of health and wellbeing promotion as a goal in and of itself, one that other sectors need to work towards. Some researchers have looked at how to shift the discourse from health inequality/inequity, which they term a 'pathogenic' approach, towards a discourse of health equality/equity – a 'salutogenic' approach (Mittelmark et al, 2017). They argue that the former focuses on risk, ill health and disease, and that such a rationale is problematic because it tends to see good health as the normal, default state of being, and ill-health an abnormal state in need of fixing. This results in a minimalist approach to public health and a neglect of health promotion, given that it starts from the assumption that unless actively harmed, the default is that people are healthy. In a pathogenic paradigm, health promotion fails to clearly differentiate itself from disease prevention, and health promotion really is reduced to disease prevention done at an earlier stage (Antonovsky, 1996). A salutogenic approach, on the other hand, sees health/illness as a continuum rather than a

binary, and puts the creation of population health and wellbeing at the centre, as a genuine priority to see how policies can maximise and create health (Rouvinen-Wilenius et al., 2019). It recognises that a *laissez-faire* stance in public health governance and in relation to distal determinants of health, does not safeguard good health, because of the propensity of that stance to exacerbate societal inequities. As such, the normative ideal of HiAP is situated in a salutogenic paradigm of population health and wellbeing, rather than a pathogenic one.

> Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making

Box 1.1. Definition of 'Health in All Policies', quoted from (Leppo et al., 2013, p.6).

HiAP is driven by a view of health as a human right and a matter of social justice. It implies that the economy should work towards attaining high levels of wellbeing, health and environmental sustainability, rather than the other way around. In 2013, HiAP was the theme of the eighth global conference on health promotion. The conference resulted in the Helsinki Statement on Health in All Policies, as well as a HiAP Framework for country action (WHO, 2013, 2014a). In that context, HiAP is a term that has been taken up by the WHO, which since then published recommendations and guidelines for implementation[5] (WHO, 2018b, 2015a). While examples drawing on this general idea could already be found in various countries, the conference gave HiAP a global significance, and proposed a common concept and a common language for this conversation (Tang et al., 2014). HiAP is now drawn upon in many different countries, including Finland, Canada, Ecuador, Thailand, and Australia (Ståhl et al., 2006; WHO, 2014a). In Ecuador, for example, social policies are required to take into consideration the 'Plan Nacional para el buen vivir', which saw social investment increase 2.5 times between 2006 and 2011 (WHO, 2014a, p.i21). Since the 2013 Helsinki Statement on Health in All Policies, the WHO is providing support for HiAP implementation, such as how to identify (or create) structures and processes for HiAP, and how to build human resource capacity (WHO, 2014a, 2015b, 2018b; for concrete examples and technical guidance for HiAP implementation, see also: WHO, 2014b). These three components;

[5] The guidelines focus more on identifying win-win opportunities for health mainstreaming, and less on inevitable conflictual situations that involve power struggle. They are therefore more concerned with policymaking than with politics and power.

structures, processes and capacity, were also the ones most emphasised by one of the interviewees[6] involved in the HiAP plan of the 2006 Finnish EU presidency.

HiAP is both about 'technical' health mainstreaming, and about the adoption of a 'political' overarching vision for a healthier, more just and sustainable society (Leppo et al., 2013; Ståhl et al., 2006). The latter aspect is the focus of this thesis. Due to this duality, HiAP carries an inevitable level of vagueness, and its meaning requires contextual adaptation. With the recognition that all policy areas impact on health, HiAP opens up a terminological 'Pandora's box' of what qualifies as public health promotion, and whether 'health' remains an appropriate term when used in such an all-encompassing way (Synnevåg et al., 2018). Admittedly, such use of language runs the risk of being perceived as 'health imperialistic' (Banken, 2001; Kemm, 2001). In response to fears of health imperialism, this thesis emphasises the need to adopt a more fluid understanding of health (or, if preferred, indeed move towards 'societal wellbeing', for more on this terminological shift, see section 6.3.1., p.188) as physical, mental, social, cultural and spiritual wellbeing.

This thesis focuses on HiAP as the most prominent example of '*broad* health promotion approaches' prevalent in the EU currently. The thesis also chooses to focus on HiAP in relation to health promotion and NCD prevention. HiAP is relevant to virtually every health related topic, and it is therefore not possible to comprehensively study it in all its aspects at once. Yet NCDs prevention and health promotion, because of their relevance to broad and political distal determinants, is a good focus to analyse the normative aspects of HiAP. In order to get a better understanding of the roots and development of the HiAP idea, it is useful to look at the story of HiAP in Finland. The next subsection is largely based on in-depth semi-structured interviews undertaken in Helsinki in April 2019. It explains the historical context in which this way of thinking about health and its relevance to other policy areas emerged. It also includes a section about the structures and processes for HiAP in Finland and how they, too, have been evolving over time.

1.2.1. From 'Health for All' to HiAP: understanding the roots of the concept

This section is informed by semi-structured interviews with two former high-level officials in the Finnish ministry of health, one former Finnish member of Parliament, two current

[6] Source: interviewee 32

officials from the ministry of health and social affairs, and one health advocate in a Finnish NGO.

Prior to the 1960s and 70s, Finland was considered one of the European countries with the worst health status. After World War Two, around 10% of primary school children were undernourished. UNICEF got involved in programmes to provide essential fatty acids and other sources of nutrients to improve the Finnish children's health status[7]. Nowadays the country's social and health model, along with the ones of similar Nordic countries, is often regarded as being among the most progressive and efficient in the world. Finland underwent profound structural transformations that have led to dramatic improvements in its population health and wellbeing. The concept of 'Health for All by 2000', which was developed at WHO level and in which Finland was particularly active, was a key catalyst of this transformation. Health for All, most Finnish interviewees agreed, was the precursor of HiAP[8]. In fact, HiAP is seen as 'an attempt to translate this health policy [approach, i.e. Health for All] into EU language' (quote from interviewee 31, see section 6.1.1., p.178).

In order to understand HiAP, it is thus necessary to look at the precursor of the concept: 'Health for All (by 2000)' (WHO, 1981). The idea of 'Health for All by 2000' started in the WHO in the 1970s. It reflects a normative vision for health that emphasises the social nature of health, considers health as a human right, and recognises that all public policy areas have an impact on determinants of health (Mahler, 1981). The global strategy for Health for All was launched by the adoption of the famous Alma-Ata declaration (WHO, 1978, 1981). This concept resonated very strongly in Finland, which managed to raise it high on the national agenda thanks to the mobilisation of both medical doctors and politicians. The development of Health for All by 2000 took place simultaneously at national level and at WHO level, notably under the three term (1967-1982) regional directorship for WHO Europe of Finnish public health scholar Leo Kaprio (Johns Hopkins Bloomberg School of Public Health, n.d.). Finland was seen as a pioneer country in implementing a Health for All Programme following WHO guidance (Melkas, 1988).

At the national level, the success of this idea was, in addition to the merits of the concept in and of itself and the science behind it, dependent on the traction gained within the social

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[7] Source: interviewee 33

[8] Source: interviewees 27, 31, 32, 33 and 34

democratic party at the time[9]. Health for All came in the context of a general move towards socially progressive, left wing governance and the ‘radical’ ideas that characterised the 1960s more generally all across the Western countries. The Health for All idea was reflected in a series of progressive welfare reforms that took place in the 70s and 80s (Finnish Ministry of Social Affairs and Health, n.d.). The approach to implementing it was to break it down into separate topics (nutrition, road traffic, tobacco etc) and then act upon them comprehensively, on multiple fronts. Melkas (2013) and Leppo (1988) provide a systematic historical account of the journey of HiAP in Finland since that time (Leppo and Melkas, 1988; Melkas, 2013). There was a ‘rural to urban’ dynamic whereby the projects started to be put in place in the rural and deprived areas of the country and were then gradually spread out to reach cities as well. One flagship initiative was the North Karelia Project in 1972. It took a broad community-based approach to improving cardiovascular health in a small community (Jousilahti, 2014). The interviewees explained that while win-win situations, ‘low-hanging fruits’ were useful and important to seize, confrontation and resistance against conflicting interests was also indispensable. They highlighted the necessity of taking a strong normative stance on policy issues relevant to health, even when the stance was deemed very unpopular at first[10]. That was the case for example in the road safety context. Between 1973 and 1978, several health policy measures were taken to improve road safety and reduce the number of deaths and injuries due to road traffic accidents. Speed limits were lowered, compulsory helmets for motorbikes were introduced, as well as compulsory seat belts in cars. These measures faced vehement opposition by several important lobby groups, including the car industry. Simultaneously, road infrastructures were improved, including the construction of broad cycling and pedestrian lanes. Opposition against these public health measures had to be confronted, and mindsets had to change. However, by the time clear and significant health benefits started to be visible, the general attitude towards these measures among the population improved. The interviewees explained that in order to bring about meaningful changes like these, patience is needed, but also strong and trustworthy institutions. The police, for example, were an ally in getting the road safety agenda through[11]. The political system in Finland which tends to result in broad coalitions was also mentioned as one factor which facilitated the continuity and long-term vision for Health for All, as well as a long-standing culture of lively civil society activism.

[9] Source: interviewees 33 and 34
[10] Source: interviewees 33 and 34
[11] Source: interviewee 33

On the international scene, Finland was actively involved in the Health for All agenda at the WHO Regional Office for Europe. While Finland was not alone in this endeavour, the link between Finland and the WHO European region was key in raising the concept of Health for All both nationally and internationally, and to amplifying Finland's voice in the global health arena. Health targets were developed in the WHO in the framework of the Health for All project, which allowed countries to gain more accurate information on the health status of their population, which at that time was very new. What was crucial, was that the international Health for All agenda was also thought to serve an additional purpose: to promote peace. One interviewee in particular explained that, with health representing a terrain of relatively low political and diplomatic sensitivity, the Health for All agenda was indeed also used to try to improve diplomatic relations. The rationale was that peace is a basic pre-requisite for a healthy population, and that is how the concept was expanded as an avenue for dialogue in the Cold War context. This East-West diplomatic stance was important for Finland, a small Nordic country with long border with the then Soviet Union[12].

What came out very clearly from the interviews undertaken with those people who were involved in the Finnish Health for All agenda, and what ultimately needs to be emphasised for the purpose of this thesis, is the normative essence and political driver of Health for All. Of course, public health measures implemented were scientifically sound, but the political support was key, which suggests that scientific soundness alone is not enough, and that explicit normative commitment cannot be neglected. In the international context as well, the core human rights and social justice values were key. Arguably, it seems like the economic paradigm of health as a means to promote growth, and health as a 'cost-effective investment' (see section 5.1., p.146), may not have dominated at that time and in that particular context, or at least not to the same extent. This is very important to point out because it already shows fundamental differences between how HiAP got started in Finland and how HiAP got started in the EU.

1.2.2. HiAP in Finland: current structures, processes and challenges

With respect to HiAP and fostering intersectoral collaboration for health promotion, Finland, as well as the Nordic countries more generally, have often been seen as forerunners. The previous section has already shed some light on the historical context which led Finland to

[12] Source: interviewee 33

develop structures and processes that facilitate – to some extent – a HiAP *way of working*. For example, Ståhl and Lahtinen (2006) explain how the preparation of the Finnish National Health Report took place in 2006, and how the 2006 report differed from previous ones. The Finnish National Health Report is published every four years, towards the end of the national government's cycle. This allows for the evaluation of the government's degree of success in promoting health and wellbeing, and serves as an agenda setting document for the next government. The preparation of the 2006 report considerably strengthened the intersectoral collaboration through the creation of a new process called the 'bilateral dialogue'. Here, all the various ministries meet with the Health and Social Affairs Ministry for an in-depth discussion and evaluation of the relevance of their own policy agenda to the population's health and wellbeing, and the role of health in their decision-making processes (Ståhl and Lahtinen, 2006). The outcomes of the new report preparation process were the establishment of new structures for intersectoral collaboration on health, such as the Advisory Board for Public Health, which included a division specialised in intersectoral cooperation (Ståhl and Lahtinen, 2006).

Another avenue for strengthening intersectoral collaboration across ministries, and including parliaments and government, was indeed (and perhaps paradoxically so) the 1995 accession to the EU (Ståhl and Lahtinen, 2006; Kokkinen et al., 2019). Important coordination efforts were made to ensure the preparation of coherent national positions with respect to EU matters. Those efforts included setting up new structures: 35 sectorial preparatory subcommittees that bring together various policy areas around one issue. The subcommittees have a restricted, ministerial-only composition, and a broader composition in which stakeholders can provide input. Proposals from these subcommittees need to be adopted in the government's and in the parliament's relevant committees (Ståhl and Lahtinen, 2006; Taipale, I., 2018). It may thus be suggested that Finland has comparatively robust structures that allow intersectoral collaboration, and allow health to be brought to all tables. This was also the opinion of one of the Finnish health policymakers interviewed.

> I think that in some aspects [*related to intersectoral action for health*] Finland has been very strong and a forerunner, including in trade and health for example. […] the openness that used to exist in the ministry to consider health also plays a role. […] There was an astonishing change, back in 2014 when we were working on the HiAP strategy at national level, the high point for me was the meeting of all secretaries from all secretariats, they all got together for a full day – including the prime minister, the minister of health etc. They sat the whole day to discuss how health should be

> included. We thought that that was a major success. It was exactly the time when you could have said 'this is how HiAP should be done'[…] (Quote from interviewee 31)

However, that same person also recognised the growing challenges to protect these structures and to ensure they are used to promote public health:

> […] But actually, it [*i.e. the outcome of the meeting mentioned in the quote above*] turned out the exact opposite, the main thrust was to have health service and health technology as a major contributor of economic growth, that was the main point from the ministry of health and social affairs. That was a shock, we were so ready for it, we had prepared so much for many years, we got everyone together… (Quote from interviewee 31)

Indeed, more critical research is examining the effects of welfare restructuring that has been taking place in Finland since the early 1990s recession (Kokkinen et al., 2019). It suggests that Finland has not been immune to the global neoliberal trends, and has seen its HiAP-like, social wellbeing and health model gradually eroded: the institutionalisation of prioritising economic interest over social wellbeing occurred through various administrative reforms, such as one which conferred decision-making regarding budgets related to healthcare and social affairs on the ministry of finance (and away from the ministry of social affairs and health). The culture of lobbyism also started to gain traction, especially since the EU accession in 1995 (Kokkinen et al., 2019). At the moment, the Advisory Board for Public Health (mentioned in the paragraph above) is no longer active, even though its legal basis still exists (WHO, 2015c).

Another example of the effect of neoliberal reforms in the 1990s in Finland on the potential to implement HiAP is the changing relationship between the central government and municipalities (Virtanen, 2016). Finland is a centralised state which confers much autonomy on the level of municipalities. This means that they are responsible for delivering most social services, including health care and education, as well as municipal land-use planning, and the overall prosperity of the municipality (Nousiainen, 2018). Municipalities also have a legal requirement to undertake a health impact assessment (HIA) for every new policy project. In addition to the budget provided by the central government, municipalities levy taxes, including corporate and real estate taxes. The central government is responsible for evening out the disparities between municipalities (Nousiainen, 2018). This special relation between central government and municipalities has been seen as a strong advantage for implementing HiAP in a way that takes into account local needs, while being guided by the government's

overarching strategic vision for HiAP. However, since 1993, state subsidy reforms 'dismantled the state's strong normative steering mechanism over municipalities' (Kokkinen et al., 2019, p.4). The budget coming from the central government to municipalities was gradually reduced and no longer ear-marked. Municipalities were encouraged to outsource and privatise traditionally public services, including parts of the health care services. The absence of strategic steering, budget cuts, and the fragmentation of service provision have made the adoption of HiAP in Finland much more difficult.

1.2.3. HiAP and the 2006 Finnish EU Presidency

Finland joined the EU in 1995. As mentioned in the section above, the 1990s was also a period of economic recession in Finland, which ushered in a range of neoliberal austerity reforms (Kokkinen et al., 2019). In many ways, Finland's EU accession did not facilitate the protection of the country's social interests. Indeed, it has been argued by multiple critical voices that, while EU membership came with many advantages and progress, the policy space for health was reduced as a result of EU membership. This was perhaps most visible in Finnish alcohol policies (Ollila, 2011; Shankardass et al., 2018). Alcohol policies traditionally have had a strong public health dimension in Finland (and other Nordic countries) which was challenged by the strictly Single Market approach taken by the EU. Finland was not the only member state who had to work hard to protect the public health logic of their alcohol policies. The other two EU Nordic member states experienced similar situations (Holder et al., 1998). Ultimately however, the message from some interviewees was that while EU competencies can sometimes provide additional challenges, it is often still possible (for certain countries at least) to simultaneously protect public services and public health measures and comply with EU laws, provided enough time and capacity is available to member states[13]. For example, the national government retained a selling monopoly on both gambling and alcohol.

The 2006 Finnish presidency theme for health was 'Health in All Policies'. It stemmed from a concern that the EU was not doing enough to respect article 168 of the TFEU (see Box 2.1., pp.66-67). Indeed, article 168 suggests that the EU has had an entry point for mainstreaming HiAP since the 1990s and that, as such the Finnish presidency did not introduce something entirely new and unheard of (Merkel, 2010).

[13] Source: interviewees 27 and 31

> You realise that you have in the Treaty, not only a mandate but a requirement to protect health. And that was seen as a major tool in maintaining health and especially public health, while keeping health systems off the EU agenda (Quote from interviewee 31).

The EU, including the EC has a mandate to implement HiAP. The case for health mainstreaming is stated in Art. 168 TFEU and is further strengthened by Art. 9 TFEU which, under the heading 'Provisions having general application' states that:

> In defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health. (Art. 9 TFEU)

Furthermore, the establishment of the Health Strategy 'Together for Health', was argued to represent an *explicit and legitimate commitment* from the EC to mainstream health objectives in all *its* actions (Merkel, 2010). Despite the thin legal basis, growing understanding of the intersectoral nature of health has led to a growing awareness of how the EU nonetheless influences population health, for example through shaping determinants of health (European Commission, 2013a; Goldner Lang, 2017; Jarman and Koivusalo, 2017; Karanikolos et al., 2013; Koivusalo, 2010; Ollila et al., 2006; Ståhl et al, 2006). The idea that health is shaped outside the health policy area and that it is necessary to foster an intersectoral approach to health promotion was well understood and oftentimes stated in interviews with officials from DG SANTE:

> I think when you're looking at the issues like health determinants or disease prevention and health promotion, I think it's important to remember that it is a multi-faceted thing and that it's not one measure that's going to change the situation. […] You have to look at the entire picture I think and that's where of course changing lifestyles is very difficult because of different factors intervening and different cultural aspects, different economic aspects, and it's only by taking a holistic approach that you can hope to make any progress over time. (Quote from interviewee 28)

However, it is fair to say that the extent to which health was taken into consideration across EU actions so far has not been satisfactory and needed (still needs) to be massively improved (see Chapter Two). This is what prompted the Finnish team to adopt this concept for their 2006 presidency. The accent was put on health protection and promotion, and the way it was

shaped was intended to be a continuation of Health for All[14]. One of the interviewees[15] explained that the EC was keen to take HiAP further, beyond the Finnish presidency. HiAP was welcomed by the EU Council at the Employment, Social Policy, Health and Consumer Affairs Council meeting, during which all of the core messages of HiAP were stressed: a recognition that health is valuable *per se*, that it is not merely a matter of personal choice, and that health determinants are shaped largely in policy areas outside the health sector. It invited the EC to set out a plan to implement it and include it in its Health Strategy, as well as to improve the knowledge base and identification of the EU policies that have an impact on health (EU Council, 2006a). The conclusions also reminded early EC commitments from the 1990s to consider health in other policy areas. A second set of Council conclusions reiterating the commitments to HiAP were published in 2010 (EU Council, 2010). The 2017 Companion Report published by DG SANTE, for example, puts forward as its first conclusion the need to address the SDH, the vicious circle between ill-health and poverty and that this action requires multi-sectoral collaboration (European Commission, 2017a). At the time of the Finnish presidency, it was also very clear that HiAP was something that needed to be put in place across EU institutions. Finland had another EU presidency during the second half of 2019, in which the social and health theme was to introduce the concept of 'wellbeing economy' (see section 6.3.1., p.188).

This section presented how the 2006 Finnish Presidency introduced HiAP at EU level. The Finnish HiAP background story explored in the sections above is important to contextualise HiAP as an idea, and the circumstances under which it was proposed at EU level. Chapter Two will dive into the literature on EU health, and how it relates to HiAP, and the empirical chapters of this thesis (Chapters Four, Five and Six) will offer a critical analysis of HiAP at EU level.

1.3. Researching HiAP implementation: a technical and political task

As explained in the first section of this chapter, the link between social, political and macroeconomic factors and population health is increasingly well understood, in light of the growing amount of research. Consequently, recommendations of policy approaches like HiAP, are also becoming more and more present. They reflect awareness of the social drivers of health, because they recognise that all public policy areas can have an impact on health

[14] Source: interviewees 31 and 32
[15] Source: interviewee 32

directly or indirectly. Rather than disciplining and nudging people's behaviour, HiAP aims for a deeper societal transformation by tackling the social root causes of health inequalities. To illustrate with a few examples, a HiAP implementation could consist of strengthening the welfare system and improving redistributive policies, promoting healthy and safe urban environments, fighting social exclusion and discrimination based on race, gender, sexuality and ability, and working towards a sustainable food system. Rather than a step-by-step guide, HiAP is normatively driven and exhorts a deeper, meaningful political change towards prioritizing societal health and wellbeing (Leppo et al., 2013). What remains a challenge is the uptake of these approaches and better understanding the barriers to implementation. Growing awareness of complexity already provides a glimpse of the difficulty of the task ahead: understanding the obstacles and opportunities to HiAP uptake and finding a way to make sense of its success or failure. Arguably, this kind of research might be new territory for some public health scholars, as it once more pushes the boundaries between political science and health sciences. Indeed, HiAP can be seen as both a health mainstreaming approach to policy-making as well as reflective of an overarching political project towards a healthier, but also more just, peaceful and sustainable society.

Arguably the most commonly used approach to investigate these questions is Kingdon's multiple streams model (Baum et al., 2014; Kingdon, 2014; Leppo et al., 2013; Mauti et al., 2019; Ollila, 2011). This model has been adopted by the WHO, as well as in the context of HiAP in Australia (Kickbusch et al., 2014; WHO, 2015b). Baum et al. (2014) propose a combination of methodological and theoretical tools to evaluate HiAP in South Australia while taking into account complexity: they draw on Kingdon's systems theory and programme logic modelling (among other concepts). With programme logic modelling, Baum et al. (2014) have intended to measure the health outcomes of the HiAP agenda in South Australia. Their methodology aims to identify HiAP's impact on population health without using statistical inference isolating causal links (acknowledging that this is an inadequate way of researching complex social issues), but by accumulating 'a burden of proof' (for more on their methodology, see Baum et al., 2014). What their findings suggested is that health benefits of HiAP were present but fairly limited, which they argue is reflective of the very limited budget dedicated to implementing HiAP. They point out that the actions were limited to 'low-hanging fruits' and obvious win-win situations, mostly pertaining to the links between environmental policies, urban planning and health. The SDH however, the root causes of much of the health burden which are traced back to power, money and resources, were left untouched by HiAP applied in that context. The authors partly explain this through

the fact that local governments do not have the means to meaningfully modify those areas. This points to a problematic situation in which HiAP is mostly attempted to be implemented at a local level. This however, will inevitably be of limited scope, proportionate to the policy space at the local level. These studies recognise that, to understand the barriers and possibilities for HiAP, a natural scientific hypothetico-deductive problem-solving approach will be not able to fully capture the complexity of the issue at hand. Some researchers have more explicitly examined the political factors influencing HiAP. The 'Health Promotion International' supplement on the Eighth Global Conference on Health Promotion (volume 29, supplement 1, June 2014) contains a variety of research papers which analyse the political dimensions of HiAP. One example is the work done by Koivusalo (2014), which explains in great detail the politics of international trade and investment agreements, and their impact on policy space for health and HiAP (Koivusalo, 2014). Another example in the same special issue is Labonté's (2014) work on the HiAP relevance of foreign policy (Labonté, 2014).

Mikkonen (2018) analyses the political, institutional, managerial and technical barriers to adopting HiAP at the WHO European Region level. His findings pointed towards the lack of emphasis on participation, avoidance of talking about politics and power (except in the context of conflicts of interests and industry) and persisting biomedical paradigms of health as barriers to HiAP (Mikkonen, 2018). On a similar research interest, the HARMONICS project looks at barriers to implementing HiAP and includes a stronger focus on politics and power. Using systems theory, Kokkinen et al (2019) have looked at the successes and failures of HiAP in Finland by contextualising the approach to health within the broader welfare state reforms that have shaped the Finnish State since the 1990 recession (see section 1.2.2., p.46). They explain how neoliberalism was introduced during the early 1990s by a Conservative government and has, since then, become 'depoliticised' in the sense that a neoliberal rationality in restructuring the welfare state became an unquestioned continued path. The authors outline the ways in which this has impacted how HiAP was made sense of, i.e. with an increased focus on economic growth and market creation (Kokkinen et al., 2019; Shankardass et al., 2018). The HARMONICS project calls for a stronger emphasis on the political dimensions of HiAP (Oneka et al., 2017). Another example of research going beyond technical evaluation of HiAP implementation is Synnevåg et al. (2018)'s work on the terminological challenges posed by a concept like 'HiAP', where 'health' is understood in a way that is broad enough to raise the question of whether the term 'health' is still appropriate (Synnevåg et al., 2018).

1.3.1. Dealing with complexity

As early as 1991, Kickbusch (1991) argued for the need to develop an 'ecological approach to public health' as an epistemology capable of adequately making sense of the Ottawa Charter of Health Promotion (see: WHO, 1986), capable of dealing with complexity, with patterns that 'elude simple models of causality and intervention' (Kickbusch, 1989, p.265). An ecological understanding of public health takes into consideration the reciprocity between the environment and human health, both of which represent social resources. She argues that an ecological model for health has the potential to bring about dialogue between natural and social sciences. Public health, in those terms, is both the science - and the art - of promoting health. The term 'ecological public health' was later reused by Tim Lang in reference more specifically to the interlinkages between the food system, the environment, and health (Lang, 2009). Furthermore, Baum (1999) has argued for the necessity for public health researchers to consider the notion of social capital, and develop a better understanding of the relationships between economic determinants, social cohesion and health (Baum, 1999). Tremblay and Richard (2011) emphasise the theoretical and methodological relevance of complexity theory for health promotion. They recognise that public health issues need to be understood in a broad way and that the whole of an issue is bigger than the sum of its parts. They argue that the complex interlinkages and interactions at multiple levels that make up the structurally, politically, socioeconomically determined public health issues, in combination with all the normative and value-driven dimensions involved in health promotion, do not allow for a cartesian breakdown of the problem into a list of sub-problems to be addressed individually. In turn, they argue that a 'developmental evaluation' method built on complexity theory to be applied to health promotion issues represents fertile ground to explore health promotion (Tremblay and Richard, 2011). The WHO Commission on SDH recognises that traditional understanding of evidence is not adequate in the case of SDH ('using "evidence" in the narrow causal link sense would be a recipe for doing nothing' [Friel and Marmot, 2011, p.229]), and takes a broader approach to what constitutes evidence, including indirect links (for example, if participatory governance is shown to improve housing conditions and improved housing conditions improve health, then it is taken that participatory governance improves health).

Generally, there is an awareness, or at the very least a suspicion, that causality and evidence in the way they are conceptualised in positivist natural sciences are ill-equipped to be applied to SDH and political determinants of health. Given the complexity, the more distal the causes

analysed, the more difficult it becomes to establish ‘causal evidence’ links in the way laboratory conditions would allow. In the same vein, Taipale (2002) warns that blind emphasis on evidence can deter from crucial questioning of the purpose and nature of the evidence (Taipale, V., 2002). Baum (2007) also argues that medical approaches to knowledge and evidence are not sufficient to solve public health issues, and that normative commitment to equity is needed. She highlights the role of individualistic ideology, the way it suits powerful interests, and how it dismisses any collectivist rationale as “Nanny State”. While she sees behaviour change as desirable in principle, the way to attain it is not by telling people how to behave but by addressing root causes of inequalities and exclusions (Baum, 2007). Behavioural frames focusing on disciplining and modifying individual behaviour alone, can actively undermine action against social determinants of health inequality, and a technocratic understanding of evidence can precipitate action towards what is measurable rather than what is desirable (Smith, 2013a). Finally, it has been argued that medically focused interventions on ‘at-risk’ populations do not benefit society at large nearly as much as measures directed at the whole of the population. This is because the first one attempts to control the causes of ‘cases’ (individual cases), which is less effective than the second option to address the causes of ‘incidence’ (population-wide strategy) (Rose, G., 1985). A population-wide approach is seen as the most efficient way to promote health and address health inequities, rather than measures targeted at ‘high-risk groups’. Baum (2007) then calls for the importance of a jointly top-down and bottom-up approach to what she describes as ‘cracking the nut of health equity’, thus putting the emphasis on both normative political commitment and civil society mobilisation. This is echoed by Blas et al. (2008), who stress the role of national government and civil society in addressing SDH: national governments need to ensure a fair distribution of what they refer to as ‘human rights and essential services’ such as healthcare and education. They must also construct regulatory frames that safeguard and prioritise health and wellbeing, and monitor the health status of their population. At the same time, civil society needs to be empowered and take a more active role in the policymaking process (Blas et al., 2008).

The complexity turn in public health, and NCDs in particular, has led to a critical assessment of the limits of a natural scientific, technocratic approach to health policymaking, and has increasingly articulated a discourse of civil society participation, democracy and social justice. This is coherent with the rights-based orientation of this research in which health and wellbeing is seen as a human right and a goal in and of itself. It has also confronted researchers of health promotion mainstreaming with important challenges pertaining to the

need to refine and rethink theoretical and methodological frameworks to analyse this issue. One implication of the complexity turn in public health, is the need to foster more critical, post-positivist approaches to studying public health. Arguably, this need applies particularly to NCD-related health promotion and HiAP, given the pivotal importance of political, distal determinants in that complex and broad area.

1.4. Conclusion: The need to study HiAP in a critical way

This chapter has introduced some of the basic premises on which the remainder of this thesis rests: the fact that NCDs are an important public health issue, including in the EU; the fact that NCDs are shaped most importantly by factors outside the narrowly defined public health policy field, i.e. factors that shape societal inequity even at a very remote level; and that, based on this understanding, it is important to mainstream health – including health promotion and NCD prevention – into other policy areas. The chapter has then continued with a presentation of one approach to public policy which aims to take the aforementioned points seriously: HiAP. Focusing on Finland as an important forerunner of the HiAP approach who also raised it on the EU agenda, the chapter has shown the normative and political roots of the concept, which can be traced back to the 1970s and the Alma-Ata declaration. It has also explained how Finland managed to set up certain structures and processes to facilitate HiAP, while at the same time challenging those very structures and values in the aftermath of the 1990s recession and the neoliberal reforms that subsist (and perhaps worsen) until today. The last section of the chapter engaged with the debate on *how* to research HiAP, on the duality between its technical and political aspects, and on the increasing awareness of the shortcomings of the orthodox public health positivist ontology.

This chapter, in conclusion, argues for the need to study HiAP from a different, more critical social science perspective. It proposes to delve deeper into the normative aspect of HiAP by looking at manifestation and reproduction of institutional, as well as ideational and discursive barriers to HiAP. Before going on to explain the theoretical framework of this thesis (see: Chapter Three), the next chapter will look at the ‘case study’ in relation to which this thesis analyses HiAP and its barriers: the EU context. As shown in this chapter, the EU has a mandate to implement HiAP, and HiAP was explicitly put onto the EU agenda. Yet because of its very technocratic and economic growth-driven nature, the EU is a particularly interesting place to critically analyse the political obstacles to HiAP. This is what the next

chapter will present in detail, underlining the relevance of this thesis to both the critical public health literature, as well as to the EU studies literature concerned with the debate around social versus economic Europe.

CHAPTER 2: Literature Review - The EU, Health, and Neoliberalism

The first chapter of this thesis has introduced the HiAP concept, and related it to the 'complexity turn' that has been occurring in public health research. This second chapter provides a non-exhaustive review of various literatures, as additional pieces of the puzzle necessary to complete the picture of what this thesis deals with. First it introduces the literature which looks at the EU's involvement in public health, and situates it within the broader EU integration literature. One common argument made by those scholars critically assessing the EU's involvement in health, is that this involvement is the result of (illegitimate) 'spill over' underpinned by a market rationality rather than a genuine concern for public health. This argument builds on the concept of constitutional asymmetry, according to which the EU's institutional structure is such that it systematically privileges economic integration over social integration (see Chapter Four). This characteristic has also been referred to as the EU's neoliberal bias. While sympathetic to this argument, this thesis argues that it is too narrow, and that a broader conceptualisation of the relation between neoliberalism, the EU and health, would allow us to explore in both more depth and more nuance, how 'neoliberal biases' manifest in the EU's (direct and indirect) involvement in health promotion, as well as explore the spaces for agency and resistance.

To understand what is meant by 'a call for a broader conceptualisation of the relation between the EU, neoliberalism, and health', the chapter's second section reviews some of the vast and diverse literatures that look at the effects of neoliberalism on public health and health promotion. After defining 'neoliberalism', this second section talks about the research linking neoliberalism with ill-health: on the macro-scale, it shows the relationship between global neoliberal processes and ill-health. On the meso-scale, it reviews some of the research evidence linking local neoliberal policies, in particular austerity measures, to worsened health outcomes. Finally, on the micro-scale, it considers the negative health impacts of how neoliberalism 'as governmentality' has established the 'individual responsibility' narrative in health promotion as the only imaginable type of policy.

One of the main contributions of this thesis (see p.207), for which the case is made in this chapter, lies in bringing together these two literatures (i.e. the EU health literature, and the 'neoliberalism and health' literature). As a result of this combination there appears a clear need, when looking at the EU and health, to consider public health and health promotion as a

normative, political domain, in which neoliberalism is a well-documented determinant of ill-health. This recognition, as a starting point of this thesis, points to the need to look at the EU's involvement in public health and health promotion much beyond the case of competence spill over and intrusion of market rationality in the area of health policy. Instead, this thesis argues that, if political determinants of health are to be taken seriously, then it is the whole of EU governance that may affect public health, to a variably more or less direct degree. And this is precisely what HiAP is about (see section 1.2., p.40).

The third part of this chapter provides preliminary clarifications of how the thesis will approach the study of political determinants of ill-health, in particular how neoliberalism affects the space for taking up HiAP at EU level. The study of how neoliberalism permeates the HiAP concept at EU level and where the spaces of resistance and contestation can be located, this chapter argues, requires taking a 'radically broad conceptualisation of health promotion'. This means defining health promotion not as policies designed to encourage healthy behaviour, but rather, as any approach to governance and policymaking which prioritises social equity, and environmental justice over market creation and economic growth for the sake of growth. Relatedly, it requires a consideration of HiAP not so much as a state of being present or absent from policies (along the lines of 'is health mentioned in this policy? yes/no'), but rather, as a *meaning-making process*. 'Meaning-making' insofar as the meaning of HiAP is not fixed and pre-determined, but evolves in different ways depending on context and underlying normative assumptions (see Chapter Six). 'Process' insofar as HiAP represents a way of working, an approach to policymaking and a commitment to a normative vision, rather than a tick-box exercise. However, these meaning-making processes do not occur in a vacuum, and are situated vis-à-vis (seeking to challenge- or buying into,) ingrained ideational structures, which are explored in Chapter Five. Studying HiAP as a meaning-making process situated within broader ideational structures will be the object of the fifth and sixth chapters, which represent the interpretivist, *discursive* parts of the analysis of HiAP obstacles and possibilities in the EU.

The final part of this chapter maps the EU governance territory in order to provide a schematic within which to navigate the *institutional* part of the analysis of HiAP in the EU, i.e. Chapter Four. It divides EU governance into three categories: hard governance, soft governance, and meta-regulatory governance. Examples, which will feature in the empirical chapters, are introduced for each category, and, while the hard/soft/meta categorisation is

mobilised particularly in Chapter Four, bearing these different categories in mind will facilitate the reading of the remainder of the thesis as a whole.

2.1. EU integration and the growing involvement in public health

This first section introduces the literature concerned with the EU's influence on public health, in particular health policy and law. However, before telling the story of the EU's involvement in public health and how it has been researched academically, it is necessary to start with a basic introduction to the EU institutions, as well as to how EU integration has been theorised.

The EU's functions are legally based on treaties, a series of which were signed over the decades. For the purpose of this thesis, and in order to get a sense of how EU governance relates to health, it is worth mentioning two treaties in particular: The Maastricht Treaty, signed in 1992, and the Lisbon Treaty in 2007. The Maastricht Treaty is the initial Treaty of the European Union. It established the three pillars of the EU: the European Communities (which was the pillar relevant to this thesis), the Common Foreign and Security Policy, and cooperation in the fields of Justice and Home Affairs (Bache et al., 2015). The Maastricht Treaty considerably furthered European integration, notably by establishing the European Monetary Union (EMU). EMU relates the creation of the Eurozone, the establishment of the Euro as a common currency, and the Stability and Growth Pact (SGP). It is because of EMU that, later down the line (especially after the Eurozone crisis), the EU became increasingly involved in Member States' fiscal policies. Maastricht also expanded the EU competencies in many social areas, including health and public health, even though this was not done through the same pathways as the expansion of economic competencies (see section 2.1.1.1. p.63). The Lisbon Treaty is the most recently signed EU treaty. The Lisbon Treaty did not consolidate all previous treaties into one constitution, as was originally hoped (and originally planned to be named the 'Constitutional Treaty'). Instead, it kept the two treaty structure[16] put in place in 1997, but with a considerable number of amendments. These two treaties are: The Treaty of the European Union (TEU), and the Treaty on the Functioning of the European Union (TFEU, formerly known as the Treaty of the European Community, 'TEC'). The TEU comprises aspects related to the EU 'overarchingly and as a whole', i.e. the conditions and processes for accession and withdrawal of the EU, the EU's broad principles, its institutional makeup, as well as matter related to the Common Foreign and Security Policy. The TFEU, on

[16] A third treaty not mentioned here is the Euratom Treaty.

the other hand, governs every aspect of the actual functioning of the EU, which can be referred to as 'the Union Method' (EUR-Lex, 2010).

The TFEU establishes the level of EU 'competence', which dictates how much the EU is mandated to do in a particular area. Some areas are exclusive EU competence, many areas are shared competencies, and in some areas the EU only has 'supportive' competence (see: European Union, 2016). These competencies are subject to three fundamental principles: the principle of conferral, which states that the competencies are conferred to the EU by the member states; the principle of proportionality, which states that in the exercise of its competencies, the EU should not go beyond what is necessary to achieve a set objective; and finally the principle of subsidiarity, which states that, in non-exclusive EU competencies, decision making and action taking should occur at EU level only if the EU member states are not able to achieve a set objective on their own (priority is given to the governance level closest to the citizens) (European Union, 2016).

The EC is (arguably) the most important institution when analysing EU level governance. It has the power to initiate legislative drafts (Staab, 2013). The EC's two biggest responsibilities are proposing legislation, and drafting the EU budget. The EC is responsible for ensuring the appropriate enactment of EU legislation by member states. If the EC or another entity (another member state or even a citizen) finds that a member state is breaking EU law, the case can be handled by the Court of Justice of the European Union (CJEU). The EC also works with executive agencies, such as for example in the area of health, the European Centre for Disease Control (ECDC), the European Medicines Agency (EMA) and also the Consumer, Health, Agriculture and Food Executive Agency (CHAFEA). As stated in Bache et al. (2015, p. 204): 'In the view of the Commission, it is only its monopoly of the right of initiative that allows a coherent agenda to emerge from the EU as a whole'. The authors highlight that this is debatable, given that the European Council also has agenda-setting powers. The European Council is composed of the Heads of member states, the EC president, and a High Representative for foreign and security policy. In terms of agenda-setting powers, the EP also has the possibility to request the EC to submit a legislative proposal under certain conditions. The EP and the Council of Ministers (normally referred to as 'the Council', as opposed to 'the European Council') are the bodies that vote on EC proposals. Once a legislative proposal has been drafted, it goes to both the Council and the EP for a 'co-decision' process. The Council is officially composed of member states ministers, but in practice it works through committees of member states officials. The

Council and the EP vote on an EC proposal either by unanimity, by qualified majority voting, or by 'reversed qualified majority', depending on the situation. The EP consists of elected members and comprises a number of committees.

Now that the basic EU institutions and concept of Treaty basis, subsidiarity, proportionality and conferral have been introduced, the next section will introduce some of the main theories pertaining to EU integration and governance. Following on, it will review some of the critical literature explaining how the EU has been increasingly involved in health and public health matters. As will be further argued below, the EU health literature has been predominantly concerned with the impact of the EU on health policy and health systems, but less so with indirect impacts on population health through its actions in other policy areas. From a HiAP perspective, however, the latter is precisely what the EU should be focusing on if it aims to mainstream health: more health considerations in non-health policy areas, rather than increased involvement in health policies and health systems.

2.1.1. EU integration theories

One of the oldest debates in the EU academic literature pertains to the clash between two fundamentally differing conceptualisations of the EU: as either an intergovernmental institution, or a supranational institution (Pollack, 2001). According to neofunctionalist theory, European integration occurs through various kinds of 'spill over'. The key neofunctionalist concept of spill over refers to how integrating in one area induces the need to expand integration beyond that area, because of knock-on effects and path-dependencies (Haas, 1958). Besides functional ('automatic') spill over, neofunctionalists argue that spill over is also intentionally cultivated by interest group who see a benefit in bypassing the national level. Additionally, and in interaction with interests groups, spill over is also cultivated by the so-called 'socialised elites' consisting of supranational civil servant who have been socialised into favouring supranational (in this case, EU-level) solutions (Jensen, 2009; Niemann and Ioannou, 2015). As will be shown below, some (in particular Greer) have drawn on neofunctionalist concepts to explain the growing involvement of the EU in health (Greer, 2006; Greer and Löblová, 2016). However, while this critical EU health literature draws on neofunctionalism, unlike mainstream neofunctionalists, it questions the legitimacy and desirability of further integration, rather than taking it as desirable by default. For long, neofunctionalist theory of EU integration stood in binary opposition to the 'intergovernmentalist' theorisation of EU integration. Among these state-centric approaches,

arguably the most sophisticated one is considered to be liberal intergovernmentalism (Cini, 2009). Liberal intergovernmentalism argues that integration results from bargaining processes of rational-acting states and occurs along the lowest denominator when economic interests converge (see: Moravcsik, 1998).

This (simplified) binary opposition between intergovernmentalism and neofunctionalism characterises much of the early-day (and still enduring) EU integration debates which draw on IR theories. The last few decades however have been marked by a shift towards other kinds of theories to look at the EU. These 'newer' theories are more concerned with analysing the EU from a governance angle, looking to explain specific parts of the EU, and avoiding 'grand theories' angles that characterise the IR approach (Rosamond, 2009, p.108). Arguably, this reflects a shift in interest away from identifying the drivers of integration, and onto understanding the workings of the EU. For example, multi-level governance approaches, and policymaking theories of the EU in general, contest the idea of a clear distinction between national and EU (and international) level implied in IR theories of EU integration mentioned above (Bache and Flinders, 2004). They focus on the intricacies of policymaking as processes determined by complex networked structures. Variants of 'new institutionalism' also reflect the governance turn in EU studies, as they put the accent on the role of institutions, which they define in different ways. New institutionalism will be discussed in Chapter Three (section 3.1., p.97). Constructivist theories have also increasingly been applied to the EU (see for example: Parker, 2018; Parker and Pye, 2018; Radaelli, 2007; Rosamond, 2002; Siles-Brügge, 2013). Both themes of institutionalism and constructivism will be explored in Chapter Three: given the discursive institutionalist framework of this thesis, Chapter Three will present the debate between 'new institutionalism' and constructivist approaches, and how discursive institutionalism seeks to position itself at the intersection of both.

2.1.1.1. Constitutional asymmetry and neoliberal biases

One important concept this thesis considers, especially in Chapter Four, is the notion of 'constitutional asymmetry' (Scharpf, 2002). The EU integration process and the institutional expansion over the decades did not happen in a smooth linear fashion, but rather with various episodes of bursts and push-backs. The EU project at its root, however, can be seen as an economic project of market integration aimed at the social goal of peace and prosperity promotion. After two world wars, the six founding members were ready to negotiate aspects

of their national sovereignty in order to promote peace and unity (Bache et al., 2015). At the same time, the Marshall Plan provided the impetus to foster economic cooperation between European countries (Staab, 2013). The initial rationale for economic integration was that pooling the market of steel and coal and increasing interdependency for the provision of these resources would decrease the likelihood of another war (Bache et al., 2015). As a result of these historical and contingent developments, the EU became much better equipped to regulate economic matters, than to get involved in social areas. One aspect to consider is that the EU is inherently a regulatory polity with very little redistributive power (Majone, 1993, 2014). The EU, for example, does not collect taxes. Its budget, proportionally speaking, is very small, around one per cent of member states' gross national income. The only clear redistributive policies are the CAP (see section 4.3., p.130), the structural and investment fund (see section 4.4.1., p.133), and the EU regional and cohesion funds. The EU also has generally limited competencies in regulating social areas. What dominates in the EU is the power to regulate economic areas, such as Single Market integration and EMU. The term 'constitutional asymmetry' encapsulates these differential integration dynamics. It refers to the disproportionate importance given to economic policies as opposed to social policies and which is reflected in the treaties, in the legal competencies and procedures in place (Greer et al., 2014).

While the EU project was primarily one of economic integration, expectations to strengthen its 'social logics' started intensifying as economic integration became deep enough for legal constraints on domestic welfare states to be felt (Scharpf, 2002). Scharpf explains how 'negative integration', which acts to remove barriers to trade and promote the freedom of the Single Market, is systematically stronger and faster than 'positive' (i.e. market correcting) forms of integration (Scharpf, 1998). Because of the executive power of the EC and the authority of the CJEU, negative integration becomes depoliticised, whereas positive integration needs political legitimation and a high level of consensus. This is often hard to achieve due to strongly varying interests and modes of welfare governance of member states (Scharpf, 2006). Relatedly, Scharpf explains that, while 'product related regulation' guaranteeing quality and safety standards have been fairly easy to put in place alongside negative integration, 'process related regulation' at EU level, such as those pertaining to labour rights, are not easily justifiable and agreed upon because they do not directly determine the safety and quality of the end product in the market (Scharpf, 1997, 2006). In the case of health promotion, this rationale is illustrated in the importance given to food

safety and sanitary and phytosanitary (SPS) regulations, as opposed to HiAP-inspired health promotion – despite NCDs being by far the biggest burden of disease in the EU.

The ease of negative integration as opposed to positive integration is symptomatic of the constitutional asymmetry, and is the reason why some researchers argue that the EU presents an institutionally ingrained *neoliberal* bias (Bailey, 2017; Gill, 1998; van Apeldoorn et al, 2009; Walters and Haahr, 2005). Neoliberalism is used here to refer to the underlying governance rationality which promotes market liberalisation and economic growth while curtailing public expenditure, and which at the same time shapes the social sphere along the same rationality, by disciplining citizens to become free yet responsible, entrepreneurial subjects (Joseph, 2012; Parker, 2013; Rose, N. et al., 2006; Peck and Tickell, 2002) (more on neoliberalism in the second part of this chapter, p.72).

This brief overview of some of the main theoretical underpinnings of EU studies will allow to this thesis to situate the existing EU health literature within this landscape. It will also allow to better formulate a critique of- and situate this thesis vis-à-vis the existing EU health literature. Overall, this thesis argues that existing critical EU health literature needs to look beyond the role of institutions, and beyond the notion of path-dependent neoliberal spill over. While this thesis is sympathetic to the argument that EU involvement in health occurs through an economic rationality, it takes a more constructivist stance and argues that discursive power dynamics, meaning-making and ideational factors allow to paint a more nuanced, and less 'deterministic' picture of existing neoliberal biases in the EU and how they manifest. The section below reviews some of the main existing critical argument in EU health literature.

2.1.2. The story of EU involvement in health

Technically, the EU only has shared competence for 'shared safety concerns in public health matters', and only supportive competencies for 'protection and improvement of human health' (European Union, 2016, p. 1-2). At first sight, one might thus question the legitimacy of EU health governance as a research subject, given the limited competencies. In practice, however, the EU has been having a tremendous effect on the population's health, both in terms of public health and individual health care, in a number of different ways (Steffen et al, 2005). Officially, the involvement of the EU in health is categorised under three pillars:

health care policy, public health, and occupational health and safety policy (Anderson, 2015). The first one is not directly related to health promotion, as it refers to curative services related to a medical definition of health: access, administration and financing of health services (hospitals and medical offices, medicines and medical devices, and health insurance). Public health policy, in the EU literature, refers in the largest part to the control and surveillance of communicable diseases, including foodborne diseases, as well as food safety more generally. The first health-specific legislation, for example, was the Directive on colorant in foodstuffs and was adopted in 1962 (Guy and Sauter, 2017). The continued emphasis on food safety is in part due to the story of the EU involvement in public health being very closely linked to the outbreak of mad cow disease in the late 1990s. Indeed, the EC's DG concerned with health was not set up 'as its own DG', but emerged as an enhancement of the DG for consumer protection, at the time of health and food safety concerns related to the mad cow disease crisis (Clemens et al., 2017; Geyer and Lightfoot, 2010). At that time, it was called DG SANCO, for health, food safety and consumer protection; whereas now the DG for health is called DG SANTE and is in charge of health and food safety. Environmental health and, to a smaller extent, the promotion of healthy behaviours, is also included under the EU public health category. Finally, occupational health and safety is the third category which characterises the EU's involvement in health. This one is also of particular historical significance, because it pertains to workers' rights and freedom of movement of labour. The first health-related provision was adopted as early as 1958 and pertained to the free movement of workers in the EU and social security coordination (Guy and Sauter, 2017).

As mentioned in the introduction of this thesis (p.13), the TFEU includes one specific public health article, i.e. article 168. Under this article, the EU has a responsibility to take into consideration and strive to improve the health of its citizens through every action it undertakes. The breadth of the article makes it compellingly strong, but its vagueness undermines this strength, as defining what promoting and safeguarding health refers to, is political.

Article 168 TFEU (ex Article 152 TEC)

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Box 2.1. Article 168 TFEU

2.1.2.1. The three faces of EU involvement in health

The way in which the EU got involved in health policy and law was in an incremental, ad hoc fashion, which may now explain the 'patchwork' or 'Christmas tree' condition of EU health law and policy: its involvement in health did not stem from a coherent, comprehensive strategy, but happened largely through a Single Market harmonisation rationale (Lamping and Steffen, 2009). Indeed, critical EU health scholars often draw on the concept of spill over, in the context of asymmetrical integration favouring economic over social integration, to make sense of the EU's involvement in health (Greer, 2006, 2014a, Greer and Löblová, 2016; Lamping and Steffen, 2009, Lamping, 2005). EU involvement in health policy is seen to result from interest groups dissatisfied at their national level governments and turning towards the EU, ultimately conferring upon it the legitimacy to act on one particular issue, and leading to an ever growing area of EU action related to that issue (Greer, 2009). As Greer (2009, p.4) puts it: 'The whole problem of EU health policy is that most of the policies enter from adjacent fields rather than health ministers or health agendas'.

According to many EU health scholars (Anderson, 2015; Mossialos et al, 2010; Sindbjerg Martinsen, 2017; de Ruijter, 2019), EU health policies have been shaped more by CJEU interpretations of internal market legislation, than by competencies in health *per se*. Brooks (2012) draws on the example of cross-border healthcare to critically emphasise the role played by the CJEU in EU health policy. She suggests that the Patient Mobility case is a good example of CJEU-induced spill over driven by free movement, market rationality. However, she then identifies the rise of the so-called 'new modes of governance (NMG)' (see section 2.4.2.1, p.89) as a major challenge to the power of the CJEU, that is, unless the CJEU is able to transform soft governance commitments into hard law. Another example of the CJEU prioritising negative, market-creating integration described by Baumberg and Anderson (2008), is the case of alcohol policy (even though they argue that portraying the EU as dismissing health concerns entirely would be an inaccurate simplification). Lamping and Steffen (2009) theorise EU health policy through the lens of Europeanization. Building on the multi-level governance approach, Europeanization looks at how member-state/EU interactions mutually shape policies, and conferring a more European and/or European integrated dimension to some policy areas. Europeanization of health policy, according to Lamping (2005), occurs through health-related supranational laws, through direct and indirect spill over effects pertaining to both Single Market and EU economic governance, and through soft governance.

In light of the asymmetric logics of EU integration systematically favouring markets over social issues, Greer has categorised the involvement of the EU in health under three 'faces', and argues that EU involvement in health is driven mostly by non-health rationales. This argument posits that what the EU mostly does is effectively impose a neoliberal market logic in areas that are, such as health, situated in the social sphere. Policies designed purely with a public health goal in mind, according to Greer, represent a very small minority of EU involvement in health. This, he classifies as the 'first face' of EU involvement in health. Instead, most involvement occurs through either Single Market integration (second face), or fiscal coordination (third face).

The first face of EU involvement in health pertains to the 'genuinely public health-only' measures. Given the limited competencies in this area, however, this type of action falls in the category of soft governance, i.e. non-binding member state support and complementation. This is largely the case in NCD prevention and health promotion. Garde (2010) points out that the development of an EU competence in obesity-related issues is limited to a supportive, non-binding role and translates in two main ways; one is the funding of public health research, and the other pertains to the coordination, evaluation, monitoring and advising of member states (Garde, 2010).

The second face of EU involvement in health identified by Greer, and arguably the most important one, relates to Single Market integration. This governance area fits into the 'hard governance' category (for more on the different types of governance, see section 2.4., p.84). That means it is regulated largely through binding legislation and regulations. Single Market regulations have implications for the free movement of healthcare-related goods, services and patient and health workforce mobility. Food safety is ensured through the Single Market laws, for example by ensuring common SPS standards. Some emblematic examples of EU health involvement through the Single Market include the directives regulating the handling of human blood, tissue and cells (European Union, 2003, 2004b), or the directive relating to patients' mobility (European Union, 2011). The latter explicitly shows how the internal market serves as a treaty basis despite the public health relevance of the directive:

> Article 114 TFEU [*i.e. the Article pertaining to the governance of the Single Market*] is the appropriate legal basis since the majority of the provisions of this Directive aim to improve the functioning of the internal market and the free movement of goods, persons and services. Given that the conditions for recourse to Article 114 TFEU as a

> legal basis are fulfilled, Union legislation has to rely on this legal basis even when public health protection is a decisive factor in the choices made. (European Union, 2011, p.45)

Beyond the Single Market regulatory action indirectly related to health and the soft governance directly related to public health, Greer identifies a more recent, third face of EU involvement in health, which is also situated in a 'hard governance' space and relates to economic and fiscal governance (see also: Fahy, 2012). This one emerged as a result of the Eurozone crisis and the toughening of fiscal coordination between member states. The EU's involvement in member states' fiscal governance has direct implications for national health systems, which are pushed towards more cost-effectiveness and modernisation/digitalisation. The impact of the European Semester (a fiscal coordination cycle for EU member states, see section 4.4., p.133) on healthcare systems is increasingly researched (Azzopardi-Muscat et al., 2015; Greer, 2014a).

As suggested above, a large part of the critical EU health scholarship conceptualises the EU's involvement in health as resulting from some form of spill over in the context of asymmetrical integration dynamics that favour freedom of market over social protection. One notably different approach is taken by Flear (2015), who uses a Foucauldian, biopolitical framework too critically analyse EU health policy. Importantly, many of these scholars see the EU involvement in health policy as illegitimate encroachment, as 'uninvited Europeanization' (Greer, 2006) that crept in through the backdoor of the CJEU and the EC (Anderson, 2015; Liebfried, 2010). These scholars argue or imply that health concerns are not even the main driver for most involvement of the EU in health, and that the public health article of the TFEU (article 168) is hardly an important legal basis for most EU involvement in health.

> Health is a perfect case of European integration – negative, deregulating integration – driven by the EU institutions without democratic legitimacy or an obvious justification. It is driven by EU institutions and produces markets where there were none, in order to make systems compatible with the EU internal market. (Greer, 2014a, p.11)

This thesis is sympathetic to the arguments outlined above. Indeed, it concurs with them to an extent (see Chapter Four in particular). However, one key aspect of this thesis – the premise of which is laid out in this chapter – is to argue that the relationship between the EU, neoliberal rationality and health, should be conceptualised both more broadly and in a more

nuanced, less deterministic way, than only as a matter of neoliberal EU 'encroachment' on health systems and health policies. Here, the thesis' theoretical underpinnings is more aligned with the constructivist turn in the EU studies mentioned above (p.63).

In critiquing the market-favouring CJEU rulings pertaining to treating healthcare similarly to (albeit not exactly like) other services, and how that paves the way for integration spill over in the highly politicised cornerstone of national sovereignty that health systems are, that literature also tends to limit its analysis to health care and health systems. This thesis argues that this neglects *determinants* of health. Relatedly, a broader conceptualisation of the relationship between neoliberalism, the EU, and health, also needs to pay more attention to the effects of soft governance areas too, which should not be neglected when it comes to critiquing the infusion of a market rationality in social areas. While much of the critical literature on the EU and health eloquently demonstrates how the increasing involvement of the EU in health is underpinned by a market rationality, it is arguably not concerned enough with the notion of neoliberalism itself, the various dynamics of how it manifests, and the multiplicity of ways in which it affects health.

Rather than showing that a concern for economic growth and market creation drives the EU's increasing involvement in health policy and health systems, this thesis uses the notion of HiAP to consider the more general effects of neoliberalism on population health, whether manifested in health policy or in entirely different policies. Here, the literature researching the relationship between neoliberalism and ill-health serves as a starting point for the thesis: the contention that because neoliberalism is a determinant of ill-health, HiAP cannot be thought of in isolation from ideological dimensions and neoliberalism. In other words, this thesis' starting point is that EU market rationality is not only a problem because it drives health policy and health system reforms (implied: in a way which exacerbates inequity), but that the neoliberal rationality underpinning the market rationality should be seen as a determinant of (ill-)health in and of itself. Once the premise of neoliberalism as a determinant of ill-health is established, HiAP becomes much broader, and the research object of this thesis comes to differ from most other EU health literature: instead of being concerned *solely* with the EU neoliberal intrusion into health policy and health systems, it is concerned with how neoliberalism is reproduced more broadly, and how that affects the possibility to consider health in other policy areas. Implementing HiAP, in that sense, would need to entail a move away from neoliberal governance. This feeds into the debates around social versus economic EU, and how to make Europe more social (Ferrera, 2017; van Gerven and

Ossewaarde, 2018), only the lens used here to look at the social sphere, is health promotion. In this endeavour, this thesis also aims to avoid overly deterministic portrayals of the EU as a neoliberal monolith, and instead seeks to tease out contradictions, contingencies and spaces for contestation (see Chapter Six).

To explore how the relationship between the EU and political determinants of health could be investigated in a broader and more nuanced way, the next section of this chapter will provide a non-exhaustive review of the literature that analyses the effects of neoliberalism on public health. This next chapter section thus explores a different, not EU-specific literature, however one of the main contributions of this thesis (see Conclusion, p.207), will be to make the case for combining both the aforementioned EU studies and EU health literature, with the wider 'neoliberalism and health' literature reviewed below.

2.2. Neoliberalism as a determinant of (ill-)health

In order to provide the starting point that neoliberalism should be seen as a determinants of health, this section reviews some of the growing literature on the politics on health, looking specifically at neoliberalism and health. The broad field of public health sits at the multiple intersections between biomedical sciences, and social sciences. Bambra et al. (2005) argued for the need to develop the field of 'political science of health', which they deem 'no less important than medical sociology or health economics on the one hand, or than political sociology or political psychology on the other' (p.192). Awareness of the importance of politics and political science in public health has indeed been growing ever since (Bambra et al., 2005; Kickbusch, 2015; Leppo et al., 2013; Mackenbach, 2014; Ottersen et al., 2014). Arguably more and more scholars, including from a traditionally 'biomedically-oriented school of thought', are interested in studying political dynamics in public health. To take some examples, Geneau et al. (2010) revise the 'political process model' to both explain the lack of political uptake of chronic diseases on the global political agenda as well as to explore avenues to rectify this shortcoming (Geneau et al., 2010). Baum and Fisher (2014) analyse the resilience of the individual responsibility narrative in health promotion (Baum and Fisher, 2014). The Lancet's University of Oslo Commission on Global Governance for Health looks at the characteristics of global governance which undermine the tackling of SDH (Ottersen et al., 2014). Swinburn et al. (2015) focus on the notion of accountability. Others have taken a 'political epidemiology' approach and aim to link political variables like voting behaviour or

parties in power, to health outcomes such as suicide rates or health inequalities (Kelleher, 2002; Mackenbach, 2014). An analysis by Zalmanovitch and Cohen (2015) into the concept of 'political will' suggests that the incentive for politicians to get involved in health promotion policies is low because of the complexity of the issue and the likely absence of short-term measurable results (Zalmanovitch and Cohen, 2015).

A considerable proportion of scholars who do look at the political science of health, have been concerned with analysing the relationship between population health and political ideology, in particular neoliberalism, which to a large extent characterises the contemporary orthodoxy in Western countries. The following section presents the arguments of some of these researchers, which justify this thesis' starting point that neoliberalism is a determinant of health, and that, consequently, health promotion needs to be conceptualised much more broadly than is currently generally done.

2.2.1. Defining the concept

Before delving into the critiques of neoliberalism in health literatures, it is worth briefly looking at the contested concept of neoliberalism and the way in which it has been thought about and defined. There are many ways to define neoliberalism: as an ideology, a set of particular economic policies, or as 'governmentality'[17] (Sadler and Lloyd, 2009). These differing approaches emphasise different dimensions and/or differ in their theoretical underpinnings, but they tend to share a similar logic. 'Neoliberalism' is often accepted as a phenomenon intellectually attributed to the Chicago school of thought, and economists like Friedrich Hayek and Milton Friedman. While it did not emerge 'out of the blue' and indeed can be traced back to the late 40s and 50s (Schrecker, 2020), it became politically dominant in the 70s and 80s, notably under Ronald Reagan in the US and Margaret Thatcher in the UK (Peck and Tickell, 2007). Arguably its strongest principle can be seen as 'the conviction that the only legitimate purpose of the state is to safeguard individual, especially commercial, liberty, as well as strong private property rights' (Thorsen and Lie, 2006, p.14). It regards promoting free markets as both the best and most *natural* way to organise social life. Practically, this thinking translates into five key tenets: minimal government intervention, market fundamentalism, risk management, individual responsibility and inevitable inequality (Ericson et al., 2000, cited in Ayo, 2012, p.99). Another fundamental aspect emphasised

[17] For more on neoliberalism as governmentality, see section 2.2.4., p.78

mostly by those looking at neoliberalism from a governmentality perspective, is the intrusion of market rationality into all other spheres of life, and the shaping of responsible, entrepreneurial citizens. Consequently, neoliberalism is not so much about mere deregulation, and more about the creation of free markets, with free individuals expected to behave in a way that makes the free market work.

This rationality has come to guide governance not only at national levels, but also in the ever more globalised international sphere, as illustrated for example in global governance institutions like the World Bank and the International Monetary Fund (IMF). More than just being adopted as a governance rationality, the basic neoliberal premises have gained a status of 'common sense' or 'inevitability' (Peck and Tickell, 2007). At the same time, neoliberalism changes and does not manifest in the same way in different places, which makes it simultaneously an obvious and an elusive, intangible concept. Peck and Tickell (2002) have looked at the transformative and adaptive capacity of neoliberalism, and prefer to think of it as a process – neoliberalisation (Peck and Tickell, 2002). The model they came up with to describe some developments of neoliberalism was the two consecutive phases: 'roll-back' neoliberalisation (anti-regulation) and 'roll-out' (meta-regulation) neoliberalisation. In the first instance in the 70s and 80s, the State was rolled back in countries that embraced neoliberalism, and post-World War II welfare institutions were weakened. This was then followed since the 90s by a 'roll-out' phase along the lines of 'third way neoliberalism'. The new concern was on how to make this governance 'palatable' to the citizens, by presenting it either as an opportunity for responsible citizens, or an inevitability (see also: Sparke, 2020). Neoliberalisation, Peck and Tickell (2002) argue, is difficult to resist because solutions offered to problems induced as a consequence of the roll-back phase, reinforce and are part of the neoliberal project (instead of resisting it). As stated by Peck and Tickell (2002, p.400):

> […]neoliberalism has demonstrated an ability to absorb or displace crisis tendencies, to ride—and capitalize upon—the very economic cycles and localized policy failures that it was complicit in creating, and to erode the foundations upon which generalized or extralocal resistance might be constructed

When trying to study neoliberalism, it can be difficult to describe it without falling into either totalising overgeneralisations or too detailed, contingent accounts that miss out the links.

> This means walking a line of sorts between producing, on the one hand, overgeneralized accounts of a monolithic and omnipresent neoliberalism, which tend to be insufficiently sensitive to its local variability and complex internal constitution, and on the other hand, excessively concrete and contingent analyses of (local) neoliberal strategies, which are inadequately attentive to the substantial connections and necessary characteristics of neoliberalism as an extra-local project (Peck and Tickell, 2002, pp. 381-382).

That same difficulty applies to those interested in looking at neoliberalism and health. Work has been done to look at neoliberalism and health from a global perspective, describing the impact of certain globalisation processes on health. These include international trade liberalisation, the growing concentration of transnational corporate power and the increased mobility of global capital. Simultaneously, research has also looked at the adverse health effects of neoliberal policies like austerity, labour market reforms, welfare reforms, and structural adjustments 'on the ground'. These are of course two sides of the same coin, and arguably these two sides relate to Peck and Tickell's reference to 'walking a fine line' between describing big, general global trends and delving into how these trends translate at a more localised level. At an even more micro-level, and as governmentality, neoliberalism also operates through the responsibilisation of individuals, whereby the imagined solution to the negative health consequences of neoliberal macroeconomic processes are limited to an individualised endeavour of either behaviour modification and/or personalisation of healthcare. Sparke (2016) defines contemporary global health formation as

> the formation of a field of research, intervention and outcomes in which we see micro neoliberal innovations in personalized health risk management frequently being advanced as answers to the destructive legacies of macro neoliberal structural adjustment (p.239).

The following subsections review different parts of the literature critiquing the effects of neoliberalism on public health. It is organised by scale of processes relating neoliberalism to health. Those scales are of course strongly overlapping and fluid, however they can be divided broadly in three levels: the macro-level of global neoliberal processes, the meso-level of local (austerity) policies, and the micro-level of individual responsibilisation and neoliberal governmentality.

2.2.2. Global neoliberal processes

In keeping with a view of health as a human right and health promotion as a far-reaching normative project intended to reduce inequities in health and promote a fair and sustainable approach to increasing the collective wellbeing of the population as a whole (see Chapter One), many scholars have argued that the recent decades of neoliberal economic globalisation have been detrimental to public health, and in particular in relation to NCDs and health inequity. While the health status of many has improved, inequalities in health have worsened. In terms of global processes, Labonté and Schrecker (2007) explain how economic globalisation has affected equity of SDH in the world (Labonté and Schrecker, 2007a, 2007b, 2007c). They define and understand 'globalisation' as first and foremost the creation of a 'global marketplace', as a mostly economic phenomenon driven by powerful interests promoting free trade, and argue that globalisation is asymmetrical and works in favour of the already powerful, exacerbating inequities, including in relation to health (Labonté, et al., 2011).

Hawkes et al (2009) show how processes of economic globalisation, notably the growing power of transnational food corporations, global marketing and trade liberalisation, and foreign direct investments (FDI) have heavily contributed to what is referred to as 'the nutrition transition', i.e. the spread of diet-related NCDs in developing countries that often simultaneously have to deal with malnutrition and micronutrient deficiencies (Hawkes, 2005; Hawkes et al., 2009). Relatedly, Clapp (2016) explains how the financialisation of the food system has had negative effects on population health and has jeopardised people's food security (Clapp, 2016). The work of Lee et al., (2009) outlines the big picture of why the global trade system is relevant to health, and Jarman and Koivusalo (2017) provide an in-depth account of how international trade agreements can have an impact on health and health systems in a complex and indirect way. They show how modern international trade agreements now have a much larger scope (they include aspects like intellectual property rights, public procurement and investor protection), which can have implications for healthcare provision and health system organisation, as well as on safety standards (Jarman and Koivusalo, 2017). Free trade agreements can also introduce strong investor protection mechanisms which can discourage governments from regulating products for public health protection purposes (for example: tobacco or processed foods) (De Ville and Siles-Brügge, 2017). Economic globalisation processes have also been criticised for their lack of

environmental sustainability, which is a public health consequence that asymmetrically affects poorer populations the worst (Labonté and Schrecker, 2007b).

2.2.3. Local austerity policies

Other work has focused more on how these processes translate into lived experiences at a local level. On the topic of nutrition-related ill-health, neoliberalisation has been shown to impact the affordability of healthy diets, increase food poverty, food deserts, and time poverty (Schrecker and Bambra, 2015). Schrecker and Bambra (2015) trace health outcomes like obesity, which is an important risk factor for NCDs, to their root social determinants which, they argue, are inequalities and insecurity. They then go on to explain how those determinants are exacerbated by concrete neoliberal governance, such as austerity policies. They also argue that austerity and stress induced by economic hardship, precarity of employment, and high stress jobs have a concrete impact on health on a public health scale (Schrecker and Bambra, 2015). Indeed there is a growing consensus among critical public health scholars that austerity, beyond failing to adequately redress the economy in the aftermath of economic crises, has harmful effects on public health: Schrecker and Bambra (2015) describe it as the removal of a safety net that strongly affects mental health, including suicide rates, through stress as well as alcohol overconsumption, which is associated with a wide range of physical, mental and social health issues. Overall this body of work stresses the exacerbating impact of austerity on health inequities.

Stuckler and Basu (2013) seek to demonstrate that austerity is *not* the only possible, inevitable answer to an economic crisis. Instead, they argue that implementing austerity measures is an ill-informed, purely ideological, deleterious and counter-productive political choice which neglects the wellbeing of the population, causing human harm while at the same time delaying economic recovery (Stuckler and Basu, 2013). These scholars argue that, more so than economic shocks alone, it is the austerity response in combination with economic crisis and a lack of social protection, that harms population health most severely (Karanikolos et al., 2013; Stuckler et al., 2017). What this suggests is that ill-health and a suffering population is not an inevitable result of an economic crisis, but that the political and policy *response* to the crisis is what either amplifies or amortises the potential increase in disease burden. Kentikelenis et al (2011) provide a bleak account of how the financial crisis and the European response to it, has left the Greek population unable to afford basic

healthcare (Kentikelenis et al., 2011). Schrecker and Bambra (2015) go so far as to claim that NCDs could be thought of as 'communicable' after all, through the geographical spread of neoliberal ideology, which they compare to the spread of an infectious disease. They argue that the harmful health effects of neoliberalism are also transmitted intergenerationally, through the reduction of social mobility resulting from ever deepening social inequalities and the stereotyping/stigmatisation of some social groups, and even through epigenetic factors (i.e. the way in which the environment influences genetic expression) (Schrecker and Bambra, 2015). Echoing a similar rationale, Sell and Williams (2020) talk about a 'structural pathogenesis' to make sense of the relation between political systems and ill-health. Other scholars have taken on the task of analysing the relationship between welfare types and/or political party alliance, and health outcomes. Navarro especially argues that there is a clear and significant link between pro-redistributive political traditions and better health outcomes (Navarro et al., 2006; Navarro and Shi, 2001). While there seems to be a link between unemployment and ill-health, it is mitigated or exacerbated depending on the welfare state model, again showing how eroding social protection is bad for health (Bambra and Eikemo, 2009). Navarro (2009) explicitly links the SDH to neoliberalism, and interprets the latter from a Marxist perspective, i.e. as a coalition of ruling class exploiting the masses (Navarro, 2009).

2.2.4. Individual responsibility and governmentality

Taking a different approach, some scholars look at neoliberalism and health promotion from a governmentality perspective, pointing out the negative and victim-blaming effects of societal pressures to conform to a certain type of healthy lifestyle, without consideration for structural factors that determine the access to such a lifestyle. Such authors highlight the way in which educating and disciplining citizens to behave in a health-conscious way and to aspire to 'healthy lifestyles' illustrates very well what Foucault described as 'governmentality': a technique of governing at a distance that simultaneously promotes individual freedom (by not intervening in citizens' lives too much via regulation) but at the same time disciplines the individuals to 'freely' behave in a way that is deemed responsible (Rose, N. et al., 2006). The considerable issue with a behaviour-centric approach is that it disproportionately emphasises agency and individual responsibility to the detriment of understanding societal, structural factors that shape health outcomes. This, in turn, leads simultaneously to blaming individuals for things that are sometimes entirely out of their

control, and deters from looking at the political, social and macroeconomic 'root' causes of NCDs. This is yet another way in which neoliberal rationality manifests, with the solutions to problems caused by neoliberal governance being displaced onto the level of individuals. In line with the logic of market rationality intruding all other spheres of life, individuals are then disciplined into behaving in a certain 'right' way – i.e. in a way that allows the market to thrive and the economy to grow, which in this case involves adopting a 'healthy lifestyle'. This manifestation of neoliberal power at the micro-level not only deters from considering the political, structural causes of issues such as ill-health, but it also tends to marginalise and stigmatise certain population groups.

Tracing the rationality of health promotion policies focused on targeting change in individual behaviour to neoliberal governmentality, has now become a common argument in the critical health literature (Ayo, 2012; Bell K. and Green, 2016). Crawshaw (2013) relates this behavioural trend to social marketing and the growing involvement of the private sector in health promotion initiatives targeted at educating people and making them behave more healthily (Crawshaw, 2013). Vander Schee (2007, 2009) explores this argument specifically in relation to school-sponsored wellness programmes and shows how they reinforce the responsiblising narrative of the 'self-actualising neoliberal worker' (Vander Schee, 2007, p.870; Vander Schee, 2009). Allender et al. (2006) critically examine health discourses perpetuated through workplace health programmes (Allender et al., 2006). Studies have also looked at how common behaviour-targeting public health messages (for example: recommendations to eat at least 5 portions of fruit and vegetables a day) are received by those who are generally perceived as non-compliant. Even though most people know the message, this research suggests that people are often inclined to resist it, deny it and feel stigmatised by it, which leads them to not follow it. This type of research situates these findings within a governmentality frame and critiques of the individual responsibility narrative (Thompson and Kumar, 2011).

Governmentality and other critical approaches are also drawn upon in the field of fat studies (for more, see: Rothblum and Solovay, 2009), to critically analyse how fat was constructed into a medical problem and the consequences this medicalisation entails (Evans B. and Colls, 2009; Schorb, 2013). According to Schorb (2013), anti-obesity policies are informed by three factors: the medicalisation of fat bodies into an 'obesity epidemic', the rise of 'healthism' (i.e. 'the individualisation of health as a moral duty' [Crawford, 1980, 2006, cited in Cairns and Johnston, 2015, p.156]) and the emphasis put on agency and individual responsibility

that emerged alongside the spread of neoliberalism (Schorb, 2013). In a similar vein, Colls and Evans B. (2014) critically deconstruct the concept of 'obesogenic environment', shedding light on the power and moral implications of this concept as a way of governing bodies and defining the 'pathological body'. They highlight the need to re-theorise the relation between society and nature and promote inclusive, participatory methods that confer a voice to fat people's experiences in their environment, in a way that does not embed weight by default in a narrative of illness (Colls and Evans B., 2014). LeBesco (2011) relates the problem of obesogenic environments to the individual responsibility narrative and the neoliberal underpinnings of that discourse (LeBesco, 2011). Guthman and DuPuis (2006) make a case for conceptualising obesity as an embodiment of the contradictions of neoliberal capitalism. They argue that capital accumulation in our modern globalised world, in which production and consumption is often geographically separated, can take the form of accumulation in the body (Guthman and DuPuis, 2006). Combining governmentality with a feminist lens, Cairns and Johnston (2015) provide a nuanced analysis of the contemporary tensions at play between femininity, food choices and healthy eating behaviour, and neoliberalism. They identify a new type of expectation directed at women and their food choices which is no longer phrased in terms of 'restriction and vanity', but is phrased in terms of empowerment and choosing health, which is what they refer to as the 'do-diet'. They assess this discourse as – in theory – apt to resolve the neoliberal tensions between choices and consumption, versus discipline and self-control. However, they show how this requires a 'calibration', balancing act from women, who need to appear both in control, but without trying too hard (Cairns and Johnston, 2015).

This brief, non-exhaustive introduction to the literature on health and neoliberalism sheds valuable light on the politics of health and health promotion, and how population health is, to a large extent, a matter of political power dynamics and ideology. As demonstrated above, the link between neoliberal ideology and population ill-health is well-documented. What this means is that recognising neoliberalism as a determinant of population ill-health is entirely justified, and indeed long overdue. The sections above suggest that neoliberalism can be considered a *distal* and *proximal* determinant, given that it affects population's health in both indirect and direct manners, and at all levels – from high political spheres to very intimate everyday practices. For simplicity, this thesis will use the term 'distal determinant of health' and refer to 'political determinants of health', when talking about neoliberal biases as obstacles to HiAP. This is because the thesis focuses on health mainstreaming in governance

rationality. However, as suggested above, neoliberalism is more than solely a *distal* determinant of health.

The purpose of this thesis is not to see *if* neoliberalism affects population health, given the existence of a vast literature on this topic. Rather, this thesis takes that relationship as a given, and is about understanding *how* neoliberalism restricts the space for mainstreaming health in EU governance. Recognising neoliberalism as a determinant of (ill-)health should lead to a radical reconceptualisation of 'health promotion'. Indeed, health promotion in light of this level of understanding of complexity stemming from the political science of health scholarship, is strongly normative and should include any approach which challenges neoliberal orthodoxy to instead promote social and environmental justice, equity, population wellbeing and sustainability. Health promotion becomes about prioritising social and environmental equity and sustainability, over economic growth and market liberalisation. This does not mean that both are necessarily always mutually exclusive, but that the economy needs to serve the purpose of social wellbeing and environmental sustainability, rather than the other way around.

2.3. Researching HiAP in the EU: a critical approach

One of the main contributions of this thesis lies in bringing together the two literatures introduced above: the literature on EU health and the broad critical literature on health and neoliberalism. This thesis contributes to the literature on EU health by bringing in a broader, more radical conceptualisation of health promotion stemming from the literature highlighting the links between neoliberalism and ill-health. By extension, this also highlights the inherently political, normative nature of public health and health promotion. The remainder of this chapter will now be concerned with the questions of how to approach the political study of HiAP defined in such a broad way and applied to a complex institutional setting like the EU. Together with Chapter Three, it will clarify the relation between the literature and theory, and the empirical chapters.

The empirical investigation in this thesis is concerned with critically analysing the obstacles - in the shape of neoliberal manifestations – to a (normatively meaningful) HiAP uptake at EU level, as well as the spaces for contestation of neoliberalism that HiAP offers. Given the ontological and epistemological positioning of this thesis, this analysis does not seek to

demonstrate any 'objective' causal link. Rather, the explanations developed are constitutive and particularistic (which does not preclude the possibility that similar dynamics take place in other institutional contexts, outside the EU setting). Rather than taking it as a 'neoliberalism versus HiAP' dichotomy, the idea is to seek to better understand how neoliberal discourses and meanings are reproduced and how that, in turn, shapes the meaning of HiAP.

The relationship between EU governance and health, as already suggested in the first part of this chapter, is complicated. Because of the institutional make-up of the EU, its evolution and history, it is a complicated relationship even if one adopts a narrow definition of health (as limited to healthcare and health systems). With a broad definition of health promotion according to which neoliberalism ought to be seen as a determinant of ill-health, studying HiAP in the EU becomes even messier. This is why this thesis does not aim to provide a comprehensive, all-encompassing 'snapshot' of its research object, and instead relies on various analytical frames to critically investigate the space for HiAP within various aspects of EU governance. The following subsections will stress two elements pertaining to how HiAP will be studied in this thesis; HiAP as a process involving meaning-making, rather than a fixed state; and HiAP defined using a radically broad conceptualisation of health promotion.

2.3.1. A 'radical' conceptualisation of health promotion

One of the purposes of this chapter has been to justify a fundamental premise of this thesis, which is to take as a starting point a 'radically broad' definition of health promotion. A growing group of researchers look specifically at political determinants of health, at the role of power and political ideology in determining health inequity. By reviewing the research that points out the links between political-economic processes and health, this has made the case for health promotion to be understood beyond narrowly defined behaviour-focused policies. Instead, the 'radically broad' health promotion put forward in this thesis is accompanied by a normative vision which fosters a more just and equal society as a whole. This vision is consistent with HiAP as described in Chapter One. The points raised in this chapter have provided more context and explanation on what was the described as the 'normative vision'-side of the dually technical and normative HiAP project (see section 1.3., p. 51).

When EU health researchers talk about the impact of 'other EU areas on health', what is often referred to is spill over. That is, the Single Market governance impacts on pharmaceuticals and medical devices, on patients' and health professionals' mobility, and how these constrain the capacity to take decisions on health systems at home. Similarly, Greer's third face of EU involvement in health (through fiscal governance) tends to be thought of as limited to the EU meddling in national health system budgets under the pretext of the SGP. While this is important, intuitive and easily justifiable, one core argument upon which the remainder of this thesis rests, is that this way of relating health to other EU policy areas is too narrow. Indeed, to better understand the effects of distal determinants of health, it is necessary to embrace their complexity and political nature. The relationship between EU fiscal governance and health, for example, should not be intellectually limited to national health system budget reduction (even though this is an important, obvious and direct link), but needs to be extended to the whole palette of austerity measures (Karanikolos et al., 2013; Stuckler et al., 2017). The same applies to the second face of EU health involvement: the impact of Single Market integration on health should not be thought of as limited to direct encroachment on healthcare related goods and services, but more broadly, any manifestation of political rationality which exacerbates societal inequities that should be considered harmful to health, essentially echoing the need to emphasise and expose the relationship between neoliberal rationality and ill-health – including with respect to NCDs. As for Greer's first face, i.e. engagement in public health through public health policies, it is important to analyse the kinds of paradigms and frames about health that these tools normalise and institutionalise. The thesis thus takes as its starting premise a radically broad conceptualisation of health promotion. This health promotion starting point resonates with what some have termed the promotion of a 'wellbeing economy' (see for example: Gough, 2017)[18]. The choice in this thesis is made to stick with the reference to 'health promotion', because it coincides better with Article 168.

2.3.2. HiAP as a meaning-making process

While its implementation and uptake has not been successful (yet), HiAP and a general sense of what distal determinants of health are, did make its way to parts of the EU institutions. But to better understand the power that plays out in relation to health mainstreaming and what happens to HiAP as a mainstreaming process in the EU, we need to look at the interplay

[18] For more on the use of the terms wellbeing, see section 6.3.1., p.188

between regularity and idiosyncrasy, between path-dependency and contingency and, more fundamentally, we need to look at how meanings are produced and reproduced (Bacchi and Eveline, 2010). This is why this thesis looks at how meanings attached to certain concepts, and the practices of creating knowledge, constitute power which shapes, in an ever evolving way, the essence of concepts (in this case 'HiAP') by shaping what is 'thinkable' and 'sayable'. In other words, HiAP needs to be studied as a process, and this requires a particular approach. As noted by Jacquot (2010) in relation to EU gender mainstreaming: 'In order to trace the effects of mainly soft, informal, and cognitive instruments like gender mainstreaming, analysis cannot be reduced to a focus on traditional, vertical and regulatory change' (Jacquot, 2010, p.132).

In turn, rather than looking at the state of play and listing all health inclusions one after the other, the analysis in this thesis focuses on the fluid process *in motion* that is mainstreaming. This is why, in addition to considering hard and soft governance spaces, the meta-regulatory governance is important too, because it is overarching and moves across the board (see section below). The reference to a process in motion refers to mainstreaming in a multiplicity of directions: mainstreaming health within DG SANTE, mainstreaming health within the EC, mainstreaming health in the EU – member states relationship. These various 'directions' of mainstreaming remain an underlying consideration throughout the empirical chapters. In Chapter Six, HiAP mainstreaming will be critically analysed in terms of a 'meta-instrument' for policy, a governing technology (Halpern et al., 2014). The focus of that chapter will be to analyse how HiAP as a mainstreaming tool, develops 'a life of its own': how it differs nowadays in the EU, compared to perhaps more 'vernacular' meanings and usages of HiAP elsewhere and at a different time, and how its meaning is an ever-evolving site of power struggle. That chapter, because of its focus on the non-fixed nature of meanings, explores spaces for contestation and agency, suggesting that the idea's 'lives of its own' does not develop in a vacuum, but via active discursive practices. Chapter Five, on the other hand, aims to unravel and expose the existing dominant ideational structures to which HiAP is confronted when it enters the EU space.

2.4. Researching HiAP in the EU: mapping the territory

The empirical chapters of this thesis will have to cover a very large ground in terms of regulatory and policy areas, and in terms of 'governance types'. This is the inevitable

consequence of studying a concept that is supposed to be mainstreamed across the board. In addition, and as outlined above, this thesis takes a very broad definition of 'health promotion', which justifies looking beyond policy areas traditionally associated with health promotion. This breadth requires first and foremost a clear and simple overview. This section aims to provide this overview. It will present a categorisation of three EC governance types: hard governance, soft governance, and meta-regulatory governance. The differentiation between 'hard' and 'soft' EU governance is widely drawn upon and relates to Scharpf concepts of negative and positive integration, and constitutional asymmetry (Greer, 2014a). In addition to the soft/hard divide, this thesis argues for the importance of a third category: meta-regulatory governance (Radaelli, 2007).

Hard Governance	Soft Governance	Meta-regulatory Governance
• The Single European Market • European fiscal governance: the SGP reforms	• New Modes of Governance	• The Better Regulation Agenda • The collegiality principle

Table 2.1. EU governance areas by EU governance types

Bearing these three categories in mind will be important to understand the empirical chapters and how each of them are relevant to HiAP. Even though the empirical analysis will demonstrate the need to look beyond the soft/hard dichotomy, the soft/hard/and meta-classification is nevertheless a useful notion to orient oneself within the EU governance sphere: Chapter Four follows the soft/hard/meta classification closely, whereas Chapters Five and Six argue for the need to look beyond these kinds of institutional power differentials and instead focus also on ideational forms of power.

While the three-face categorisation is very useful[19] and particularly well-adapted to studying healthcare-related policy in the EU, it does not entirely fit in a context of studying HiAP. Indeed, studying HiAP in the EU is not so much about 'how do non-health EU competencies spill over into the health sector and in turn affect health', but more about 'how do non-health EU competencies affect distal (political, social and economic) determinants of population health themselves'. In other words, the critical EU health literature argues that 'EU health

[19] The 'three face logic' will be built on in Chapter Four

policy is about economics', whereas this thesis analyses 'why EU economic policy is detrimental to health'. It then becomes necessary to go beyond the three-face categorisation that considers only soft and hard governance styles, to also look at the EU meta-regulatory agenda.

2.4.1. 'Hard' governance

Hard governance refers mostly to EU exclusive (and shared) competencies, and any areas of EU governance in which the EU exerts power, in a legally-binding, sanctionable way. In this section, examples of hard governance presented are Single Market integration, and European fiscal governance (especially since the Eurozone crisis). Both these areas mostly pertain to economic affairs as opposed to social affairs – even though arguably the European Semester can be seen as a link between the two.

2.4.1.1. The Single European Market

One of the main aspects of EU integration has been the drive to create a single European market. This started with the creation of a customs union and the gradual removal of tariff barriers, and later also non-tariff barriers, between member states. The idea of a Single Market is associated with the famous 'indivisible four freedoms' principle enshrined the treaties: freedom of movement of goods, services, capital and labour. DG GROW is the DG responsible for the internal market, industry, entrepreneurship and SMEs. Its task is to integrate the Single Market and remove barriers to trade. It aims to unleash 'the full potential' of EU businesses and offer more choice and freedom to consumers, while promoting economic growth. Proponents of the Single Market emphasise how high consumer protection standards have allowed the Single Market to increase consumer choice, lower prices while safeguarding safety and quality standards (including in food safety), making those standards the EU market distinctive brand (European Parliament, 2018). The 'hard', binding instruments at the disposal of the EU for pushing Single Market integration are mostly regulations and directives. Regulations are directly applicable, whereas directives need to be transposed into national legislation (European Union, 2004a).

Critics of the Single Market have pointed out pressures from the EU to open up and liberalise national services such as healthcare, and public transport among other things (Buch-Hansen

and Wigger, 2010; Hall, 2002; Héritier, 2001; Van Apeldoorn and Horn, 2018). The Single Market has also been criticised for challenging national public health policies deemed unfair trade barriers, notably alcohol policies in Nordic countries (see p.49). Many Single Market-related acts are directives, which means they set out a goal, and member states are free to decide how they will transpose it into national legislation. This can give considerable discretion in interpreting and implementing Single Market policies. *Some* of those member states generally reluctant to embrace neoliberal governance have been broadly able to protect their national services from 'wild' deregulation[20], albeit not without hard work and negotiation (Melkas, 2013). A newer aspect of the Single Market which is growing in importance since the Juncker Commission is the 'Digital' Single Market. The idea of the Digital Single Market is to boost and remove barriers to e-commerce within the EU, jumping on the big data analytics bandwagon, improving digital facilities, and improving consumer data protection (European Commission, 2015a).

2.4.1.2. European fiscal governance: the SGP reforms

The EU adopts a hard governance stance when it comes to economic governance and the coordination of the economic and monetary union of the EU, especially since the Eurozone crisis. If the initial EU project was about creating a Single Market and removing barriers to the free movement of capital, goods, services and people within that market, the creation of the EMU has increasingly developed an important additional area of integration and coordination. The stronger interdependence between member states resulting from the EMU led to the adoption of the SGP. The purpose of the SGP is to ensure all member states aim to keep their national debt and deficit below a certain threshold, to ensure the stability and economic convergence of member states. After the Eurozone crisis, (some) member states decided the mechanisms to ensure compliance with the SGP should be tightened. This led to the so-called six-pack and two-pack reforms of 2011 and 2013. These reforms consist of a set of preventive and corrective, binding measures that empower the EC and the Council to shape national fiscal governance in a way that they see will fit with the SGP.

One of the preventive tools that was introduced during the post-2008 fiscal reform is the European Semester. The European Semester is a cyclical policy coordination tool that assesses and coordinates the fiscal governance and sustainability of member states. It starts in

[20] While this may be the case for the Nordic member states, it is not necessarily so for Mediterranean countries most affected by the crisis (see: Greer, 2014b).

October: before the submission of member states' budgets to national parliaments, member states submit their draft national budget to the EC. At that stage, the EC can ask member states to redraft their budget if it considers that it is incompatible with the SGP. In November, the EC publishes the EU yearly budgetary priorities (which includes the 'Annual growth survey'), the direction of which are already set out in the 7-year MFF. At this stage the EC also publishes a report that flags up potential 'macroeconomic imbalances' that may result from member states' national budget plans, singling out those member states that will require 'in-depth review'. In March, the Council adopts the EU economic priorities based on the EC's reports. After that, in April, member states need to submit their fiscal plans and national reform programmes for the EC to review. National reform programmes are aimed at incorporating EU 2020 priorities at member state level and setting out a plan to reach EU targets, such as reducing unemployment, for example. Some of these targets were agreed in a soft governance setting, and are now incorporated in the EU Semester process, which is why the Semester is seen as the link between soft EU 'social' governance and hard EU economic governance, subordinating the former to the latter (Greer et al., 2014).

Based on the scrutiny of the national fiscal plans and reform programmes, the EC elaborates 'country specific recommendations' (CSR), all with the view to ensuring member states align with the SGP. The CSR are then endorsed by the Council, discussed and adopted by the DG responsible for economic and financial affairs (DG ECFIN). While the Semester represents the 'preventive' arm of the fiscal compact, it does not preclude the possibility of sanctions for non-compliance (Delors et al, 2011; Köhler-Töglhofer, 2011; Savage and Howarth, 2017; Verdun and Zeitlin, 2017). Out of all the fiscal governance reforms and mechanisms to ensure compliance with the SGP, the Semester has been said to represent the 'softest' of tools. However, EU fiscal coordination as a whole should be considered in the category of hard governance because it is binding, and sanctions are applied in case of non-compliance. Greer has compared these tools to the structural adjustment programmes imposed on developing countries in the 1980s and 90s (Greer, 2014b). The Semester might seem a softer tool at first sight, but because of its interlinkage with the other coordinating mechanisms, the degree to which the Semester represents merely a voluntary nudging tool is highly contentious.

2.4.2. ‘Soft’ governance

Soft governance refers to areas of governance in which the EU generally has only supportive (and shared) competencies and uses non-binding, voluntary means to promote integration. Those governing means have been referred to as ‘new modes of governance’ (NMG). This section will elaborate on the NMG. Broadly speaking, hard governance is more widespread in economic areas of governance, and soft governance is more widespread in social areas of governance, which again is a consequence and cause of the maintenance of constitutional asymmetry (see section 2.1.1.1., p.63). As such, the EU does not only regulate using hard law and binding coordination tools. Much of the EU’s activity, and most of that in the area of social governance and shared/supportive competencies, takes a much ‘softer’ approach, one that is not binding and ‘coercive’ in the way laws are, but that still shapes governance fields and topics in more subtle ways. According to some scholars (see for example Radaelli, 2003; Schäfer, 2004), soft governance results from the ultimate EU drive to seek convergence between member states, but in places where the EU does not have clear treaty bases. Where the EU does not have exclusive competence, promoting convergence can happen through coordinated learning, for example through common research and innovation agenda, and through the tools of NMG.

2.4.2.1. New modes of governance

After the Maastricht treaty in 1992 and the creation of the EMU, the EU’s governance areas were considerably extended to economic and social issues, including public health. However, the latter could not be done by applying the same ‘supranational legislative’ Community Methods that had existed previously (notably for the Single Market), because the Treaty basis was too weak, and member states re-emphasised the importance of subsidiarity (Bruno et al., 2006). The early 1990s thus represented a time of further EU integration under the context of growing EU scepticism, including towards the single currency project, CAP reforms and the extension of EU competences to social areas (Bache et al., 2015). This ‘legitimacy crisis’ led the EU to creatively come up with other tools and modes of governance that would allow the EU project to be perceived as more democratically legitimate. This context is associated with the development of the NMG (Borrás and Jacobsson, 2004). NMG are soft, non-binding, and are more concerned with coordinating, steering and producing subjects than with dominating and coercing subjects. In attempting to promote a ‘participatory’ kind of governance, deemed

more legitimate, these NMG also tend to bring every sector of society together, blurring the lines between the governing and the governed (Kohler-Koch and Rittberger, 2006). Generally speaking, NMG relies on voluntary cooperation and dialogue between stakeholders from all different sectors, including the public, private and voluntary sectors. The idea is to 'get everyone involved' to work towards common goals (commonly accepted by all, such as economic growth promotion, competition, but also social goals like good health or reduced inequalities) and to learn from each other and develop 'best practices'. Governing structures facilitate cooperation by offering a platform for dialogue and coordination (Eberlein and Kerwer, 2004). A key underlying assumption of NMG is that collaboration will lead to more efficient and more legitimate outcomes. There is also an anticipated peer pressure effect which would incentivise industry to commit to socially responsible behaviour. This rationale was pushed in particular by technocratic EU bodies like the EC, as opposed to the EP (which, in line with the institution's interest, takes a view on democratic legitimacy as strengthened through more power for elected representatives) (Smismans, 2003). In the case of the EU, the soft governance turn can be understood in relation to the commitments to increased participation and perhaps as a result of 'democratic experimentation'. The process of designing and using NMG further gained strength with the Lisbon Treaty (Diedrichs et al., 2011).

One of the most European 'democratic experiments' illustrating NMG is the OMC. The OMC is a tool of the Lisbon strategy. It is a form of soft law-making framework in which member states' representatives exchange best practices, set benchmarks, and develop measurement indicators to tackle social issues which fall under member states' competence. The idea is that member states can learn from each other, learn from their differences and similarities and work together (Sabel and Zeitlin, 2008). The member states are expected to evaluate each other and learn from each other. The process is supervised by the EC, which does not directly intervene, and the outcomes are not legally binding (even though now they can be directly related to the EU fiscal governance, as suggested above). The OMC does not involve other EU institutions such as the EP or CJEU (EUR-Lex, n.d.). The literature on the OMC is vast, but largely concentrated on the employment and pensions OMC. Vanhercke and Wegener (2016) have looked at the health care dimension of the Social OMC. What they identified, beyond the usefulness of having a platform for discussion and being able to compare health care policies between countries, was a lack of concrete impact of the process on actual member state policymaking, which the authors attributed to an absence of sense of ownership of the OMC and actor rivalry within the health care policy field (Vanhercke and

Wegener, 2016). There is an OMC-*like* platform for member states' representatives to discuss public health promotion and NCD prevention: the HLG (see section 4.1.2., p.125). It is not an OMC *per se*, however the concept presents some similarity with OMCs insofar as member states' representatives come together to discuss ideas and exchange knowledge and experiences about health promotion and NCD prevention around healthy diet and physical activity promotion in particular.

2.4.3. 'Meta-regulatory' governance

Meta-regulatory governance transcends the soft/hard divide and relates to 'the governance of governance'. Meta-regulatory governance relates to guidelines and processes about regulatory and decision-making processes. As such, it shapes the overall vision of the EU at the highest level, perhaps in the most influential but also least 'tangible' way. This section introduces the Better Regulation agenda and the collegiality principle of the EC as meta-regulatory governance tools.

As will be detailed below (p.93), the EC shares a collective responsibility for its actions, and has an obligation to follow the political guidelines established by the EC president (European Commission, 2000a, p.2). Any major decision (such as initiating new legislation or revising existing legislation, for example) needs to be approved by a simple majority in the College (European Commission, 2014a, p.4). The Juncker Commission working method emphasised the need for the EC to work closely together, to improve the coherence and efficiency of EC actions where action is necessary, while moving away from action deemed less necessary – based on evaluations of EU added value. Its priorities were the following:

> a new boost for jobs, growth and investment, notably by means of a EUR 300bn investment plan; a connected Digital Single Market; a resilient European Energy Union with a forward-looking climate change policy; a deeper and fairer Internal Market with a strengthened industrial base, including a Capital Markets Union and based on the principle that the same work at the same place should be remunerated in the same manner; a deeper and fairer Economic and Monetary Union in which social dialogue is given new importance; a reasonable and balanced free trade agreement with the United States; an area of justice and fundamental rights based on mutual trust; a new EU policy on migration; making the EU a stronger global actor; and bringing about a Union of democratic change (European Commission, 2014a, p.2).

2.4.3.1. The Better Regulation Agenda

One of the most important priorities set up to work towards these goals in the EC in terms of *way of working* is the implementation, across the board, of an agenda called Better Regulation. Better Regulation is a regulatory process agenda which dates back to the 1990s, but has gained strength over the last two decades in particular. It is a strongly present theme in both the Lisbon agenda and the Europe 2020 agenda. Better Regulation is part of a broader governance make-over which aims to simplify regulations by repealing outdated ones, cutting red tape and diversifying governance tools, favouring especially the use of non-binding tools.

Better Regulation can be seen as a meta-regulation (Radaelli, 2007) with the ambition to 'improve' and simplify the regulatory process. As meta-regulation, it presents structural and discursive properties. 'Better Regulation is a type of meta-regulation because of its emphasis on standards and rules which, instead of governing specific sectors or economic actors, steer the process of rule formulation, adoption, enforcement and evaluation' (Radaelli, 2007 p.191). It is based on the principle that the EU should focus its actions on areas where it has the greatest added value, and that its involvement should be as minimal as possible without compromising the policy objectives (European Commission, 2015b). Better Regulation, according to the EC, is about ensuring that the EU rules are 'fit for purpose, modern, effective, proportionate, operational and as simple as possible' (European Commission, 2015c, p.4). The Better Regulation agenda includes various tools, which reflect the agenda's rationale for regulatory processes: impact assessment (IA), stakeholder consultation and ex-post evaluations (European Commission, 2015b). The Better Regulation documents put an emphasis on evidence, and suggest that more openness of the regulatory process will lead to better evidence-informed regulations, through stakeholder consultations and IA (European Commission, 2015c). These tools were already important in the EU regulatory processes before the Better Regulation agenda gained traction, however the Juncker Commission's aim was to mainstream this agenda deeply and across the board, 'embedding Better Regulation in the Commission's DNA' (European Commission, 2017c, p.2). The 'Better Regulation for better results' document also emphasises the necessity for other institutions to embrace and adopt the Better Regulation agenda, including the EP, the Council and member states more generally. Better Regulation is also about continuous assessment of the quality and adequacy of existing regulations. For this purpose, the EC developed the Regulatory Fitness and Performance (REFIT) Programme. The idea of REFIT is to modernise and update existing EU laws and regulations by targeting unnecessary burden, quantitatively estimating the cost

that could be saved by optimising the regulation, and embedding the REFIT tool into the EU political landscape (European Commission, 2015c).

In summary, the Better Regulation logic underpins and permeates all the EC's work[21]. It is based on three pillars: IA, stakeholder consultation, and regulatory evaluation cycles to identify unnecessary 'red tape' that can be cut (European Commission, 2017c). Better regulation covers the whole policy cycle – planning, adoption, design, implementation, application (including enforcement), evaluation and revision. (European Commission, 2017d, p.6).

2.4.3.2. The collegiality principle

The EC has agenda-setting and executive power, its role as the 'guardian of the treaty' includes a responsibility to interpret the TFEU. The EC is divided in two main sections, the College of Commissioners, which represents the political leadership of the EC and is appointed for five years, and various DGs, each headed by one Commissioner, which are the technical, supportive bodies of the EC. Each DG deals with a particular policy area, however they are supposed to work together and make decisions with one single voice. This is part of the reason why certain commissioners have a 'vice president' role. This means that their portfolio has a coordination element that cuts across the various DGs (European Commission, 2017b). Under the Juncker Commission (2014-2019) the DG in charge of health and food safety was abbreviated DG SANTE and was headed by Lithuanian Commissioner Vytenis Andriukaitis. The First Vice-President was Dutch politician Frans Timmermans, who was in charge, among other things, of coordinating the implementation of the Better Regulation Agenda across the EC (European Commission, 2019a). The collegiality principle is still very much emphasised under the new von der Leyen presidency, however it must be stated that the priorities and political directions have changed, in comparison to the Junker Commission. Frans Timmermans, for example, is still First Vice-President, however his responsibilities are now centred more around implementing the European Green Deal (European Commission, 2019h; see also: section 6.2., p.198).

The EC then works as a united block, and every Commissioner is equally responsible for any EC decision. This is what is meant by the concept of 'collegiality'. The collegial decision-making process is based on regular (weekly) meetings of the College, as well as meetings of

[21] Better Regulation also extends beyond the EC (see: European Commission, 2015b)

the heads of cabinets to prepare the work. Beyond decision making, the College also uses 'orientation debates', which are meta-regulatory debates meant to set the framework within which proposals should be developed and which reflect the broad, strategic political guidelines of the EC. As explained in the EC Working Method document (European Commission, 2014a), the President does not consider new proposals unless they have been recommended by at least one of the Vice-Presidents, 'on the basis of sound argument and a clear narrative that is coherent with the priority projects of the Political Guidelines' (p.5). As part of the collegiality requirement of the EC, inter-service consultations are launched by the relevant Commissioner and in agreement with a Vice-President, on any major initiative or proposal, prior to the political decision-making process. The consultation process is likely to feature the analysis of an IA (European Commission, 2009a, 2014a).

2.5. Conclusion: A broader relationship between the EU, health and neoliberalism

The purpose of this chapter has been to introduce the various literatures within which this thesis is situated, to clarify where this thesis is positioned within them, and how it will contribute to them. Presenting the literatures on EU health and the critical literatures on neoliberalism and health, it has set the scene for the case of bringing both together. It sought to conceptualise the relationship between EU health and neoliberalism much more broadly than is generally currently done by defining what constitutes health promotion much more broadly (based on a recognition that neoliberalism is a determinant of ill-health). Relatedly, it pointed to the need to explore reproduction of neoliberalism beyond the spill over narratives, and instead as present both in institutional architecture as well as in ideational and discursive frames and paradigms shaping what is thinkable and sayable in health promotion.

Given the breadth of scope of this study, and given the DI framework applied in this thesis (see next chapter), one empirical chapter (Chapter Four) will approach the analysis of HiAP in the EU focusing on institutional power, whereas the other two empirical chapters (Chapters Five and Six) will focus on different manifestations of ideational power. To set the scene for Chapter Four in particular, the last part of this chapter has presented the soft/hard/meta- categorisation of EU governance, in order to better navigate the vast territory on which the study of HiAP and neoliberal obstacles to HiAP is now applicable. To set the scene for Chapters Five and Six, this chapter also clarified its emphasis on HiAP as a

meaning-making process, which needs to be contextualised within dominant ideational structures, where these processes either challenge or reproduce ideational orthodoxy.

The next chapter presents the DI theoretical framework used in this thesis, and justifies how and why DI will be used to study the political/neoliberal obstacles to a HiAP approach in the EU, as well as to explore the agency spaces for resistance and contestation.

CHAPTER 3: Theoretical framework - Discursive Institutionalism

So far, the thesis has established what HiAP is and why this approach is needed (in Chapter One), as well as why it is worth looking at it in relation to neoliberal ideology, and in particular in the EU context (in Chapter Two). Additionally, the end of Chapter Two has reflected upon various challenges to looking at HiAP in the EU, first in terms of how broadly HiAP and health promotion is defined, and secondly in terms of how vast and complex the EU institution is. To address these difficulties, the thesis will take a view of HiAP as a meaning-making process, and of EU governance as divisible into broadly three categories: soft-, hard-, and meta-regulatory governance. This chapter will now explain how these elements fit together within one overarching theoretical framework.

This chapter introduces the overarching theoretical framework that guides the thesis' empirical chapters. This framework is Vivien Schmidt's discursive institutionalism (DI). First, the chapter introduces DI, and explains the various most relevant elements of it: a focus on the power of ideas to bring about endogenous change (or continuity) in institutions, categorised in different ways; a conceptualisation of institutions as socially constructed; and a need – in order to make sense of institutional change and continuity – to take into account three *overlapping and co-constitutive* elements: the institutional context, background ideational abilities which constrain and shape the way in which the world is made sense of, and foreground discursive abilities of agents in institutions, which can have the capacity to articulate a discourse critical (or not) of their own institutions. Importantly, these three elements are seen as overlapping and co-constituted. Ultimately, DI allows for a sophisticated analysis of institutional change and continuity, in a way that aims to avoid over-emphasising individual agency (i.e. to understand the structural constrains beyond simply institutional ones), but without falling into overly deterministic accounts of institutions. The relative emphases on these different aspects, according to Schmidt, is up the researcher to position themselves towards, as she sees her framework as a broad umbrella framework capable of including different types of research.

The second section of this chapter explains why DI is an appropriate framework to use in the context of this thesis, drawing on existing empirical applications of DI, but also very much outlining in what ways this particular use of DI will differ from many previous ones. Most

importantly, that section will justify why this thesis takes a more structurally oriented approach to DI, and to do so, redefines the background ideational element as *structures* rather than abilities. Finally, the third part of this chapter sets out exactly how DI will be applied in this thesis. This last section provides overviews and figures to clarify the purpose of each of the three empirical chapters, and which additional concepts they each use in order to zoom into their respective element of DI (institutional context, background ideational structures, foreground discursive abilities). This, with the ultimate aim to make sense of HiAP in the EU: to make sense of why it has failed to bring about fundamental change, but also why it is still a non-negligible concept.

3.1. Introducing Discursive Institutionalism

DI is a group of theoretical approaches which aim to evaluate the role of ideas, discourse and institutions to understand institutional change and continuity. For Schmidt, DI can be defined as 'an umbrella concept for approaches that concern themselves with the substantive content of ideas and the interactive processes of discourse in institutional context.' (Schmidt, 2015, p.1). DI is a label that can be attributed to any research which is concerned with the study of the interplay between ideas and discourses within an institutional context (Schmidt, 2017a). Schmidt makes it very clear that her 'family' of institutionalism is an inclusive one, which can even host varying ontological and epistemological standpoints (Schmidt, 2017a), and provides a vast overview of various work which she considers discursive institutionalist (Schmidt, 2015).

The shift towards ideas and discourse stems from an increasingly felt need to 'endogenize institutional change' (Schmidt, 2010a, p.2). Since the nineties especially, new institutionalism has become an increasingly popular group of theory used to explain the functioning of the EU, with a focus on the concept of governance (instead of thinking about the EU in terms of state-centric IR theories that rigidly delineate the national from the international/supranational, see section 2.1.1., p.62). The term 'new institutionalism' commonly refers to three variants of institutionalism: rational choice institutionalism, historical institutionalism, and sociological institutionalism. As Schmidt explains, these institutionalisms all have a tendency to conceptualise institutions as rigid, inert and constraining structures. This means that, according to those approaches, institutional continuity is the norm, and changes tend to happen as a result of exogenous shocks. Rational choice institutionalism, for example, considers the agency of actors within institutions as

being guided by rational interest calculations. This theoretical approach is based on the idea that institutions represent 'rules of the game', and that actors within these structural constrains behave in a (predictable) way that seeks to maximise their interests (Pollack, 2006). Historical institutionalism focuses on the historical, path-dependent developments of institutions. This specific variant of institutionalism has been extensively used to analyse the EU (Bulmer, 1994, 1998, 2009; Risse-Kappen, 1996), including to understand the EU's response to the Eurozone crisis (Verdun, 2015). Historical institutionalism analyses how possibilities arising, and choices made during so-called 'critical junctures' set the path and shape the future developments of the institution over the long term through path-dependencies. Finally, sociological institutionalism looks at norm internalisation, organisational culture, the notion of 'appropriateness', to understand how institutions function, how they are socially constructed and reproduced (Niemann and Mak, 2010). Looking at the role of the EP and the perceived democratic deficit of the EU, Goetze and Rittberger (2010) made the sociological institutionalist argument that 'political elites have become "entrapped" […] in a behavioural mode that makes the institutional democratization of the EU by empowering the EP a "matter of habit"' (p.51).

Overall, the move from new institutionalism towards discursive and ideational considerations is a response to the (arguably) overly deterministic nature of new institutionalism as a group of theories (Gorges, 2001; Schmidt, 2010a). This constructivist take on institutionalism, including DI, rejects both the idea that agents existing within institutions are rational actors with predictable, rational interests, and the idea that institutional evolution is necessarily historically or culturally pre-determined (Blyth, 2002; Hay, 2010). Sociological institutionalism is perhaps the more naturally fitting type of institutionalism to take a discursive turn. The difference between sociological institutionalism and DI, Schmidt explains, depends on how ideas are conceptualised, more or less fluid, or more or less culturally pre-determined (Schmidt, 2010a). Arguably, scholars from all three new institutionalism strands have been gradually incorporating more and more of a focus on ideas and discourse, whether they officially decided to rebrand their institutionalism or not. As such, elements of different institutionalisms can inform each other, and the boundaries between different variants can be fluid (ontological differences notwithstanding).

One of the key tenets of DI, as suggested above, is the focus on ideational power. Ideational power is defined in that context as 'the capacity of actors (whether individual or collective) to influence other actors' normative and cognitive beliefs through the use of ideational

elements' (Carstensen and Schmidt, 2016, p.321). This can take place in different ways, such as with power *though* ideas, power *over* ideas, and power *in* ideas. Ideational power can thus mean various things simultaneously: power *through* ideas refers to mechanisms like persuasion, and the ability to challenge others to think outside their 'institutional box'. Power *over* ideas, the authors explain, represents the power to attribute and define the meaning of ideas. Power *in* ideas represent the authority that certain ideas have, whereas others become dismissed out of hand, and are not even discussed. Depoliticisation, for example, is one form of power *in* ideas (Carstensen and Schmidt, 2016). In addition to forms of ideational power, *institutional* and *coercive* power are also cited as forms of power that contribute to explaining how institutional change and continuity takes place. This is because, while DI focuses on the role of ideas and discourses, it is not oblivious to other kinds of power dynamics. While it conceptualises institutions as socially constructed and fluid, it does not reduce them to something entirely detached from material reality.

Looking at each of these types of power goes beyond the scope of this thesis. In this thesis' empirical chapters, the focus will be on *institutional* power, power *in* ideas, and power *over* ideas respectively. Power *through* ideas, which is the third type of ideational power categorised by Schmidt, will be analysed alongside the other 'agential' power *over* ideas. This choice is justified based on the ontological position of this thesis, and the remaining of this chapter will explore the rationale, trade-offs and implications entailed by this choice.

To understand institutional change, DI posits that it is necessary to take into account these three co-constitutive and overlapping elements: *institutional context*, *background ideational abilities*[22], and *foreground discursive abilities* (Schmidt, 2010a, 2010b, 2015). How these elements relate to each other through ideational power, is best and most concisely explained by Schmidt (2008) in the following paragraph (p. 314):

> [Discursive institutionalism] treats institutions at one and the same time as given, as structures which are the context within which agents think, speak, and act, and as contingent, as the result of agent's thoughts, words, and actions. As objects of explanation, such institutions are internal rather than external to the actors, serving both as structures (of thinking, saying, and acting) that constrain actors and as constructs (of thinking, saying, and acting) created and changed by those actors. As a result, action in institutions […] is better seen as the process by which agents create and maintain institutions through the use of what we will call their '*background*

[22] Background ideational abilities, in this thesis, will be conceptualised as pertaining more to structure than to agency, and will therefore be referred to as background ideational structures.

> *ideational abilities*' [emphasis in original], which underpin agent's ability to act within a given meaning context. But it does not stop here, because such institutional action can also be predicated upon what we will call the '*foreground discursive abilities*' [emphasis in original] through which agents may change (or maintain) their institutions. This represents the logic of communication which is at the basis of agent's capacity to think, speak, and act outside their institutions even as they are inside them […].

The empirical chapters of this thesis follow this organisation into three elements, with a corresponding form of power for each category: the chapter on institutional context will focus on institutional power; the chapter on background ideational structures will focus on power *in* ideas; and the chapter on foreground discursive abilities will focus on power *through* and *over* ideas. The sections below will briefly introduce each of the three elements separately.

3.1.1. Institutional context

DI as a new strand of institutionalism developed to improve the understanding of how institutions can change even without exogenous shocks[23], not as much through radical change (revolution), but through incremental, gradual shifts in ideas, norms and discursive constructions of the world (evolution). Consequently, DI takes a much less rigid, and much more fluid and dynamic conceptualisation of institutions: as social constructs co-constitutive of ideational and cognitive frames which shape and maintain what is thinkable, but constructs which can also be discursively challenged and constantly redefined.

> For DI, […] institutions are internal to sentient agents, serving both as structures (of thinking and acting) that constrain action and as constructs (of thinking and acting) created and changed by those actors. (Schmidt, 2010b, p.82)

However, DI does not intend to invalidate the insights from 'older' new institutionalism. Instead, it offers to look *beyond* 'traditional' conceptualisations of institutional structures. The insights from the 'older' new institutionalisms can still inform the contextual element of DI: what path dependencies and historical developments shape the institutional context, what norms have become established in that space over time, how institutional structures are skewed in ways that favour certain interests over others. This dimension is contextual rather than central to DI, because it is less concerned with ideas *per se*. However it is still worth using that context as a starting point, as a map. Indeed, it would be difficult to justify completely ignoring the more 'traditional' traits of institutions as structures, perhaps

[23] The need for an additional strand of institutionalism is of course contestable; see for example Bell S., 2011.

especially in the EU. The point of DI and of the thesis is not to claim that treaties do not matter, and that the EU institutions are somehow purely the result of cognitive constructs that exist without context. This is the reason why in this thesis, the institutional context will be the object of a whole separate chapter dealing with institutional power. This is all the more important in a setting that is as unique as the EU, and for which a literature on institutional asymmetrical power dynamics already exists and can be drawn on.

3.1.2. Background ideational abilities/structures

Background ideas, in DI, are ingrained representations of the world, commonly accepted, taken-for-granted 'truths'. They are not explicitly articulated, but tend to be taken as 'common knowledge', 'obvious', simply the logical and only possibility to make sense of the world. They are seen as having a life of their own, even shaping reality by providing a lens through which phenomena are made sense of. These background ideas infuse how people think about themselves and the world, how policymakers make sense of social phenomena, and how the policies aimed to solve them are designed. The ideational background is constructed through established 'power *in* ideas', which, as Carstensen and Schmidt (2016) puts it, concerns

> […] the ways that agents seek to depoliticise ideas to the degree where they recede into the background, meaning that they become so accepted that their very existence may be forgotten, even as they may come to structure people's thoughts about the economy, polity and society (p.329).

Ascertaining whether background ideas are the result of agency or structure is not the point here[24]. However, given that a certain set of background ideas is, at a moment in time, successfully ingrained, they will be thought of herein more in terms of structure (not pre-determined and fixed, but slowly evolving structure), regardless of the extent to which they initially originated from agency. Typically an idea like neoliberalism can be seen as representing a worldview-structuring, taken-for-granted idea that has become so accepted that it fades into the background while guiding what is thinkable and sayable (Schmidt, 2016). This kind of authority of ideas is described as being situated at a 'deeper level' than policy ideas or programmes, as being left unarticulated yet shaping the realm of possibilities of how to even think about reality, the realm of what is acceptable to think. However, even this kind of power is not pre-determined and immutable, even though changes here tend to occur very

[24] see the discussion in the introduction (pp.24-25) on 'whether agents are discourse users or constituted in discourse' (Bacchi, 2005)

slowly. To theorise power *in* ideas, especially in the context of neoliberalism, Carstensen and Schmidt (2016, pp. 330-331) draw on Foucault's notion of governmentality (see: also Panizza and Miorelli, 2013). What this means is that, even though DI so far has tended to take a more agency-oriented approach and focus more on power *through* and *over* ideas, it does not neglect the ideational constraints composed of underlying, taken-for-granted worldviews. However (and this is in line with Foucauldian approaches as well), DI still emphasises that, however difficult and slow the change process may be, background ideational structures are not inevitably pre-determined and do evolve.

3.1.3. Foreground discursive abilities

Arguably, the 'foreground discursive abilities' element of DI is what allows us to explain the largest parts of endogenous change. One way to make sense of the three DI elements is to think of institutional context and background ideas as the mutually-reinforcing, co-constituted 'structural' dimensions, whereas foreground discursive abilities would be the more 'agential' dimension[25].

Most DI scholars focus particularly on the discursive, communicative practices of the 'foreground discursive abilities'. This entails a focus on the agential-oriented 'power *through* ideas' and 'power *over* ideas' angle of ideational power, as opposed to ideational structures which relates more to 'power *in* ideas'. Many take a deliberative democracy approach to DI (see section 3.2.1., p.106). But the term discourse is contentious and can mean quite different things depending on who is using it. For DI scholars who draw on deliberative democracy, discourse refers to a Habermasian idea of communicative action (Dryzek, 1990). In those cases, DI scholars are particularly interested in looking at the discrepancies between coordinative discourses, through which policymakers construct policies 'behind closed doors', and communicative discourses, which occur in the interactions between policymakers and the general public (both top-down and/or bottom-up), and where policies are discursively legitimated and/or contested.

Discourse, in part, refers to the discursive process – the 'who says what to whom, when, where and how?'. Focusing on the process angle will entail an exploration of power *through*

[25] This is how DI is interpreted in this thesis, but by no means the only possible or 'right' interpretation. Additionally, it is not actually possible to disentangle background ideational abilities from foreground discursive abilities, especially in the case where foreground discourses promote institutional continuity (see introduction, p.25).

ideas, and coercive power. Power *over* ideas refers to 'the politics of attributing meaning to ideas', and refers to the content, more than the process, of discourse. The term discourse as used by Schmidt (2015) encompasses both the content and the process:

> the representation or embodiment of ideas – as in discourse analysis […] but also the interactive process by and through which ideas are generated in the policy sphere by discursive policy communities and entrepreneurs […] and communicated, deliberated, and/or contested in the political sphere by political leaders, social movements and the public […]. (p.171)

The reason power *through* and *over* ideas will be considered alongside, is because the overall focus of Chapter Six is on the malleability of the meaning of ideas: as such, power *through* ideas is illustrated in the strategic adaptation of the meaning of ideas to persuade others to take it up in the first place; and power *over* ideas is illustrated in the adaptation of the meaning of ideas to redefine the idea 'once taken up'.

Both content and process are co-constitutive, and therefore power *over* and *through* ideas cannot be neatly separated. In the vein of an inclusive umbrella term, Schmidt (2015) notes that DI scholars can have different emphases in their research, with some tending to focus more on discursive speech processes, whereas others might focus more on the content and substance of ideas. The latter is the case of this thesis, and in that vein, the sixth chapter (on foreground discursive abilities) will focus on 'power *over* ideas' (the active power struggle to define the meaning of HiAP), as well as on power *through* ideas (the discursive efforts to persuade others of the validity of one's idea). The division between power *through* and *over* ideas, is artificial and serves an analytical purpose[26]. The logic behind this division, is that the introduction of HiAP into the EU space in 2006, represents an instance of power *through* ideas, where the Finnish team sought to convince the EU officials of the importance and validity of health mainstreaming as an idea. What happens after this introduction, the power struggles to define and delimit the meaning of HiAP, relates to power *over* ideas (see figure 6.1., p.175).

It is important to bear in mind that the separation of the three elements (institutional context, background ideational structures and foreground discursive abilities) is created for analytical purposes. All three elements are better seen as co-constitutive. For example, the institutional

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[26] Ideational power expressed through foreground discursive abilities can also overlaps with coercive forms of power (see: Carstensen and Schmidt, 2016).

context is constructed by both the reproduction of established background ideas and the discursive agency of sentient beings in that institution. Institutional context and background ideas are mutually reinforcing. Foreground discourses do not exist in a vacuum, and while they may well be critical of institutional continuity, they cannot be seen as entirely separate from background ideas, with the former potentially even coming to shape the latter in the long run.

3.2. Why use discursive institutionalism?

DI is concerned with how ideational frames and discursive practices interact with institutional context to maintain or change it. In the case of this thesis, the main characteristics of the institutional context have been introduced in Chapter Two, specifically the notion of 'constitutional asymmetry', and how it creates an ingrained neoliberal bias that favours economic integration over social integration. However, the position taken in this thesis, which justifies using DI as a framework, is that institutional context alone cannot explain either why HiAP made its way to the EU in the first place, nor does it explain exactly what happens to this idea once it reached that space. In other words, looking at health in the EU purely from a constitutional asymmetry angle would provide an overly deterministic picture, which would invariably point towards the inevitable reproduction of neoliberalism.

In quite a similarly deterministic way, some research drawing on governmentality to critically analyse neoliberal rationality also tends to end up seeing neoliberal governmentality everywhere and consistently, and seeing deep philosophical ideas as never changing (Schmidt, 2015). This becomes equally unhelpful, as pointed out by some researchers sympathetic to the concept of governmentality, but keen to draw more attention to- and put more weight on agency, and the non-inevitability of current domination of rationalities (Bell K. and Green, 2016; Cairns and Johnston, 2015). The problem with painting a totalising picture of neoliberal governmentality is that it would negate the whole point of looking at discourse and ideas. Put simply, if the discourse is omnipresent and always coherently neoliberal, then one might as well call it an institution. As Parsons (2007, p.110) put it:

> If certain […] ideational elements were strongly explicable themselves – if they followed as the obvious or unavoidable responses to preceding conditions – then their effects are just derived effects of the preceding conditions. To generate distinctive […] ideational causal segments we must separate the man-made arrangements from other causal conditions by positing some contingency in their creation or endurance.

This is why using DI represents a good solution that combines a sophisticated conceptualisation of power as arguably more complex than traditional new institutionalisms would provide, and which considers the interplay of ideational structures (ingrained ways of making sense of the world) and institutions, but without neglecting the space for agency, the possibility for agents to also reflect critically upon the institution within which they act, and perhaps even their own normative assumptions. Arguably, this inclusiveness can be seen as a weakness, or a sign of potential unawareness of ontological incompatibilities. This critique of DI has been made in the context of the calls for a feminist DI (Bacchi and Rönnblom, 2014). However, for the purpose of this thesis, this chapter argues that DI is both generally well-suited, and open enough to be further modified to fit this thesis even better, as will be further justified in the remainder of this chapter.

DI is well suited to analyse neoliberalism. Schmidt (2016) has used DI to explain the dominance and resilience of neoliberal ideology in European political economy since the 80s. The issue with looking at big overarching rationalities like neoliberalism, is that they can appear immutable and inevitable, as it is often difficult to identify any kind of change. This is where zooming in on how background ideas like neoliberalism translate at a more 'concrete level' can allow us to better identify continuity and change. As suggested in Chapter Two (section 2.2.1., p.73), 'roll-back' neoliberalism under Thatcher in the 80s is different to 'roll-out' third-way neoliberalism. One of Schmidt's arguments is that, while indeed neoliberalism appears to have reached a kind of unquestioned authority, it has not done so in a vacuum, and it is not 'fixed' in one shape. Instead, it is worth looking at processes of negotiation, of reinforcement, and of contestation. This allows us to better understand *how* ideas created and modified through these processes, have led to neoliberalism becoming unquestionably accepted, and to explore *how* this can be challenged. Schmidt (2016) suggests that the 2008 Eurozone crisis has brought neoliberalism out of the background and into the forefront as something worth explicitly questioning. This does not mean that it has led to a fundamental and radical paradigm shift, but that at least some previously taken-for-granted and technocratised assumptions can be opened up to re-politicisation[27].

[27] On a more speculative note, and writing this in March 2020, it will be interesting to see whether the current Covid-19 global pandemic will have an effect on potentially re-politicising issues like the place of the free-market and the state.

3.2.1. Discursive institutionalism in practice

DI has been used most prominently to empirically investigate ideational power in relation to the Eurozone crisis (Carstensen and Schmidt, 2018). The advantage of using DI to look at how and to what effect ideas and discourses about the crisis have been vehiculated, is that DI is a broad umbrella term open to using a combination of concepts in order to highlight different facets of a phenomenon (Schmidt, 2014). As such, DI allows us to first look at the contents of ideas and discourse, where they come from in terms of ingrained assumptions and worldviews. Contrasting neoliberalism and neo-Keynesianism, Schmidt (2014) looks at the level of generalisation of ideas and identifies three levels: philosophical ideas, programmatic ideas and policy ideas[28]. She also analyses how ideas, which result from cognitive and normative arguments, take on different shapes. Taking as an example the response to the Eurozone crisis she explains how a neoliberal case (which can be driven both cognitively and/or normatively) to address the crisis, manifests through pro-austerity frames. This can then be translated into narratives of German ordo-liberalism, and stories involving 'the Germans who save' (Schmidt, 2014, p.192). Schmidt traces these stories back to collective memories of Germany's hyperinflation of 1923 (Schmidt, 2014). DI then allows to move on to looking at agents and their discursive abilities, whether to maintain or challenge a given representation. Still in relation to the Eurozone crisis, DI scholars examine the problematic nature of the communication about the crisis, which took place differently among member states leaders, compared to the communication to the markets and to the general population (Schmidt 2013, 2014; Crespy and Schmidt, 2014).

Linking together and highlighting the relationship between the ideational content element of DI with the communicative analysis element of DI, Carstensen and Schmidt (2018) provide a deep and broad picture of how power operated in various ways in the context of the Eurozone crisis management.

Beyond the Eurozone crisis, DI has been used, amongst other instances, to reflect upon recent political shake-ups like Brexit and the election of Donald Trump (Schmidt, 2017b). Hope and Raudla (2012) have elaborated a modified version of DI to analyse the phenomenon of policy stasis, the underlying idea being that policy stasis is not only a consequence of immobile

[28] This categorisation echoes Rushton and William's (2012) framework in which a deep core shapes paradigms and frames, whereby deep core is similar to Schmidt's philosophical idea, paradigms correspond to programmatic ideas, and frames would equal policy ideas. For simplicity, this thesis will use Rushton and William's (2012) terminology, see Figure 3.1., p.109).

structural constraints, but also a result of lack of space for alternative discourses and ideas to be heard, or a lack of focus of these alternative ideas leading to the diffusion of the space for policy change. Fairbrass (2011) used DI to analyse the development of EU policies related to corporate social responsibility. In particular, she looked at the tensions between ideas around the level of regulation required in that area. Lauber and Schenner (2011) used DI to analyse the discursive struggles between the EC, and the EP and the Council, around a support scheme for renewable electricity. They highlight how the EC's discursive frame is underpinned by a neoliberal market liberalisation rationality, whereas the EP and the Council re-framed the issue in terms of subsidiarity.

Another example, closest to this thesis, is Smith's (2013b) use of DI to look at how institutions shape the relationship between research and policy in the area of health inequalities in the UK. She argues that policymaking institutions play an important role in the success or failure of certain research ideas to influence policy. In particular, she explains how the institution's silo-structure, the ideational underpinning of those silos, and prevailing hierarchies affect the research/policy relationship. Those ideas that fit the prevailing institutional makeup are prioritised, whereas those research ideas that challenge the institutional status quo tend to be either ignored, or modified, 'co-opted' to fit into the dominant orthodoxy. She also suggests that institutional memory tends to be short, which means that the same ideas become re-cycled and re-presented, and appear novel even though they have essentially been around for a while. These insights are precisely what Chapter Six will be concerned with in relation to HiAP in the EU: the discursive dynamics of watering down HiAP, versus the discursive dynamics of re-cycling it.

3.2.2. Discursive institutionalism to look at HiAP in the EU

So far, most studies applying DI to empirical cases have done so by organising their analyses around two elements: discursive *process*, how things are communicated, which they related to foreground discursive abilities, and the *content* of discourse, the ideational dimension and its underlying norms, which they relate to background ideational abilities. In both process and content analysis, the accent is generally put on agency: indeed Schmidt's original DI categorises 'background ideational *abilities'*, which implies an emphasis on agency. Taking an agency-centric starting point, these studies look at coordinative versus communicative discourse (see amongst others also: Boswell and Hampshire, 2017; Herranz-Surrallés, 2012;

Wahlström and Sundberg, 2018). Institutional context is not necessarily separated out in its own right, but is integrated within the two aforementioned elements.

In this thesis, DI will be applied in a different way: rather than taking as a starting point the dynamic discursive processes and then analysing their contents, it takes the philosophical ideas underpinning discourses as the starting point and then analyses how these are reproduced as well as challenged. Conceptually, this means that, instead of putting the agent in the middle of the analysis and considering how structure acts upon it, this thesis puts the structure (institutional and ideational) in the centre, and then considers how the agent can nevertheless challenge and change it. This is why this thesis conceptualises background ideas as structures rather than as abilities. Ingrained background ideational structures may indeed have stemmed from particular agents successfully articulating ideas in a way that they ended up becoming unquestioned and fading into the background. As such, structure and agency is never really entirely separate. However, the emphasis in this thesis, and with respect to background ideas, is to look at how dominant ones structurally constrain and undermine HiAP. This approach is closer to Smith's (2013b) use of DI. As such, it draws less on Habermas-inspired notions of co-ordinated versus communicative discourse (see Schmidt 2008), and more on Foucault-inspired notion of power *in* ideas (see Carstensen and Schmidt, 2016). Importantly, DI does not consider both approaches as being incompatible, rather, as highlighting different facets of a phenomenon, with emphases on different kinds of power dynamics (Schmidt, 2017a).

To critically analyse the background ideational landscape as structure, this thesis will apply Rushton and Williams' (2012) framework (see figure 3.1. below). This framework sheds light on how global health policymaking is shaped discursively, through interaction between by frames, paradigms and power.

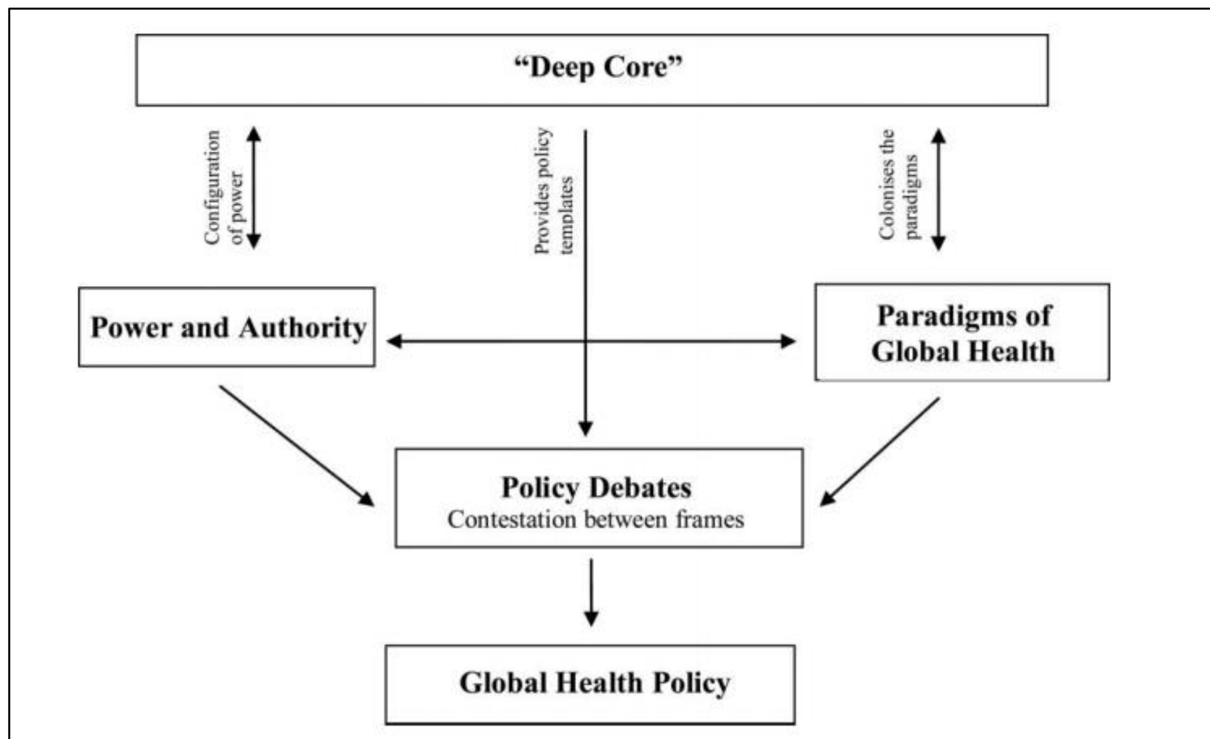

Figure 3.1. 'Framework for Analysing Global Health Policy-making' (Rushton and Williams, 2012, p. 154)

By 'frames', they refer to linguistic and cognitive devices at the most 'immediate level' of discursive construction of a problem (Rushton and Williams, 2012). This echoes what Schmidt (2016) calls 'policy idea' (see section 3.2.1., p.106). 'Frames' imply that global health issues, or any kind of phenomena for that matter, do not exist objectively 'out there', but are constructed and made sense of discursively. Frames lie in the cognitive foreground of actors. 'Paradigms' refer to background cognitive devices that inform frames. They are situated in the 'background' of frames (they 'frame the frames'). This echoes what Schmidt (2016) calls 'programmatic ideas'. Examples of paradigms informing global health frames and policies mentioned include the economic paradigm, or the biomedical paradigm among others (see: Rushton and Williams, 2012)[29]. Power, in this framework, relates to the agency of certain groups to shape the frames, and shape the policies. However, all these dimensions; frames, paradigms and power, are underpinned by what they call an overarching 'deep core' (or 'philosophical idea', according to Schmidt's terminology), which determines what is doable, sayable and thinkable in the very first place. The deep core, according to them, is neoliberalism.

[29] Some health paradigms were introduced in Chapter One (section 1.1., p. 35-36).

> […]the hegemony of the neoliberal orthodoxy results in a situation where all of the paradigms of global health exist and develop in a context defined by neoliberal ideas. (Rushton and Williams, 2012, p.165)

The authors conclude by stating that these processes need to be traced and studied empirically. Chapter Five will draw on this framework to investigate the background ideational structures dominating in EU health governance. This will allow to unpack manifestations of the 'deep core', manifestations of neoliberalism through paradigms and frames, that undermine a normatively meaningful HiAP shift at EU level.

The purpose of the thesis, put simply, is to explain the (so far) failure of HiAP at EU level, while also exploring its potential. Using DI and looking at ideas and discourse in the case of HiAP in the EU is particularly interesting: why has HiAP become a concept used in the EU, despite the prevailing institutional neoliberal bias? But equally, one can ask why HiAP, while having made its way to the EU, has not led to any fundamental, radical transformation? How do obstacles to a normative HiAP manifest through existing institutional structures as well as through existing background ideational structures that provide a frame within which to make sense of the world, including of HiAP? Where and how is a more radical HiAP discourse articulated, if at all? How do proponents of HiAP discursively react to the challenges the idea faces in the EU setting? To investigate these questions, DI appears to be a well-suited framework. It offers a balance between the structure and agency dimensions, and a sophisticated conceptualisation of institutions as more than a rigid, externally pre-existing structure. Rather, it conceptualises institutions as both co-constitutive of established ideational structures, and subject to endogenous change as a result of the agency of the members of that institution. Here, DI is well-equipped to allow for a nuanced analysis of the interactions between prevailing (neoliberal) ideational frames (for example frames of health and NCDs, as well as frames of what constitutes evidence), institutional structures that reflect constitutional asymmetry, and the space for contestation in the very idea of HiAP, as well as in its actively driven evolution. DI then allows to shed light onto the overarching research question of this thesis, by addressing all three sub-questions: HiAP in relation to EU institutional, ideational, and discursive contexts, where institutional and ideational contexts represent structural limitations, and discursive context represents the agential possibilities for HiAP (see pp.16-17). The interactions between all three elements lead to a unique and ever-evolving blend of tensions between change and continuity, hegemonic norms and resistance, in ways that do not represent a radical paradigm shift, but rather, a contingent, gradual and incremental struggle.

3.3. <u>Applying discursive institutionalism empirically</u>

The way DI will be applied in this thesis, as already introduced above, is with an emphasis on the three types of *ideational* powers, and on *institutional* power. This differs from existing studies using DI and which tend to focus more strongly on agency, i.e. more strongly on power *through* ideas, *over* ideas, and *coercive* power. As such, each theoretical chapter will focus on one of the three components of DI and its respectively most relevant form of power: Chapter Four will deal with the institutional context and *institutional* power, Chapter Five for background ideational structures and power *in* ideas, and Chapter Six will look at foreground discursive abilities, and power *over* and *through* ideas.

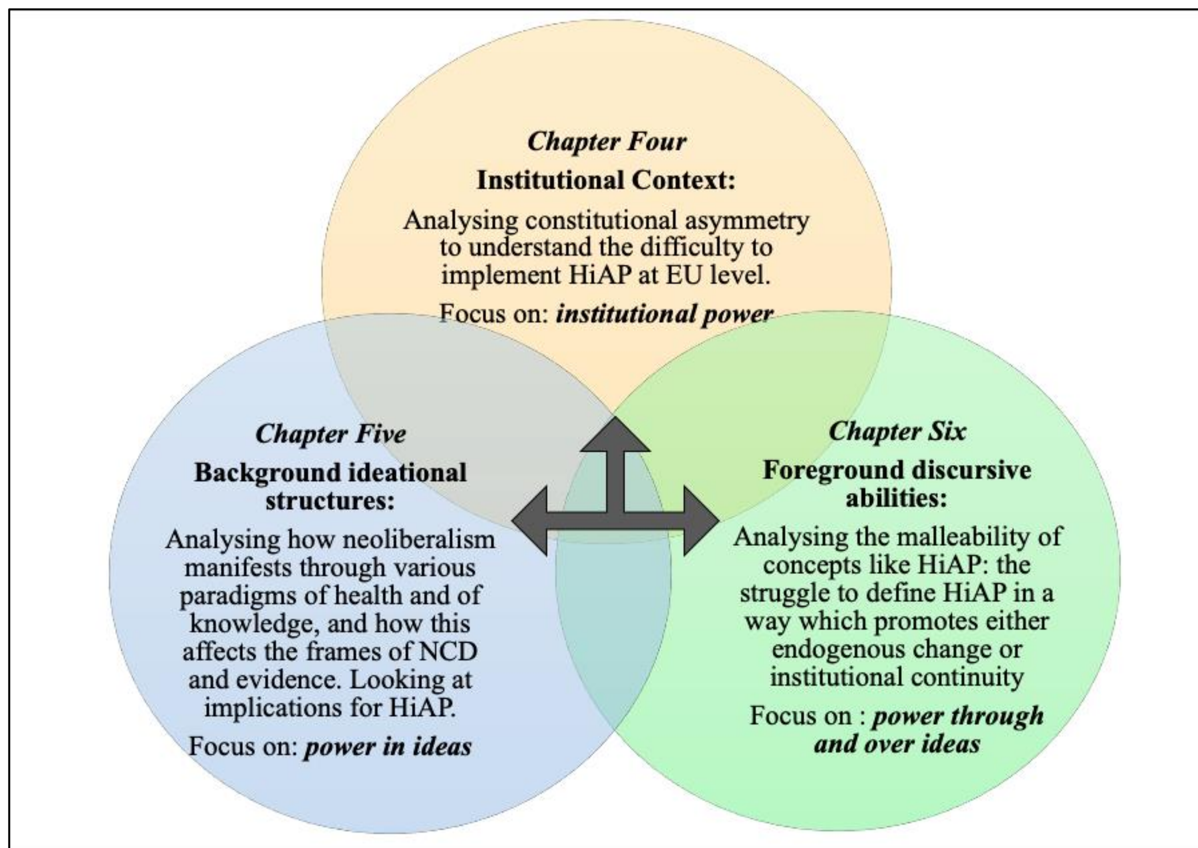

Figure 3.2. Conceptual overview of DI theoretical framework as applied to empirical chapters of this thesis. Each circle represents one empirical chapter and one of the three main component that form the object of research in DI. The arrow in the middle indicates the co-constitutive nature of the three components.

The following sub-sections will provide an overall schematic of each empirical chapter, as well as a brief introduction of an additional concept that will be used in each of these chapters. Chapter Four will draw on the notion of constitutional asymmetry (see section 2.1.1.1., p.63). Chapter Five uses the framework for analysing global health policy-making

(Rushton and Williams, 2012; see Figure 3.1. p.109) to unpick how paradigms and frames around health in the EU are rooted in neoliberal ideology. Chapter Six draws on Smith's (2013a) categorisation of ideas, in particular the concept of 'chameleonic ideas' to explore the active discursive re-defining of 'HiAP', from its radical potential to its risk of co-option.

3.3.1. Chapter Four: HiAP and the EU institutional context

While most empirical studies using DI do not set aside a section on institutional context, and rather take it into consideration more tacitly and throughout their analysis of discursive content and processes, this thesis makes the case for a separate chapter on institutional context. This is because of the particularly interesting and well-theorised nature of the institutional context in question: the EU.

When it comes to analysing how neoliberalism in EU institutional architecture affects the scope for mainstreaming a more social agenda, there already exist numerous concepts and a considerable amount of useful literature, which can provide good insights when applied to the case of HiAP. Due to the unique nature of the EU institutional context, how it evolved and the power asymmetries that resulted from its development (see section 2.1.1.1., p.63), a separate chapter will thus be dedicated to analysing the *institutional power* at play in relation to HiAP in the EU. To avoid ontological incompatibilities with the other chapters, it is important to bear in mind the fluid conceptualisation of institutions that DI adopts, as both constraining structures and actively created constructs that do not exist independently of its sentient beings (see section 3.1.1., p.100). The first empirical chapter will draw on various concepts explained in Chapter Two: the different aspects of EU governance (soft/hard/meta-regulatory); the different faces of EU involvement in health (Single Market [hard governance], fiscal coordination [hard governance], and public health [soft governance]); as well as the notion of constitutional asymmetry and positive versus negative integration. These conceptual tools will be deployed to analyse the institutional space for HiAP in the EU, drawing on examples from each governance aspect.

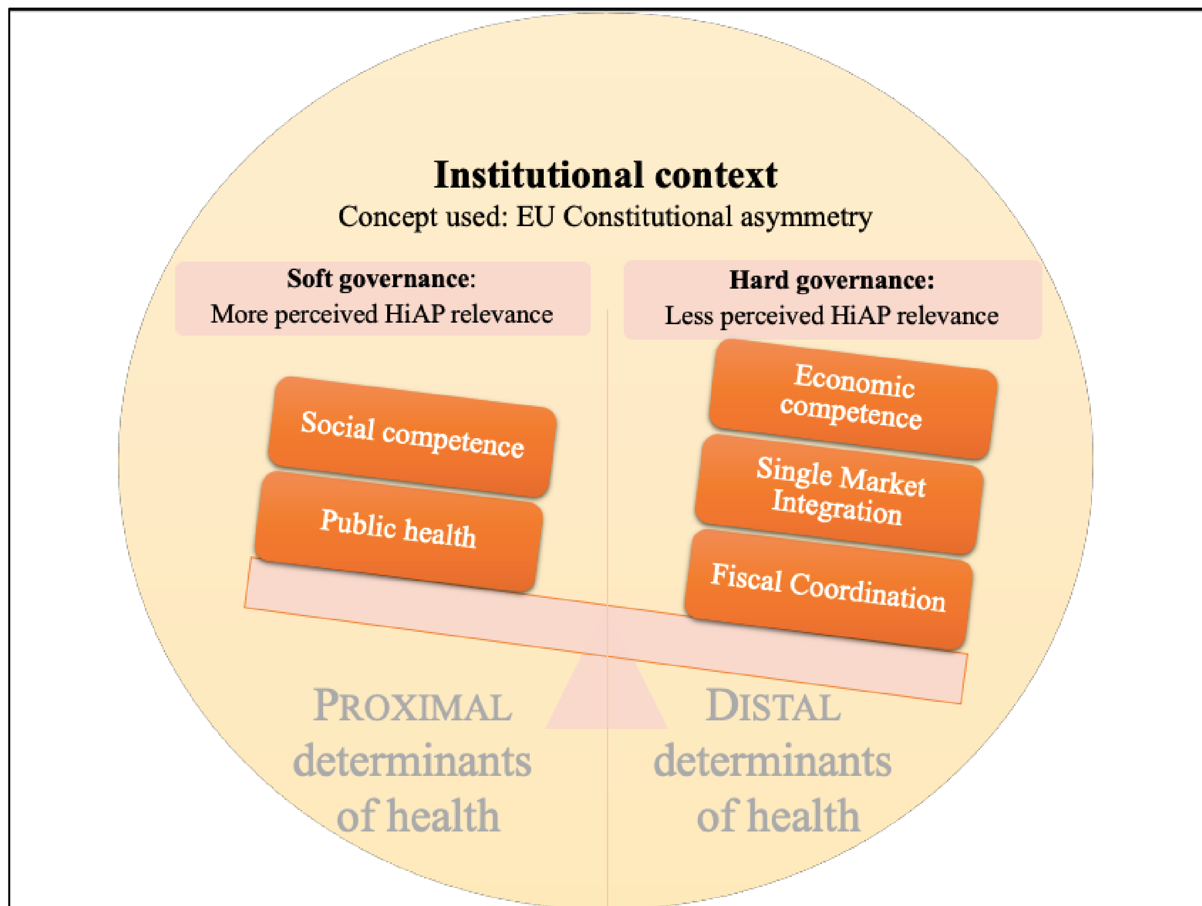

Figure 3.3. Schematic overview of Chapter Four: analysis of the space for HiAP in the EU institutional context using the concept of 'constitutional asymmetry'.

3.3.2. Chapter Five: HiAP and background (neoliberal) ideational structures

The aim of Chapter Five will be to unpack how neoliberalism is ideationally reproduced in paradigms of health and knowledge that underlie frames of NCDs and of evidence. As such, this chapter is particularly concerned with what Schmidt call the power *in* ideas.

Here, the thesis draws on parts of the framework for analysing global health policy-making (Rushton and Williams, 2012) (see Figure 3.1. p.109). Specifically, it will look at the relationship between *deep core* neoliberalism → *paradigms* of health and of knowledge → and *frames* of NCDs and of evidence. It will also reflect on the implications of these relationships for HiAP. The first step in this chapter, is to expose and analyse the dominance of the 'economic paradigm of health' and its underlying neoliberal roots. This paradigm conceptualises health promotion as a cost-effective investment, highlighting the relationship between better population health and increased economic growth. The second step consist of analysing how this paradigm, in conjunction with other health paradigms (in particular the security and the biomedical paradigms of health), is mobilised in the problem representation

of NCDs. This problem representation, the chapter argues, tends to put a strong emphasis on NCDs as the natural consequence of the ageing population, i.e. of the progress made in terms of life expectancy. The idea put forward in the first half of the chapter is that, infused with neoliberal 'overarching' rationality, the economic paradigm of health interacts with other paradigms of health (security and biomedical) to shape the dominant framing of NCDs. Chapter Five then goes deeper into the knowledge paradigm which dominates in the EU and drives the dominant frame of evidence, and how that knowledge paradigm relates to neoliberalism and HiAP. This section looks at the dominant meaning of what represents 'legitimate' evidence, and how it undermines the possibility to consider HiAP in all its normativity and complexity.

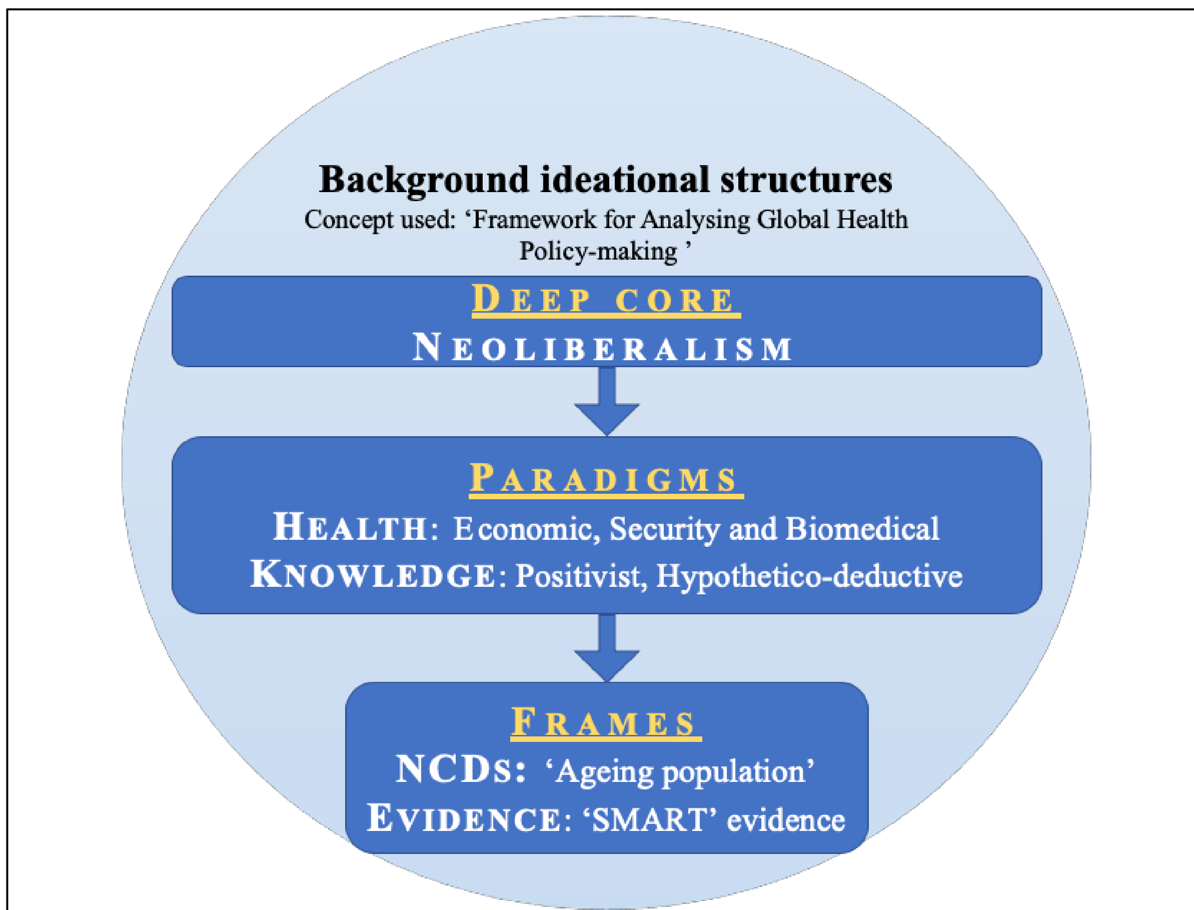

Figure 3.4. Schematic overview of Chapter Five: analysis of how, in the EU context, neoliberalism permeates through the ways in which health, knowledge, NCDs and evidence is made sense of.

3.3.3. Chapter Six: HiAP and the space for agency in foreground discursive abilities

The last empirical chapter will focus on the discursive malleability of meanings of HiAP, both in terms of shaping its meaning to advocate for its adoption (power *through* ideas) and in terms of reshaping and redefining its meaning down the line (power *over* ideas). The

purpose of Chapter Six is thus to look at the various (contradictory) meanings of HiAP, where it takes them on, and by whom these various meanings are put forward. This will allow for a better insight into the space for (gradual, incremental) institutional (and ideational) change, without being overly optimistic and recognising the struggles for HiAP advocates to resist the risk of co-option.

Chapter Six will draw on Smith's (2013a) categorisation of ideas. She categorises four types of ideas, including one type she calls 'chameleonic ideas'. This concept refers to ideas that are formulated vaguely enough to appeal to various audiences. In relation to public health research, these often refer to ideas that have been 'strategically packaged' to be perceived as acceptable in mainstream governance spaces (see section 6.1., p.175). Ultimately, identifying chameleonic qualities of ideas points to the fact that meanings of ideas are not fixed, and can be challenged and changed. Furthermore, meanings of ideas are not only changeable, but various contradictory meanings of chameleonic ideas and concepts can co-exist. This does not mean that completely randomly contradictory meanings of ideas co-exist; Chapter Six will investigate how HiAP can become co-opted to fit the dominant EU neoliberal rationality. At the same time, HiAP can also be a space for agency in which actors within an institution can articulate discourses critical of that institution. This is visible in the actively driven evolution and 'recycling' of HiAP into the 'economy of wellbeing' idea (see figure 3.5. below: the malleability of the HiAP concept, and the ways in which it can be reshaped and recycled to mean very different, potentially opposing things, is why 'HiAP' is situated in the overlapping part of the Venn diagram). Furthermore, and as explained throughout, HiAP is a very broad and normative concept. Consequently, various different ideas can share a same normative vision with HiAP, without necessarily being called 'HiAP'. That may be the case for more radical ideas like the 'degrowth' movement.

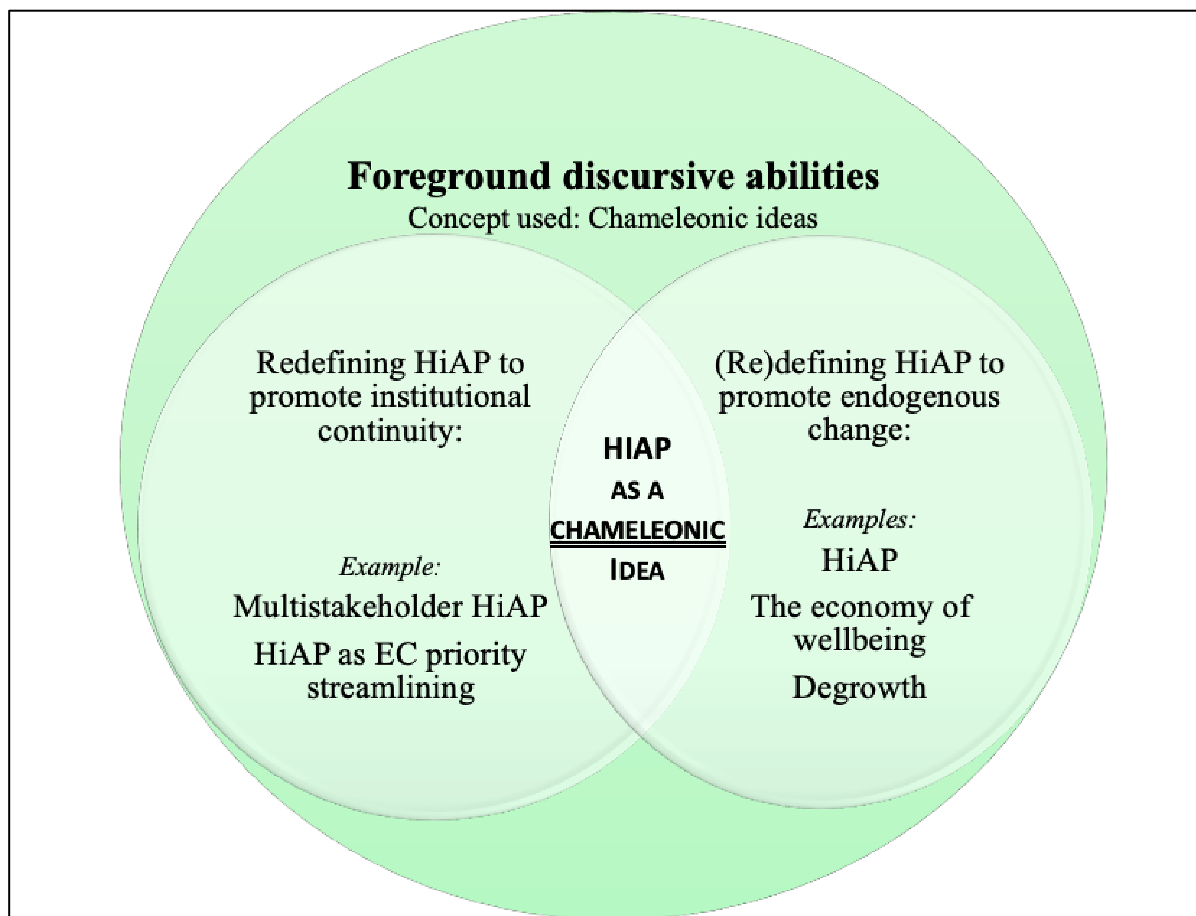

Figure 3.5. Schematic overview of Chapter Six: analysis of the malleability of the HiAP idea, the chameleonic nature of the HiAP idea. HiAP can become co-opted to fit the dominant institutional and ideational structures, but it also represents space for agency as a radical idea, the essence of which is also reproduced in other related dissenting discourses.

3.4. Conclusion: A discursive institutionalist framework to study HiAP in the EU

This chapter has introduced the overarching theoretical framework of this thesis: DI. Key elements that matter to DI are a genuine focus on the role of ideas (whether substance and/or processes), a conceptualisation of institutions as not pre-existing rigid structures, but rather as fluid and evolving constructs, and the space for agency which can bring about endogenous institutional change.

This chapter argued that DI, as an umbrella term, offers a useful framework to use to analyse HiAP at EU level. This is because it allows for the striking of a balance between structure and agency when looking at the effects and promotion of ideas intended to foster institutional change: it allows us to take seriously institutional and ideational 'structural' constraints, without neglecting the space for agency. Equally, DI also allows us to investigate the power struggles between discourses at a communicative level, without overemphasising agency and

neglecting structural constraints. Situated on the more 'structure-heavy' side of the DI structure/agency spectrum, this thesis presented the three elements of DI that will be the focus of each respective empirical chapter, and the types of power that will be analysed in each chapter, along with the additional theoretical concepts needed for that purpose. The table below offers a summary of how DI will be applied in the empirical chapters:

	Chapter 4	**Chapter 5**	**Chapter 6**
DI element	Institutional context	Background ideational structures	Foreground discursive abilities
Object of study in relation to HiAP	EU institutional architecture	Dominant paradigms and frames around health and scientific evidence	Active shaping and re-defining of HiAP
Form of power	Institutional power	Power *in* ideas	Power *through* and *over* ideas
Emphasis	Structure *(although evolving, not pre-determined)*	Structure *(although evolutive, not pre-determined)*	Agency *(although not entirely independent of structure)*
Research Sub-Question (see pp.16-17)	How does the EU institutional architecture, particularly its neoliberal bias, limit the possibility for a meaningful HiAP uptake?	How do neoliberal background ideational structures in the EU limit the possibility for a meaningful HiAP uptake?	What are the various discursive power struggles at EU level around the meaning of HiAP, and how do active redefinitions of HiAP promote institutional change?
Theoretical concept used in conjunction	Constitutional asymmetry (Scharpf, 2006)	Framework for analysing global health policy-making (Rushton and Williams, 2012)	Categorisation of ideas (chameleonic ideas) (Smith, 2013a)

Table 3.1. Applying the theoretical framework to the empirical chapters: summative table

CHAPTER 4: Institutional obstacles to HiAP in the EU

To understand the EU's involvement in public health and the reasons it struggles to prioritise public health and citizen wellbeing, scholars have related the particular issue of health to the broader debate around institutional constellations that favour an economic Europe over a social one. As seen in Chapter Two (section 2.1.2., p.65), some explain the lack of a public health vision as being reflective of the fact that the EU, ultimately, is a market-creating endeavour that promotes first and foremost economic integration. In turn, they show the mechanisms through which the involvement of the EU in public health tends to occur via a Single Market rationale, and, more recently, via fiscal coordination of member states.

This first empirical chapter applies the literature's key concept of constitutional asymmetry to analyse institutional obstacles to HiAP in the EU. Following Schmidt's DI framework, this chapter engages with the 'institutional context' element of the framework. It provides insights into the constitutionally asymmetrical power dynamics in the EU and how they undermine a normatively meaningful HiAP. This chapter will critically analyse the space for HiAP starting from soft- to hard-, and meta-regulatory governance areas. Importantly, 'institutions' are not seen as neutral, objectively pre-existing entities, but they are the product of normatively driven social construction. As put by Schmidt, institutions are both constraining structures that shape what can be done and how actors can behave within them, as well as enabling constructs, which come about through a combination of underlying rationalities which shape what is thinkable, as well as individual actors' agency within them. What this points towards is the non-inevitability of the way in which institutions are at one moment in time, acknowledging the scope for change and evolution, while at the same time recognising the obstacles to change.

This chapter is concerned with examining how the institutional configuration in the EU shapes the scope for implementing HiAP. In turn, the analysis will have to examine the various EU governance types seen in Chapter Two (section 2.4., p.84). It needs to consider both the proximal and the distal locations of 'health promotion': EU involvement in health promotion traditionally has been thought of in terms of regulation of NCD risk factors. While this needs to be taken into consideration, it is not sufficient: health promotion also needs to be located and mainstreamed in entirely different spaces, such as for example fiscal governance. This is very much the point of HiAP. Yet making the link between policy areas like trade,

economic governance, foreign policy, and health is often neglected, and the attention pragmatically focused on easier win-win situations. The proximal/distal health promotion relevance scale tends to loosely correlate with the soft/hard dichotomy of EU governance, with proximal determinants of health being dealt with through soft governance, while distal determinants of health often remain shaped in hard(er) and more 'overarching'[30] governance areas. The hardest EU governance areas, and those that pertain to the overarching vision of the EU, tend to be those with the least *perceived* relevance to health promotion. This chapter highlights and contrasts these differential dynamics as illustrations of how EU constitutional asymmetry operates in relation to taking up HiAP, and how constitutional asymmetry precludes an understanding of HiAP as being about distal determinants of health. Critiquing the mantra coined under the Juncker Commission - according to which the EU needs to be 'bigger and more ambitious on big things, and smaller and more modest on small things' (European Commission, 2014a, p.2) - this first empirical chapter shows the difficulty for a meaningful HiAP shift in an institutional context where economic growth is systematically privileged over societal wellbeing and health, because of the institutional architecture being skewed in favour of negative integration over positive integration. Bearing in mind the breadth of the scope of this analysis, this chapter uses concrete examples that are relevant for health promotion mainstreaming. The table below explains the rationale for the chosen examples, their position on the hard-, soft- and meta-regulatory governance categorisation, and their relevance to health promotion mainstreaming.

[30] What is meant here with 'overarching', is meta-regulatory governance. Meta-regulatory governance is not classifiable as hard or soft *per se* (it tends to be a combination of both), but it shapes the institution at a both high and deep level

Type of governance - soft/hard	Governance area	Policy or 'tool' (broadly defined)	Analytical purpose of example chosen	Type of health determinant at stake
Soft governance (NMG)	Public health promotion and NCD prevention	The EU Platform for action on Diet, Physical Activity and Health	The scope for HiAP in the soft governance approach to health promotion which relies on industry self-regulation and corporate social responsibility actions	*Individual behaviour/direct risk factors*
		The High Level Group for Nutrition and Physical Activity	The scope for HiAP in the soft governance approach to health promotion which facilitates voluntary knowledge exchange and mutual learning between member states (OMC)	*Individual behaviour/direct risk factors*
Hard governance	Single Market Regulation	The Audio-Visual Media Services Directive	The scope for health promotion mainstreaming in a non-health Single Market regulation	*Individual behaviour/direct risk factors*
	The Common Agricultural Policy	The 'post-2020 CAP' Reforms	The scope for health promotion mainstreaming in the largest EU redistributive policy	*Food system*
	EU economic governance	The European Semester	The scope for health promotion mainstreaming in the EU economic governance	*Socioeconomic inequities*
Meta-regulatory governance		The Better Regulation Agenda	The scope for HiAP in the EC's impact assessment and stakeholder consultation regime	*Governance processes and rationality*
		DG SANTE 2016-2020 Strategy	The scope for HiAP in the context of collegiality and the Commission priority streamlining	*Political vision and rationality*

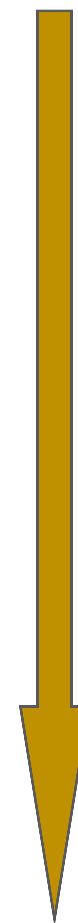

Table 4.1. Overview of Chapter Four structure and rationale.

The remainder of this chapter follows the organisation outlined in the table above. Each example listed above is first described, before analysing the scope for HiAP they offer. Overall this chapter highlights the EU constitutional asymmetry in relation to HiAP and in particular in relation to the need to adopt a radically broad vision for health promotion. This chapter shows the institutional dynamics through which the policy space and understanding of HiAP remains constrained in a way which does not address distal determinants of health.

4.1. HiAP and EU public health promotion

This first section takes a look at what Greer qualifies as the first face of EU involvement in public health, i.e. specifically public health promotion policies. Public health promotion policies, which in this case refers to policies specifically designed to improve what is commonly referred to as the population's 'lifestyle' (the promotion of physical activity and healthy nutrition), are situated in the realm of EU soft governance. Their main purpose is to foster voluntary commitment and voluntary collaboration to achieve a stated aim like promoting healthy 'lifestyles'. Arguably the two best examples of EU policy in this area are the High Level Group on nutrition and physical activity (HLG) and the EU Platform for Action on Diet, Physical Activity and Health (EU Diet Platform). The HLG is a type of OMC-like space that brings together member states to collaborate and learn from each other in the field of NCDs prevention and health promotion. The EU Diet Platform is a multistakeholder platform aimed at incentivising private and public stakeholders to commit to healthy lifestyle promoting actions. This section will take look at both of these policies, and critically evaluate the scope that these policies allow in terms of reflecting a HiAP approach.

4.1.1. The EU Platform for Action on Diet, Physical Activity and Health

The EU Diet Platform is a multistakeholder Platform which brings together NGOs and industry to make commitments towards reducing the burden of diet and physical activity related NCDs. Members include representatives of the private sector, such as the advertising industry, the food industry, and the retail industry. They also include representatives of health advocacy groups and NGOs, as well as members of medical and paramedical profession groups and a few research-focused associations (European Commission, 2018a). Platform members are required to commit to concrete actions, referred to as 'commitments', in the field of healthy nutrition and physical activity.

> The idea is that, led by the Commission, the platform will provide an example of coordinated action on this problem by different parts of society that will encourage national, regional or local initiatives across Europe. (European Commission, n.d. [a]).

Platform members can be representatives of umbrella organisations and may not necessarily have commitments directly, in which case commitments need be made by at least one of their own members. This is an important point insofar as some industry members represent a very

large number of very large companies (for example FoodDrinkEurope or the Union of EU soft drinks associations [UNESDA]). Critics of the Platform have argued that, due to the inclusion of such large umbrella organisations representing a large number of large food corporations, and the amount of resources that the private sector can dedicate to the Platform compared to the voluntary sector, the Platform is very much dominated by the private sector, despite the number of official members being more or less balanced between private and voluntary sector. Additionally and quite fundamentally, issues of inherent conflict of interest arise when positioning the food industry as a norm setter and policy influencer in reducing the diet-related NCD burden (Garde et al., 2017).

These weaknesses and critical problems have led to the recent withdrawal *en masse* of NGOs from the EU Diet Platform, much in the same way they withdrew from the twin multistakeholder Platform for Alcohol policy, the 'Alcohol Forum' in 2015 (EurActive, 2015; European Heart Network et al., 2019a). The withdrawal from the EU Diet Platform came after DG SANTE failed to respond to a call from these NGOs for 'an urgent, profound and meaningful overhaul to improve the Platform's outcomes' (European Heart Network et al., 2019a, p.1; European Heart Network et al., 2019b).

To analyse the (in)compatibility of the EU Diet Platform with the HiAP idea, it is worth taking a look at the kinds of results the EU Diet Platform produces. Platform commitments tend to revolve around traditional public health initiatives that conceptualise healthy behaviour as an individual responsibility:

> 'The active commitments focus on six activity areas:
> - Advocacy and information exchange (21 commitments);
> - Composition of foods (reformulation), availability of healthy food options, portion sizes (18 commitments);
> - Consumer information, including labelling (12 commitments);
> - Education, including lifestyle modification (33 commitments);
> - Marketing and advertising (14 commitments); and
> - Physical activity promotion (11 commitments).' (European Commission, 2016a, p.1)

It is not surprising to observe that these are the kinds of commitments taken by what are predominantly processed food and soft drink companies. These types of commitments do not reflect an understanding of- or a willingness to consider the complex political and ideological determinants that underlie the NCD burden, which are rooted in health inequities. Instead, these activities neatly fit the individual responsibility narrative of public health according to

which healthy eating and healthy moving is largely a matter of educating people. The EU Diet Platform, in turn, nudges corporations to act responsibly – if they wish – in a way that facilitates individuals to do the same. Corporate social responsibility ultimately might serve the corporation's self-interest in various ways: to avoid future regulation and to position themselves as norm-setters, thereby increasing their power in society, among other reasons (see for example: Garriga and Melé, 2004). In the case of healthy diet promotion, the corporate social responsibility agenda of food and drink industries serves to reinforce individual responsibility narratives as well (Herrick, 2009). Many interviewees, including some EC officials[31], expressed their rejection of the 'individual responsibility narrative' in public health and in relation to NCDs, and were aware of the links between that discourse, industry self-regulation, and neoliberal capitalism. Many health policymakers seem to be aware of the need to address structural determinants of health, and the need for approaches like HiAP which consider policy areas that shape socioeconomic inequities. Policy-wise however, governance tools like the Platform do not reflect this understanding.

This tension between HiAP awareness and elaborating/maintaining policies like the EU Diet Platform reflects a tendency for policies and initiatives to revert back to individual behaviour modification. This tendency has been identified in the literature as the 'lifestyle drift' (Powell et al., 2017; Williams and Fullagar, 2019). The 'lifestyle drift' is a phenomenon in public health policy defined as 'the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors.' (Popay et al., 2010, p.148). Baum and Fisher (2014) provide an overview of the multiple explanatory dimensions of the lifestyle drift – historical, ideological technical and interest-driven. In terms of historical and ideological factors, they clearly link lifestyle drift with the deployment and consolidation of neoliberal rationality (Baum and Fisher, 2014). Carey et al (2017) have applied a framework of the sociology of social problems to explain the lifestyle drift. Their model is based on the idea that social problems are considered 'negative residue' of dominant political processes. The politics of placing a problem within or outside the social sphere is key, as the exclusion of problems outside the social sphere (and into either the private, personal sphere, or the medical, pathological one, or one that is limited to particular groups of people deemed 'abnormal') is a way to obscure the problematic consequences of a particular political system or a particular ideology. They used this sociological model to argue that the way in which obesity as an

[31] Source: interviewees 3, 8, 12, 13, 20, 26, 31

issue is placed outside the public sphere and is framed as a problem affecting mostly people from vulnerable socio-economic background (Carey et al., 2017). Once a problem is framed in such a way, the route is paved for interventions targeted at disciplining and/or saving 'at-risk groups' and thinking of health inequities as a gap to fill by targeting policies at poorer people (Carey et al., 2017; Douglas M., 2015; Smith, 2013a; Wilkinson and Pickett, 2010). When asked about the Platform's potential to address inequalities, the response of one policymaker interviewee illustrated this rationale that action on inequalities is about upward-filling of a gap:

> I think the Platform can develop ideas for improving approaches for vulnerable population. One example […] is the idea of introducing quality criteria for food banks. Food banks are not necessarily carrying the poorest quality food but might not be in a position to pay enough attention to the nutritional quality of the food. I think it's quite possible to look at the aspects of social inequalities within the Platform and indeed the intention is not to improve the health of the ones at the top, but to improve the health of the ones at the bottom. (Quote from interviewee 29)

This is a common conflation between inequality and poverty and, which, following the sociology social problems model, places the issue of NCDs in the realm of the private. What is more, the EU Diet Platform and its underlying normative assumptions are not put in relation to inequalities as determinants of inequities, but the Platform is portrayed as a tool for solving those very inequities. Improving the food quality of food banks is about changing food bank providers, as well as changing the behaviour of poor people by facilitating their access to healthier food. In no way is this kind of policy targeted at reducing the number of people who would need food banks in the first place.

The point is not that the EU Diet Platform should address the structural determinants of NCDs, but that the EU Diet Platform cannot address and even *actively deters from addressing* structural determinants of NCDs, because of the very nature and essential characteristics of that governance tool. It is incompatible with the essence of the HiAP idea at EU level insofar as its rationale places the responsibility for HiAP away from EU policymakers and away from policy areas that *appear* to be unrelated to health and onto 'responsible corporations' and 'responsible citizens'. This undermines the whole point that HiAP is about understanding and addressing the indirect, distal determinants of health

situated precisely in non-health policy areas, and moving away from conflating health promotion with individual behaviour modification[32].

4.1.2. The High Level Group on Nutrition and Physical Activity

The HLG was created in 2007, at the same time as the EC published its obesity strategy (European Commission, 2007b). The group is composed of EU and European Free Trade Association (EFTA) member states government representatives who are involved on this particular public health issue at home. The role of the HLG is defined by the Commission as follows:

> […] The group
>
> - Enables governments to share health and economic analysis, policy ideas and best practices and develop common approaches;
> - Works on priorities such as improving food products recipes, reducing children's exposure to marketing of foods high in fat, salt and sugars, physical activity, labelling and public procurement of food;
> - Enhances contact between governments and the EU platform for action on diet, physical activity and health, so that relevant collaboration with and between stakeholders can take place.
> - Facilitates the sharing of evidence, data and best practices for policy makers;
> - Identifies research gaps and supports health in all policies;
> - Works on reducing health inequalities (European Commission, n.d. [b])

The overwhelming opinion of HLG members on the group was positive[33]. The opportunities that the HLG offers were very much valued, including the possibilities to go abroad and learn about the implementation of particular policies or ways of working in a different member state[34]. The group is presented by the EC website, as an opportunity to foster dialogue between governments and the EU Diet Platform (see quoted text above). In reality however, none of the HLG members interviewed were actively supporting the idea of promoting more proximity between them and the EU Diet Platform, with some of them explicitly criticising that[35]. One interviewee stressed that the HLG was a space in which attempts were being made to really put HiAP at the centre, including by the EC[36]. The HLG was also perceived by some members as a very useful lever to raise public health issues on their respective national

[32] For a discussion on how the meaning of HiAP itself has been redefined to include an emphasis on multistakeholder involvement, see section 6.2.1., p. 181.
[33] Source: interviewees 15, 17, 18, 19, and 27
[34] Source: interviewees 18 and 19
[35] Source: interviewees 17 and 18
[36] Source: interviewee 27

agendas[37]. The informal, less tangible, social perks of being a group with common interests and expertise that meets regularly was also raised as a very valuable dimension of the HLG.[38]

Another concrete example of the usefulness of the HLG portrayed in one interview was the pivotal role it played in the inclusion of the health and nutrition related marketing restrictions in the AVMSD (see section 4.2.1., p.128). One interviewee described how it would not have been possible to coordinate a reaction on this issue from health ministries across member states if it hadn't been for the HLG and the fact that, thanks to the group, they knew each other and could get in touch easily and rapidly:

> When they started negotiating these parts that covered food marketing, and I noticed that the text they were proposing did not include the food and health related issues that the HLG had emphasised. So, I sent the message to my colleagues in the HLG saying 'Have you seen this?!' […] And there was immediate reaction: in two days they'd contacted their colleagues in their relevant ministries. So, it can work as a kind of catalyst. (Quoted from interviewee 27)

As seen above, supporting HiAP is an officially stated aim of the HLG, and HLG members are keen to see this group as an opportunity to work towards implementing HiAP in their respective member states and through influencing EU legislation. But how effective can a tool like the HLG be with respect to fostering a normatively meaningful HiAP along the lines of a radically broad understanding of health promotion? In other words, is the HLG a radical 'game-changer' that can bring about structural change towards prioritising societal wellbeing?

Even though it is not defined as an OMC, in some aspects the HLG is similar to an OMC: it shares OMC core principles like the fostering of voluntary collaboration among member states through knowledge and best practices exchange. Much work has criticised the OMC on various fronts: some provide critical accounts of the (lack of) democratic legitimacy of these NMGs, and of the OMC in particular (Kröger, 2007; Radulova, 2007; Kohler-Koch and Finke, 2007; Smismans, 2008; De la Porte and Nanz, 2004). Others have argued that the OMC, as a tool of the Lisbon agenda for promoting growth and competitiveness, has reshaped the problematisation of social policy towards equipping responsible individuals to face modern labour market challenges, rather than protecting the solidarity-based mechanisms of traditional social policy (Parker, 2008). Despite its 'soft' and voluntary

[37] Source: interviewees 17, 18, and 19
[38] Source: interviewees 18 and 19

nature, the OMC has been effective at what Bruno et al. (2006, p.532) call 'cognitive and normative harmonisation of national policies [that] disciplines the processes of Europeanization, by regulating governmental policy-making in a conceptual and pragmatic way, which conforms to the "management spirit"'.

However, the HLG also differs from the social OMC, most importantly in the benchmarking and monitoring of member states' progress on agreed upon goals. The HLG did set out a voluntary framework with benchmarks and targets for member states who want to take action on food reformulation, specifically saturated fats, added sugar and salt (European Commission, 2008a, 2011a, 2012a, 2015d). However, the purpose of such benchmarking is not directly related to the EC overarching agenda in the way that the social OMC is (see: Borrás and Jacobsson, 2004; De la Porte and Pochet, 2012; Shore, 2011). Consequently, it is not formally linked to the EU's economic governance through the European Semester. The HLG is not, as Bruno et al. (2006, p. 529) 'subordinated to the Broad Economic Policy Guidelines' in the quite the same direct way as real OMCs. In theory, this could allow more freedom to come up with 'radical' suggestions to implement HiAP. In practice however, and in the grand scheme of things, the agency and scope of the HLG remains fairly limited, and is unlikely to bring about radical change on its own. The HLG's work remains largely concerned with proximal determinants of health, such as food reformulation, even though the more recently officially added themes like supporting HiAP and reducing health inequalities might indicate an attempt – at least by the more critical members – to move beyond proximal determinants of health. This thesis suggests that, as long as it is limited to proximal determinants, the HLG might enjoy relative operational freedom. At the same time however, the group is unlikely to carry enough weight to take HiAP further and adopt a radically broad approach to health promotion. This suspicion is based on the description interviewees gave of the process and the amount of work invested to include health in the AVMSD, and the outcome it ultimately led to (see section on AVMSD below, p.128).

4.2. <u>HiAP in Single Market Regulation</u>

This next section will investigate one example of the scope for including health considerations in non-health Single Market regulation. While this echoes Greer's second face of EU involvement in health, it is different insofar as this section is not about how Single Market regulations directly affect health(care), but about whether indirect effects of non-

health Single Market regulations on health can be better taken into consideration. When asked about a Single Market, non-health policy which illustrates an attempt to mainstream HiAP in relation to NCD prevention and health promotion in the EC, some interviewees mentioned the AVMSD[39]. The case of the AVMSD and the efforts to include health-related considerations in it, was also brought up when discussing the role of the HLG (see previous section).

4.2.1. The Audio-Visual Media Services Directive

In 2015/2016, the AVMSD underwent the REFIT programme (see section 2.4.3.1., pp.92-93). REFIT is a tool of the Better Regulation Agenda to assess whether EU regulations are still up-to-date and do not cause an unnecessary burden on EU businesses and citizens (European Commission, 2017e). The public consultation on the directive addressed the issue of adequate consumer protection (European Commission, 2015e, p.5). In 2016, the EC published a proposal for a revised AVMSD, in which it stated that it aimed to strike a balance between promoting competitiveness and protecting consumers (European Commission, 2016b, p.12). In terms of protecting consumers from advertisement of unhealthy foods and alcohol, the proposal suggested strengthening self-regulatory and co-regulatory codes of conduct. However, evidence of the efficiency of industry self-regulation in the food and alcohol industry is weak (Moodie et al., 2013; Ronit and Jenson, 2014; Thornley et al., 2010). The European Public Health Alliance was one of the EU public health advocacy groups who used the REFIT cycle as an opportunity to actively campaign for a stronger inclusion of public health concerns in the AVMSD, in particular regarding restricting advertisement of unhealthy foods to children; excluding alcohol and unhealthy food (‘high fat, sugar, salt’ foods) from product placement and sponsorships; and allowing adequate regulatory space for member states on public health grounds (European Public Health Alliance, 2016a, 2016b, 2017). As seen above, the HLG also worked to include a stronger health basis in the AVMSD (see p.126). The revision of the AVMSD was not unanimously seen as successful from a public health standpoint, and some of the health advocates interviewed expressed their frustration at the limited scope of the public health-related provisions in the proposal, as well as the EP’s stance vis-à-vis the proposal[40].

[39] Source: interviewees 13, 20 and 28
[40] Source: interviewees 13 and 20

> A couple of MEPs were supportive but overwhelmingly [we faced] a brick wall. We had much more traction with member states on that particular issue. I think the reason for all this resistance was that the dossier wasn't dealt with by health attachés but by culture attachés […]. I've never encountered such resistance like in the AVMSD. […] We were a bit naive as well, because we later realised that asking them to stop advertising alcohol and junk food between 6am and 11pm was basically asking them to dismantle the whole system upon which their profit-making is based on. We didn't realise that we just blindly went in. That might be why we weren't successful. (Quoted from interviewee 20)

Arguably, the EP's amendments and amendment proposals[41], which revolved around encouraging industry self- and co-regulation to limit advertisement of unhealthy foods and alcohol, further weakened any pressure that could be put on the industry. The EP proposed to replace the reference to WHO nutrient profile guidelines with references to the EU Pledge[42] and the EU Diet Platform. They also proposed to replace the term 'with a significant children's audience' to 'content aimed at a children's audience' (European Parliament, 2017, p.79-102, in particular see amendment 14, p.88). The final text adopted in November 2018 refers to 'children's programmes' (European Union, 2018). The new AVMSD was passed on the 14th November 2018, and in the end, it does include more explicit references to advertisement and product placement of unhealthy foods and alcohol than the 2010 Directive: the two main changes are that it now forbids product placement in children's programmes, and more explicitly encourages member states to foster effective industry self- and co-regulation (European Union, 2018, p. L303/73; European Parliament, 2019).

The case of the fight to include health concerns in the AVMSD is illustrative of the difficulty of generating positive integration and implementing HiAP. The regulatory process is such that it is difficult to accommodate HiAP, echoing what Scharpf conceptualises as negative and positive integration. While it now includes a line that mentions saturated fatty acids and some marketing restrictions, the struggles that were faced to achieve this relatively small step shows the absence of vision for health and wellbeing at the centre of EU governance. Hard work may well have been done to include a sentence referring to public health in a particular

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[41] In the EU legislative process, both the Council and the EP follow consultation procedures and add amendments to the initial proposal, which will then again be voted on. If after the second reading no agreement is found, the proposal undergoes a conciliation procedure, where it can ultimately end up being accepted or rejected. The procedure varies for the adoption of the EU budget and in certain other cases (see: Bache et al. 2015).

[42] The EU Pledge is an initiative led by food and beverage companies. It establishes norms and voluntary guidelines on responsible advertising to children. It is supposed 'to support parents in making the right diet and lifestyle choices for their children.' (See EU Pledge website: https://eu-pledge.eu/)

policy, but this does not mean that the EU, including the EC, has undergone a shift in vision which now puts societal wellbeing and health above economic interests and growth. The dominant view remains that, in the process of integrating the Single Market, these kinds of health aspects should not be regulated. This is in line with the imperative of preserving the freedom of the market as much as possible, and it is reflected in the prevailing and re-affirmed position to first and foremost encourage industry self-regulation. Notwithstanding that the AVMSD case represents an attempt to implement HiAP, the relative success of this attempt is very much limited to one small technical aspect of HiAP. But it is not accompanied by a more diffuse normative change towards HiAP.

4.3. HiAP in the Common Agricultural Policy

The CAP is the oldest, and remained for a long time the only, EU redistributive policy (Ackrill et al, 2008). The CAP's history dates back to the 1960s, as part of the broader integration plan to create a common market (Garzon, 2006; Walls et al., 2016). It was created to ensure stable food supply. However flawed the initial price support system was, its logic was a reflection of the post-war period and the immediate concern with preventing food shortage. As such, some have argued that the CAP was inherently a public health measure as well as a market integration measure (European Public Health Alliance, 2016c, p.5). There are obvious reasons why the CAP is a policy with very strong relevance to HiAP, including in specific relation to health promotion and NCD prevention: poor diets, alcohol and tobacco consumption are important determinants of NCDs, and agricultural policies play a very important role in configuring the availability and price of these products within the EU Single Market and abroad. Until now, the CAP's objectives revolved around five key principles:

- support farmers and improve agricultural productivity, ensuring a stable supply of affordable food
- safeguard European Union (EU) farmers to make a reasonable living
- help tackle climate change and the sustainable management of natural resources
- maintain rural areas and landscapes across the EU
- keep the rural economy alive by promoting jobs in farming, agri-foods industries and associated sectors (European Commission, n.d. [c]).

Important issues remain in terms of the health-sensitivity (as well as environmental sustainability) of the budget distribution. Over the last decades, taking health and

environmental protection into account in the CAP has proven a political minefield. With the current system dominated by direct payments, the CAP disproportionately benefits a small group of large, richer, intensive farms. The post-Eurozone crisis proposed cuts to the CAP were shaped in part by the powerful farmer lobby who proposed to save money mainly from the environmental measures and rural development pillar (Pe'er et al., 2019; Roederer-Rynning and Matthews, 2019). As shown in the figure below[43], the CAP money in 2005 predominantly supported food groups of which consumption needs to be decreased (for health as well as environmental sustainability reasons), as well as harmful products like wine and tobacco.

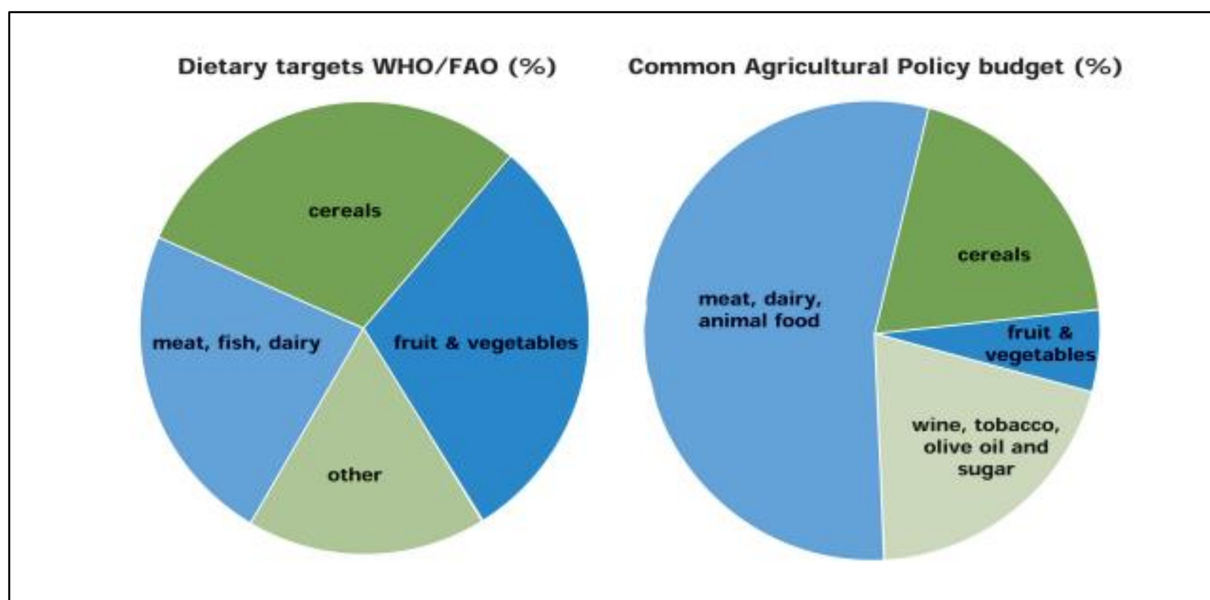


Figure 4.1. Dietary targets and CAP budget spending in 2005. (Birt et al., 2007, cited in European Public Health Alliance, 2016c, p.9)

4.3.1. <u>The post-2020 CAP Reforms</u>

With the growing public outrage about the climate emergency and the unsustainability (both environmentally and socially) of the global food system, the CAP is under increasing societal pressure to respond to modern food-related challenges, including the health aspects of agricultural practices and food production. According to a Eurobarometer study (cited in: Pe'er et al., 2019, p.449), 92% of non-farmers and 64% of farmers agree that the CAP should do more to address environmental challenges such as the climate crisis. The CAP is set to be reformed again for the post 2020 period, and some health NGOs have been advocating for

[43] More recent data unavailable

reforms that more strongly reflect the linkages between agriculture and health (European Public Health Alliance, 2016c). The EC has recently released a set of proposals for a reformed CAP with new objectives. Overall, it is mainly presented as a response to the need to modernise and simplify in a way that gives more autonomy and flexibility to member states and farmers (European Commission, 2017f, 2018b, 2019b). The new objectives of the policy, while expressed vaguely, are to be revised in a way that better reflects the challenges of today. The last specific objective is explicitly to protect food and health quality (European Commission, 2018c, n.d. [c]).

Given these new objectives and the repeated emphasis put on issues like climate change and the link between public health and farming, could it be expected that the new CAP represents a 'HiAP-sensitive' reform? One interviewee from an EU health NGO pointed out that, while rhetorically it would be almost untenable not to pay attention to these so-called 'societal challenges', how this will be reflected in practice, is far from clear:

> It is very positive, because you say ok this policy has a social element, an environmental element, an economic element, a health element. That's something you'd expect from a holistic policy in principle. So, in principle it looks quite progressive. But a lot will depend on how member states are kept accountable to it. (Quoted from interviewee 13)

Indeed, the first obvious shortcoming is the lack of clear mechanisms to enforce compliance with the newly listed goals (European Commission, 2018d, 2018e; European Public Health Alliance, 2018; Pe'er et al., 2019). It is unclear how the EU will make sure member states comply with these new goals, especially when the accent of the reform is put on increased subsidiarity, and increased freedom for member states to adapt, adjust, and interpret the CAP according to their national contexts. The other strong emphasis, along with providing member states more flexibility and subsidiarity, is to make the CAP more 'results-oriented'. To do so, the EC will resort to defining indicators that are supposed to measure how well a member state is performing. However, especially in the areas relevant to public health and environmental protection, the indicators tend to be limited to measuring the proportion of farms that have made various commitments, but it does not capture what Pe'er et al. (2019, p.451) refer to as 'real impacts' (European Commission, 2018f). Additionally, there is little concrete guidance about how the goal of promoting nutritious food is supposed to be achieved (see: European Commission, 2018f, p.6). In terms of addressing the inequities among farmers of different sizes, the new proposed CAP is also likely to disappoint: the

proportion of payment as direct payments – which have been consolidating social and environmental unsustainability – is increased, and the redistributive mechanisms directed at rebalancing inequities and help smaller farms 'remain weak' (Pe'er et al., 2019, p. 450). Similarly to the post-Eurozone crisis budget cuts, the expected Brexit-induced budgetary decrease is also likely to affect the second CAP pillar funding (i.e. funding related to rural development, which includes much of the environmental and social sustainability aspects) disproportionately (Roederer-Rynning and Matthews, 2019).

While rhetorically, there may well be increased consideration for food and farming as closely linked to health, and health understood broadly in a way that includes environmental wellbeing and animal welfare, in practice there is still more to be done for these ideas to be meaningfully reflected in action. The absence of a meaningful environmental, economic and social sustainability-oriented mindset of these reforms, raises serious doubts with respect to how much improvement – if any at all – they will be able to achieve (Pe'er et al., 2019).

4.4. HiAP in EU fiscal governance

This section analyses the scope for HiAP in the EU fiscal governance area. It is related to what Greer calls the third (most recent) face of EU involvement in health. This section takes as a starting point the implications of the increased streamlining between the ESIF and EU fiscal governance mechanisms, in particular the European Semester. It then reflects on the broader relevance of EU fiscal governance to distal determinants of health, calling for the need to look beyond impacts solely on national health systems, and towards a recognition that all measures influencing public spending are relevant to public health.

4.4.1. Investment in health and the European Semester

The second largest EU budget expenditure (after the CAP) is the ESIF. Health related investments under the ESIF have been said to represent HiAP in action (Merkel, 2010). Over the 2007-2013 period, 1.5% of the structural funds were invested in health infrastructure, which amounts to just under EUR 5.2 billion (European Commission, 2016c, p.10). It is, in absolute terms, much more than the expenditures under the Health Programme (HP) (see section 5.2.2., p.163), which amounted to EUR 321.5 million for the 2008-2014 period (European Commission, 2015f, p.3). This sum is also limited to health infrastructure

expenditures and does not include other investments that have a positive impact on health indirectly. The 2014-2020 ESIF programming period saw an increase in health-related investment (or at least an increase of what falls into the classification of health-related investment). Based on an analysis of the ESIF projects approved by August 2017 for the 2014-2020 programming period, (and more specifically within the three sub-funds relevant to health[44]) over 7000 projects had relevance to health and more than EUR 8 billion were spent on health (European Commission, 2019c, p.19). One of the key evolutions of the ESIF for health is the move away from favouring investment in large infrastructure projects (what is called 'hard' investment) and towards investment in human capital and resources, training, life-long learning and so on (referred to as 'soft' investment).

The other important way the ESIF has evolved is that, for investments in health, it is now closely related to the European Semester process, and member states who benefit from ESIF money and wish to invest in health – which is the case in largest part for Eastern European countries and, to some extent, Southern European countries – need to make use of this money as part of a broader strategic framework aligned with Semester recommendations on health systems (European Commission, 2019c). What this means is that this EU redistributive tool at the disposal of member states wishing to use it to invest in health is now increasingly streamlined with the EU fiscal and economic governance.

Given the relevance of the ESIF to HiAP, it is worth analysing what the increased streamlining of the ESIF with the European Semester might mean in practice. Out of the various EU fiscal governance reforms, the Semester has been perceived as the least opaque and rigid one, one that might potentially be malleable enough to be directed in a more socially progressive direction. At the same time, there is concern with the Semester's intrusion – through health systems CSR – into national health systems, an area which has always been vehemently guarded to remain in the hands of member states (Azzopardi-Muscat and Brand, 2014; EuroHealthNet, 2018; Zeitlin and Vanhercke, 2014). Indeed, it has been argued that health care systems are increasingly becoming a shared competence, as the Semester now attributes health-related CSR (Azzopardi-Muscat et al., 2015). The emphasis of these CSR is put on (financial) sustainability and cost-effectiveness, as opposed to a

[44] The European Regional Development Fund (ERDF), the European Social Fund (ESF) and the Cohesion Fund (CF). It excludes the European Agricultural Fund for Rural Development; and the European Maritime and Fisheries Fund

framing in terms of the social pillar to combat poverty and social exclusion. This represents a clear instance of constitutional asymmetry.

The rationale for the involvement of the EC in member states' health systems through the health-specific CSR, is that health systems represent an important part of public spending, and that for the EU's economic stability in this post-crisis period, it is important to ensure that member states' health systems are fiscally sustainable:

> Modern health systems need to remain accessible and effective while pursuing long-term sustainability. To do this, they have to remain fiscally sustainable. The Commission supports member states in this work, providing analysis and forecasts, and recommending reforms as part of the European Semester process […] EU health systems have not coped equally well with the economic crisis and some have had to implement major and sometimes painful reforms in a very short time. (European Commission, 2014b, p.10).

Concretely, the Semester's health specific recommendations are oriented towards, among other things, towards promoting eHealth, mHealth, and performance assessments (European Commission, 2017g, p.9). This is seen as the innovative direction that will help fiscal sustainability of health systems (European Commission, 2017g). Pensions and healthcare are the two largest public expenditures in the EU (European Commission, 2016d), and the two are seen as relatedly growing given the ageing population[45]. Generally speaking, the Semester's advice in terms of pensions seems to be to decrease pension benefits and/or revise the age of retirement. It is worth reflecting upon the coherence of these kinds of policy direction, as regarding their potential impact on the financial burden of the ageing population on the healthcare system (see section 5.1.2.1., p.153). The current involvement of the Semester in the area of health has little to do with caring for population health *per se*, rather it is about ensuring fiscal sustainability of the health systems and making health systems more cost-effective (Azzopardi-Muscat et al., 2015).

The point in this chapter is to highlight how economic priorities are cemented in the conditionalities for accessing the ESIF. It does not represent a normatively meaningful HiAP: on the contrary, it illustrates the constitutional asymmetry which systematically prioritises economic growth over social wellbeing. As a result of the toughened EU fiscal control mechanisms elaborated after the Eurozone crisis, the EC and the Council now have powerful tools to shape member states' public spending. Chapter Five will provide a deeper analysis

[45] see section 5.1.2., p.152 on 'framing of NCDs'.

into the normative paradigms that drive the Semester's involvement in health, and the frames through which this takes place.

4.5. <u>HiAP in EU meta-regulation</u>

The last section of this chapter is concerned with analysing the scope for HiAP beyond specific governance sectors, and in terms of overarching governance logic, that is, in terms of meta-regulation. This governance aspect does not fit with any of Greer's faces of EU involvement in health, because it does not necessarily fit with the model of neo-functionalist spill over into the field of public health and health care. Starting from the notion that HiAP is a concept that needs to be taken up across the board – mainstreamed – it is important to evaluate the scope for HiAP in the EC's meta-regulatory landscape. The elements analysed in this section are the ones briefly introduced under the relevant section in Chapter Two (section 2.4.3., p.91): Better Regulation, on one hand, and the collegiality principle, on the other.

4.5.1. <u>Better Regulation: impact assessment and stakeholder consultation regime</u>

One of the most important aspects of Better Regulation is the need to undertake extensive integrated IA. IA goes hand in hand with stakeholder consultations, as the process includes them at multiple stages, and relies on information provided by stakeholders (European Commission, 2009b, 2015c). Once political validation by the relevant Commissioner and Vice-President(s) has been obtained, an inter-service group (ISG) made up of officials from various DGs on whose area the proposal is likely to impact, is created. The ISG is responsible for drafting the evaluation roadmap and inception IA. At this early stage the process normally includes a plan to consult stakeholders: they have four weeks to provide input (European Commission, 2017d). A Regulatory Scrutiny Board also issues opinions on the IA, fitness checks and evaluations, separately from the other DGs. All feedback has to be taken into careful consideration. The IA is then re-evaluated and published for another eight weeks of stakeholder feedback (European Commission, 2017d).

The integrated IA is supposed to consider not only economic, but also social and environmental impacts. The 2017 Better Regulation guidelines include a section on assessing health impact. While it does mention, at several stages, the existence and importance of non-monetary estimations of health impacts, and the requirement that health impacts should be

presented in both monetary and non-monetary terms (such as the number of life years lost) the largest part of the guideline section focuses on monetary estimates (how numbers of life years lost translate into lost productivity, for example). The limitations of these measurements are acknowledged in the guidelines (European Commission, 2017d). In terms of stakeholder consultation, the EC has shown increasing commitment, over the past few decades, to engaging more with civil society groups and NGOs in domains not usually associated with civil society, and to increasing transparency (Kohler-Koch and Finke, 2007).

How, then, does HiAP fit into this meta-regulatory picture? HIA could be seen as the logical 'HiAP dimension' of Better Regulation. They have been considered with much enthusiasm by some researchers and in particular one health advocate interviewed[46], provided HIA can be perfected and taken seriously (Kemm, 2006).

However, the process of heavy IA and thorough stakeholder consultation has been argued to be strongly skewed in favour of business interests. The remainder of this section critically evaluates the scope for a HiAP rationale at the meta-regulatory level of Better Regulation. The most striking example in the literature on corporate interest permeating the Better Regulation agenda is the tobacco industry's effort to shape and use the IA process to its advantage (Costa et al., 2014; Peeters et al., 2016; Smith et al., 2009; Smith et al., 2010a; Smith et al., 2015). These investigations reveal how the shift towards Better Regulation was actively pursued by the tobacco industry as a means to neutralise the threat posed to them by the precautionary principle. The precautionary principle refers to the need and legitimacy for policymakers to intervene to prevent public health hazard if there are reasonable grounds to believe that a hazard would occur and result in severe or irreversible damage to public health. This principle applies even if there is no clear scientific consensus about the likelihood of the hazard occurring (see: Smith et al., 2015, p.332). The tobacco industry reckoned that, if it succeeded in institutionalising a risk assessment, which the industry itself would play a considerable role in shaping, the regulatory landscape would shift from a cautious rationale to protect human health, to one in which 'new measures are not adopted unless they will achieve significant risk reduction at a reasonable cost, and [in which] new regulations and legislation are based on quantitative risk assessment' (Smith et al., 2015, p.334).

[46] Source: interviewee 26

To push its desired IA agenda, the tobacco industry hid behind the mobilisation of a coalition of businesses, which gave the impression of consensus across the private sector, and behind certain trusted Brussels think tanks such as the European Policy Centre. Calls for more transparency and dialogue also served the tobacco industry in placing itself in a privileged position to provide data and influence the policymaking process (Smith et al., 2015). Smith et al (2010b) have outlined eight fundamental concerns about IAs and their ingrained bias in favour of industry. One of the concerns was that IAs, given the extent and time-consuming nature of this bureaucratic task, are often used to delay regulation[47] (Smith et al., 2010b). Delays can be achieved for example by invoking 'lack of evidence'. This tactic relates to the instrumentalisation of evidence and what Parkhurst (2017) refers to as 'technical bias' in evidence-based policymaking. This point was highlighted by one interviewee from an EU NGO:

> Impact assessment now has become much more complex. [...] It's also become a battle ground; so again *[regarding]* the most recent tobacco control directive. An impact assessment was done [...]. And then the industry lobbied against it, called it into question, complained to the impact assessment board in the EC. So the EC had to, they decided to commission not just one new impact assessment on the draft directive, but they commissioned 5 impact assessments. Which built in another 2, 3, 4 years delay. (Quoted from interviewee 20)

Given all the considerations above, one can understandably be critical about the space for a HiAP rationality in the current Better Regulation context. HIA can be seen as the most technocratic interpretation of HiAP, and it can also be perceived to 'degenerate into a tokenistic "tick box" procedure' (Kemm, 2006). Furthermore, HIA may not be adequate for national and international policy evaluation, as it was created mainly as a tool to evaluate smaller-scale projects at local levels (Koivusalo, 2010). Importantly, HIA is no match for the integrated IA structurally biased in favour of private economic interests. Finally, and more fundamentally: A strong and protected precautionary principle reflects a HiAP rationality far better than the pursuit of a flawless HIA. This does not negate the value of researching health impacts and how to measure them, but it warns against the legitimisation of a system skewed against public health interests.

[47] The others pertain to the overreliance on simplified, aggregate monetary prediction which obscure uncertainties and complexities of policymaking and its effects, and which also obscures the nuances of varying distribution of impacts. They also note the problematic asymmetry of information resulting notably from relying on industry data to estimate the costs to business of an additional regulation, a cost which is easier to calculate than future societal benefits stemming from the regulation. They also highlight the problematic nature of the economic paradigm of for health and how it is perpetuated though the IA rationale.

4.5.2. EC collegiality and the DG SANTE Strategic Plan

EC decision-making is guided by the principle of collegiality (see section 2.4.3.2., p.93). This means that decisions, such as new legislative proposals, need to be approved by the college of commissioners as a whole. At the suspicion that the voice of certain DGs, in the collegial space, carry more weight than others, one interviewee responded:

> I wouldn't say it's fair at all. It depends I think on the amount of evidence you have for a specific argument. […] If you have that evidence [*that a minimum pricing unit reduces alcohol harm to society*] you're in a stronger position than if you don't have that evidence. It all boils down to how strong the evidence is. (Quoted from interviewee 28)

This quote suggests that the collegiality principle is somehow neutral, and that streamlining EC priorities through fostering this close collaboration leads to rational decision making based on available evidence. In theory, then, one would expect that increased collegiality could offer the space to raise health on the agenda across DGs, and to facilitate HiAP. However, reinforced collegiality in the decision making process has in certain cases meant that a DG's agency becomes more constrained. This is especially true for small DGs like SANTE. One MEP assistant explained how collegiality has meant a reduction in the number of proposals initiated by DG SANTE (a reduction in numbers of legislative and regulatory proposals is, after all, one of the most crucial goals of Better Regulation):

> […] there's a different procedure now. Before, DG SANTE could just come up with ideas, with proposals. But now it has to undergo a cross… it has to be decided by the Commissioners from all different DGs, because of collegiality. A lot of initiatives have been stopped because of the new procedure. (Quoted from interviewee 21)

The relatively recent increased number of invitations of health to the negotiating table also meant, according to one interviewee, that those supposed to represent health can easily become caught up in a dynamic of subordinating their own sector to the needs and imperative of other sectors (see section 6.2.2., p.183). Arguably, this issue is visible in how the aims and goals of each DG have been aggressively streamlined towards EC overarching priorities: in the case of DG SANTE, the need to streamline Juncker priorities is reflected in the DG's strategic plan for 2016-2020 (European Commission, 2017h). The plan states that 'DG SANTE's primary objective is to contribute to jobs, growth, and investment in the EU' (p.11), and that 'DG SANTE's ultimate goal is to achieve better conditions for trade: greater

market access for EU exports at the same time as ensuring our food standards are not compromised on imports' (p.28).

Throughout the document, the case for health is justified in terms of how it contributes to the Juncker priorities. In terms of growth and jobs, the narrative is one that stresses the health and care sector, as well as the food sector, as two very important parts of the economy. The justification for investment in health is that it can prevent large amounts of money getting lost to burdensome and expensive treatments of diseases, and that therefore the EU needs to invest in preventing diseases, as well as developing innovative solutions to absorb the costs of healthcare, such as e-health, m-health and telemedicine (see section 5.1.1., p.147). In terms of competitiveness, the strategy speaks of promoting the internationally recognised 'safety brand' (p.4) and remaining a world leader in the safety of products, such as foodstuffs, that move inside the Single Market. The way SANTE negotiates competitiveness and food safety, which at first sight can seem contradictory (insofar as competitiveness is associated with deregulation and safety is associated with regulation) is in terms of the 'EU brand' as being a world leading example of safety and trustworthiness (European Commission, 2017h). Key challenges for DG SANTE in the 2016-2020 period identified in the strategy include increasing cost-effectiveness, balancing safety and competitiveness, global health threats, making policy-making more evidence-based, and balancing consumer safety and industrial interests. Regarding industry interests, the strategy also proposes to intensify close collaboration with stakeholders. DG SANTE is also placed within a context of trade relations and identifies as one of its roles the promotion of trade relations, including through working towards removing SPS trade barriers with the US. Interestingly, the burden of NCDs and health promotion only figure under the 'improving cost-efficiency' headline, and social determinants of health, HiAP or health inequities are not mentioned in the operating context.

The 2016-2020 Strategic Plan makes it very clear that population health is not the primary concern of Juncker's DG SANTE, but that health is merely an avenue to contributing to economic growth and competitiveness, which is aligned with the overarching EC priorities. While this does not preclude some very limited, technical instances of including health in non-health related policy areas, for example in the form of calculating the financial impact of proposed policies on health systems, it does not allow for a normatively meaningful HiAP (see section 1.2., p.40), given the way the EC and DG SANTE priorities are clearly stated.

4.6. Conclusion: An unfavourable institutional context

This chapter has shown that the EU institutional context is not favourable for implementing HiAP in a normatively meaningful way. That the institutional setting of the EU is geared in favour of the free market and economic growth, and that therefore it offers little scope for HiAP, is not surprising, and concurs with the critical literature on EU health that situates the involvement of the EU in health within the constitutional asymmetry context and the neoliberal bias of the EU (see section 2.1.1.1., p.63).

This chapter has contributed to this critical EU health literature with new empirical foci related to health promotion, rather than healthcare services and health systems, which tended to be the focus thus far. By taking a radically broad conceptualisation of health promotion, this chapter has explored some of the institutional barriers to HiAP using examples from a large variety of EU governance aspects: it started with soft governance tools directly aimed at public health promotion and NCD prevention. Here, the chapter showed how the EU Diet Platform illustrates an instance of the 'lifestyle drift' phenomenon, and how it contributes to perpetuating that phenomenon. It also shows how the OMC-like space for nutrition and physical activity, the HLG, while it is not subject to the same pressures as the social OMC, ends up having little scope beyond action on proximal determinants of health. In the 'hard governance' category, this chapter has provided examples of the lack of a HiAP vision in the Single Market (the AVMSD), the CAP reforms, and EU fiscal governance. Yet all these governance areas are relevant to HiAP: the Single Market and the CAP shape the availability and prices of products, and all three areas have indirect implications on health through shaping socioeconomic inequities. They pertain in large part to 'distal determinant of health' (even though admittedly, the health consideration introduced in the AVMSD still largely pertains to proximal, behavioural determinants of NCDs). Finally, the chapter has looked at the space for HiAP in the EC meta-regulatory landscape, given that HiAP is supposed to be 'mainstreamed', which means that it is supposed to permeate all EU activities. As this chapter has shown using the examples of Better Regulation and the collegiality principle, the meta-regulatory agenda reflects the EU constitutional asymmetry and prioritises economic interests and growth over societal wellbeing and HiAP.

Each section of this chapter has illustrated the difficulties of implementing HiAP and taking up a radically broad understanding of health promotion. Looking at the relationships between the various sections, it is also clear how a minimalist understanding of health promotion as

limited to proximal determinants of health sits neatly in the constitutional asymmetry context. Policy areas which have a bearing on distal determinants of health tend to fall within the remit of harder and meta-regulatory governance, where the perceived relevance to health is limited and where the goals pursued are economic in nature (growth, competitiveness, etc), while proximal, risk-factors-related public health promotion remains governed by 'soft' methods directed at disciplining and responsibilising individuals and corporations. This is illustrative of the EU institutional neoliberal bias. Importantly, and as pointed out in the literature (Greer, 2014a), promoting population health is not the main objective even of EU activities related to health, let alone in activities of other DGs. Promoting health across sectors, based on growing understandings of the complexity and interdependencies that shape public health burdens, would entail considerable priority shifts not only in DG SANTE and in health policies, but across DGs and non-health policies (as well as across EU institutions). As suggested earlier, the fact that member states are reluctant to confer healthcare and health system competencies on the EU does not in any way undermine or cancel the obligation of the EU to enhance and/or promote population health and wellbeing through all its *other* actions. When taking a broad conceptualisation of health promotion, as outlined in the previous chapter, it should become clear that HiAP is not about subsidiarity infringement, but about creating the policy space for prioritising societal health and wellbeing.

The neoliberal institutional structures, in a 'conventional' sense, however, do not tell the whole story of why HiAP fails to be taken up at EU level. This institutional configuration, however powerfully anchored, did not 'happen' out of the blue and does not sustain itself independently, without an underlying cognitive and linguistic system of meaning to support, reinforce and sometimes challenge it. Furthermore, constitutional asymmetry is unlikely to be the only factor standing in the way of HiAP at EU level. Yet at the same time, the dominant institutional dynamics are not homogenous, given that HiAP was elevated to the EU agenda in the first place. Limiting the analysis of HiAP at EU level to institutional factors would fail to capture underlying dynamics that shape those factors, and it would run the risk of presenting institutions as immutable, regular entities that operate in a predictable, monolithic fashion. Instead, this thesis argues for the need to look beyond constitutional asymmetry and the soft/hard governance dichotomy to analyse the power in dominant ideas and representations of health and knowledge (Chapter Five), before highlighting the spaces for contestation in the meanings of ideas (Chapter Six). Going back to the various elements in

Schmidt's DI, the next chapter will take a closer look at the discursive obstacles to HiAP, or what this thesis refers to as 'background discursive abilities'.

CHAPTER 5: Ideational obstacles to HiAP in the EU

Chapter Four told part of the story of why HiAP struggles to be taken up due to neoliberal institutional biases. However, the institutional architecture is not the only dimension that reflects neoliberalism. Furthermore, the institutional architecture does not sustain itself on its own, independently of ideational and discursive dynamics. Going beyond 'conventional' institutionalism means rejecting the assumption that, if the soft governance areas were stronger and able to counterbalance the weight of hard governance, then little would stand in the way of HiAP. Or, more generally, that little would stand in the way of a 'less neoliberal, more social EU'. Rather, one also needs to consider underlying 'systems of meanings', or to put it in DI terms, the 'background ideational structures', in order to better capture how neoliberalism is reproduced ideationally, through frames, their embeddedness in paradigms, and how paradigms are 'colonised' by neoliberal rationality (Rushton and Williams, 2012).

Applying Rushton and William's (2012) framework for analysing global health policy-making (see Figure 3.1., p.109) on the empirical material gathered through document collection and semi-structured elite interviews (see Methods section, pp.20-26), the chapter suggests that neoliberalism is reflected in paradigms of health and of knowledge, as well as in the framings of NCDs and evidence which they induce. Note that paradigms should not be thought of as somehow *independent* of 'conventional' institutional dynamics seen in Chapter Four. Quite the opposite: the concept of constitutional asymmetry explored in Chapter Four, for example, is closely related to the economic paradigm of health. Arguably, one could think of these two concepts as two manifestations of neoliberal rationality which reinforce each other: constitutional asymmetry being the institutional manifestation, and the economic paradigm of health as the ideational one. This thesis does not argue, then, that the ideational and the institutional sides of the (neoliberal) coin are somehow separate. Rather, this chapter explores ways in which the multiple different paradigms and frames reproduce neoliberalism while being mobilised *in spaces other than the constitutional asymmetry*. In turn, this chapter is concerned with Schmidt's second element of DI, the background ideational structures. To get a better sense of what happens to HiAP at the EU, it is necessary to look beyond the soft/hard governance divide, aligned with a conventional conceptualisation of power in binary terms. This chapter looks at power *in* ideas, power as present in language and reproduced through knowledge production and meaning-making. This suggests a more pervasive presence of neoliberal rationality, but also a less rigid, less inevitable one.

Concretely, this chapter presents a discourse analysis (see Introduction, pp.23-26) applied to EU documents (pp.23-24) and interview data (p.21). It explores the interactions between paradigms and frames and how neoliberalism permeates and is reinforced through them. Starting with briefly presenting various paradigms of health that have been argued to fit neatly with neoliberal rationality, it zooms into and unpacks in particular the economic paradigm of health and how it manifests at the EU level. Through interview and document quotes, this chapter presents the recurrent themes and ideational pathways through which health is repeatedly thought of in relation to economic growth. Based on the empirical discourse analysis of the EU documents and based on interview data from EU officials (from DG SANTE and EP) and EU health advocates, this chapter suggests that the economic paradigm of health dominates in the EU in relation to NCDs and health promotion. It then looks at how the economic paradigm of health, in conjunction and overlapping with the security and the biomedical paradigms of health, shapes the framing of NCDs. The implication of these frames and paradigms for HiAP, and their rootedness in a 'neoliberal deep core', is subsequently reflected upon. The second half the chapter draws on the empirical material in the same way as the first half. Using discourse analysis of EU documents and using interview material collected from DG SANTE officials, EU health advocates and a representative of a research and evaluation company, it identifies the positivist, hypothetico-deductive knowledge paradigm as dominant in the EU context. In particular the theme of 'evidence', and what is considered usable and legitimate evidence were identified and critically analysed. Here, the analysis put in relation frames of evidence, with the positivist paradigm of knowledge, and the neoliberal 'deep core' which underpins that paradigm.

Dominant health and knowledge paradigms, and their neoliberal underpinning, are mutually reinforcing. Dominant paradigms and frames have important implications in terms of scope to take up HiAP. This is particularly the case in relation to the normativity and complexity of HiAP. Figure 5.1. below provides an overview of the chapter's rationale, and how the argument is structured. Ultimately, this chapter argues that, in the EU context, HiAP is not only undermined by a prevailing (neoliberal) constitutional asymmetry, but also by a neoliberal ideational asymmetry. Importantly, it argues that the latter is *more* than a simple consequence of the former.

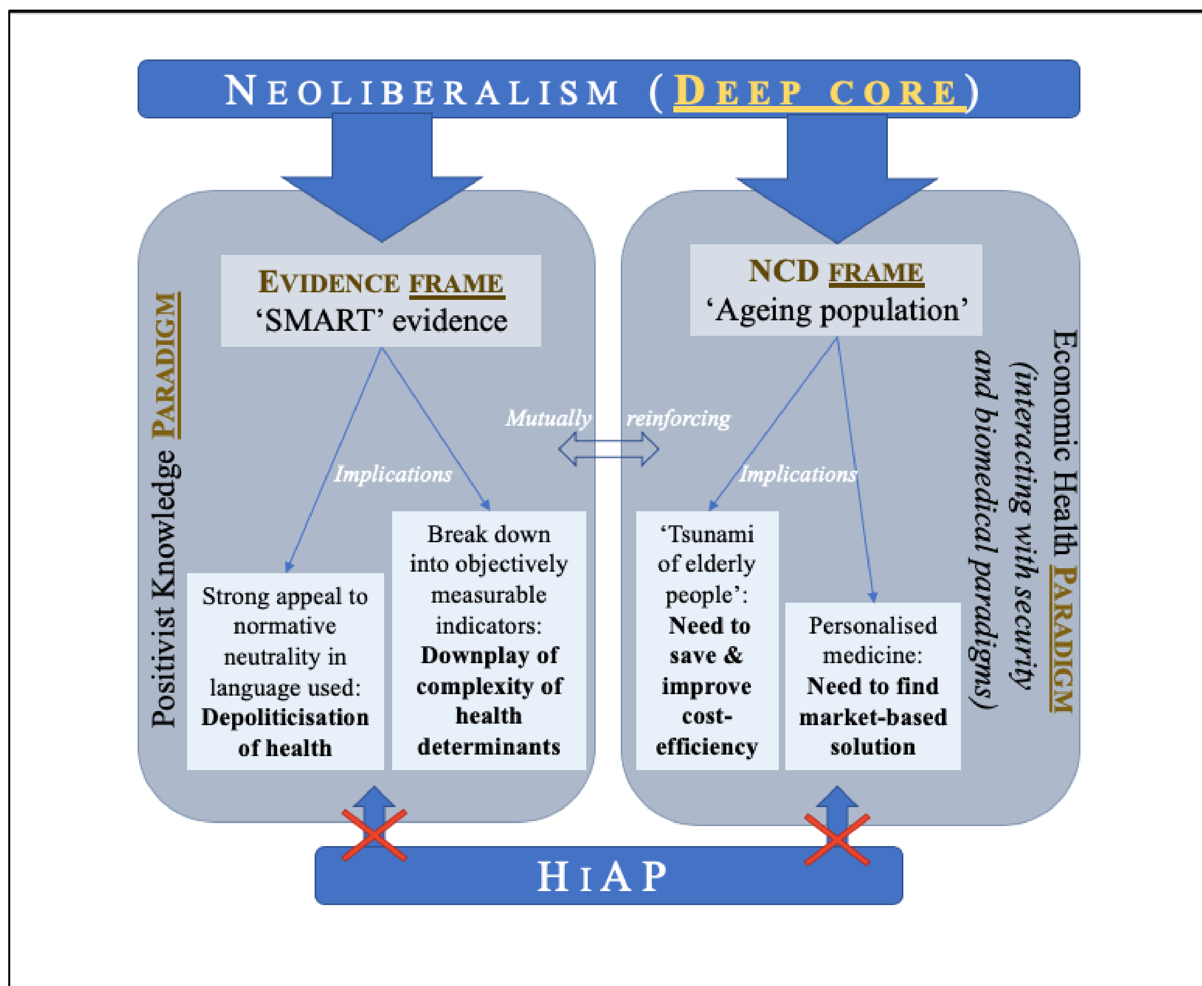


Figure 5.1. Overview of Chapter Five: Exploring EU background ideational structures

5.1. Health paradigms and frames of NCDs

Arguably the most heavily prevailing health paradigm relevant to NCDs and health promotion which can be deciphered in many EU documents, is what will hereafter be referred to as the 'economic paradigm of health' (see also Rushton and Williams, 2009). This paradigm tends to value action and investment in public health because of its return on investment and the profitability of this market. The economic paradigm is not the only existing paradigm of health. For example, Chapter One already introduced the notion that health can be seen in terms of biomedical, behavioural and social paradigms (pp.35-36). Some health paradigms, including the biomedical one, have been deemed particularly well aligned with neoliberalism (Glasgow and Schrecker, 2016; Rushton and Williams, 2012). That is also very much the case for the economic paradigm and the behavioural paradigm of health. Arguably, however, the latter has already been researched extensively, and has also already been talked about in this thesis (see section 1.1., pp.36-37; section 2.2.4., p.78; section 4.1.1., p.121). While it will be referred to in this chapter as well (in relation to the

push towards self-management for NCD patients), the behavioural paradigm will not be the central element of this analysis.

Rather, this chapter section will look at the mutually reinforcing neoliberal dynamics between the economic, the biomedical, and the 'security' paradigms of health, and how they are mobilised in the framing of NCDs as largely the result of life expectancy improvements reflected in the ageing population. The security paradigm of health is built on a 'threat-defence' logic (see Elbe, 2006) and tends to be used mostly in relation to infectious disease control and threats of pandemics or biological warfare (McInnes, 2015). However, this chapter argues that elements of the framing of NCDs draw on the securitisation paradigm in conjunction with the economic one.

5.1.1. The economic paradigm of health in the EU

The logic driven by the economic paradigm of health in the context of NCDs, is that ill-health is expensive, and that it is therefore preferable to invest in health promotion than to pay the cost of curative healthcare and lost productivity (European Commission, 2013b, pp.4-5; European Commission, 2014b, p.2; European Commission, 2017h). In addition, the economic paradigm of health conceptualises health as a vibrant economic field with a lot of innovative potential which, when harnessed, can bring about economic growth (European Commission, 2014b, p.3; European Commission, 2017h; European Commission, 2017m). One important disclaimer is that this paradigm is by no means specific to the EU[48]. Indeed, the economic paradigm of health has been widespread at global, international and national levels elsewhere, for a while now (see for example: Jamison et al., 2016; OECD, 2010; Sachs, 2001).

Aligned with that paradigm, numerous EC public health documents (for example European Commission, 2017h; 2017k), start with an acknowledgement that health is a desirable goal in and of itself and a human right, only to then emphasise the financial cost of ill-health, the loss of productivity that results from ill-health, and the amount of money and economic growth that could be generated if the population was healthier. Economic language seems to be the most 'serious' and legitimate explanation, and the human rights language does not carry the same weight and is merely cited *en passant*. In a way reminiscent of the 'lifestyle drift' (see section 4.1.1., p.123), there tends to be an 'economic drift' when talking about the

[48] Neither are the other health paradigms, either.

importance of health in the EU space: it starts off with recognising the importance of health on its own right, only to drift into focusing on the impacts on the economy. This discursive drift is visible in various EU documents (European Commission, 2014b; European Commission, 2017a, p.10; European Commission, 2019c, p.17).

> Besides being a value in itself, health is also a precondition for economic prosperity, as recognised in the Commission staff working document 'Investing in health', which is part of the Social Investment Package. People's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending. (European Commission, 2014b, p.3)

The ubiquity of the economic paradigm of health does not mean that all individuals working in relevant fields value it more than rights-based justifications for health. One interviewee in particular insisted that, far from being a preference, adopting the language of health as a means for economic growth is something inevitable, a necessity if health is to be heard by other policy areas[49].

The link between health and economic growth is well researched, and even some critical public health practitioners have stressed the power and usefulness of highlighting and using this link to advance the public health cause[50]. They argue that it is not something public health experts should reject or downplay, as long as they remain acutely aware of the risk of co-option, and the necessity of seeing the economic argument as a tool to achieve health and wellbeing, rather than the other way around. In that vein, the aim of this chapter section is not to critique the point that good health contributes to economic prosperity. Similarly, economic prosperity matters and is an important condition for people to live fulfilling and emancipated lives. The point of critique, however, is the dominance of the economic paradigm of health over the reasoning that health should genuinely be seen as a goal in itself, not only in the health sector, but in other policy areas as well (HiAP). As will be detailed below, and as already argued by others (Baum and Fisher, 2014; Smith, 2013a), the economic paradigm of health is unlikely to lead to an approach to health which adequately prioritises health equity. As such, it is an impediment to HiAP, and represents a manifestation of neoliberal rationality in public health policy. The economic paradigm of health presents two main faces: on the one hand, health promotion and public health is seen in terms of return on investment, as a way to avoid costs related to ill-health. At the same time, health is seen as a market ripe for profit making. The two faces of the economic paradigm are often present together.

[49] Source: interviewee 8
[50] Source: interviewees 31 and 27

5.1.1.1. Ill-health as a financial burden to avoid

The first face – health promotion and disease prevention as a necessary investment to prevent healthcare costs spiralling out of control – is exemplified in the quote below:

> 80% of healthcare cost are going on chronic diseases. And therefore, the member states are very anxious to make sure that the drivers of this epidemic are slowed down. And therefore, we need to step up prevention and promotion as much as possible. Because otherwise the health systems are not sustainable. (Quoted from interviewee 28)

Arguably, then, investing in health is seen first and foremost as a way to minimise a financial burden, rather than for the sake of creating a healthy, thriving and fair society. This distinction matters enormously, as while both recognise that health leads to economic prosperity, both are fundamentally differing in terms of underlying values and worldviews: instead of working towards creating health and wellbeing for its own sake and taking on a paradigmatically 'salutogenic' approach to health promotion (see section 1.2., pp.41-42), thinking of health promotion are merely a way to cut healthcare costs reflects a 'pathogenic' approach to health, focused on risk factors to minimise, rather than a public good to maximise. The absence of willingness to adopt a more salutogenic approach to thinking about health, health promotion and NCDs can be seen in this quote from an MEP:

> Prevention for example, I proposed to appoint a Commissioner for prevention. Because the money we allocate for health disappears in the hospitals more or less. But prevention means to work with healthy people and prevention is still not considered as an economic category but when you land in the hospital then you become economic category. (Quoted from interviewee 24)[51]

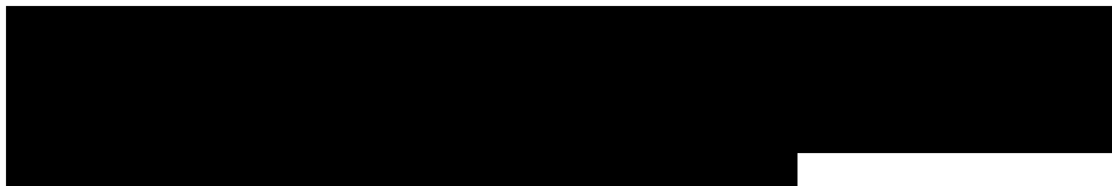
What this quote suggests, is that the dominant way to think about health is in terms of economic cost, which rises when people are ill and need to use the health system. This reflects a pathogenic approach to health, which focuses on ill-health treatment – and prevention for the sake of cost-cutting – rather than focusing on health and wellbeing generation. There is no vision for creating a healthy, wellbeing society, but only a vision to reduce the financial burden of member states. As expressed in the quote above, EU added value is perceived as justified when it comes to creating more cost-effective, modern health systems ready to cope with the 'economic category' of (elderly) chronically sick people, but

[51] The same idea was suggested by interviewees 17, 18 and 19

not when it comes to imagining and creating a world in which fewer people would be chronically sick. In that area, the scope for what is conceivable for the EU to do in terms of health promotion is reduced to merely fostering knowledge and best practice exchange among member states (see section 5.2.2., p.163). Note however that the quote of the MEP itself points to the existence of critical discourses that challenge the orthodoxy[52].

5.1.1.2. Health as a lucrative market

The other face of the economic paradigm of health, is to argue that the health sector represents a great sector for producing wealth. Here, the idea is that health is a large sector of the economy, and has a lot of potential for innovation and wealth creation on the global market. This rationale can be found in numerous EU documents and spaces (see notably European Commission documents in relation to the 'personalised medicine' priority: European Commission, 2017m, European Commission, n.d. [i]). By and large, most of the EU health-related funded research concerns pharmaceutical and medical device innovation, as well as innovations for digital solutions, and a general favouring of projects developing personalised medicine (European Commission, 2015g, 2017i, 2019d)[53].



As the quote above suggests, the rationale of health as a profit-making market carries the obvious risk that priorities will be guided not by what has the greatest societal value, but what will lead to profit through marketing treatments or devices which might be useful to some people – especially wealthier people – but would do little to promote health on a societal level and reduce inequities.

This face of the economic paradigm of health is visible for example in the creation of the first subgroup within the Steering Group for health promotion, disease prevention and management of NCDs (SGPP) (European Commission, 2018g, 2018h). The purpose of the

[52] That MEP was involved in the organisation of the Post-Growth conference, see section 6.3.2.1., p.195.
[53] Exceptions include: PHC 4 – 2015: Health promotion and disease prevention: improved inter-sector cooperation for environment and health-based interventions (European Commission, 2015g, p.10), PHC 31 – 2014: Foresight for health policy development and regulation (European Commission, 2015g, p.46) and SC1-PM-07-2017: Promoting mental health and well-being in the young (European Commission, 2017i, p.18)

SGPP is to ‘provide strategic advice to the Commission and a forum for consultation among member states on the strategic planning of health promotion as well as prevention and management of non-communicable diseases’ (European Commission, 2016e, p.1). The mandate of the SGPP is unequivocally about gathering knowledge, and discussing broad strategies for health promotion and disease prevention in particular in relation to NCDs. Yet the EC decided to create a time-bound, topic specific subgroup on proton therapy within the SGPP (European Commission, 2018g, p.5; 2018h). Proton therapy is a high-tech innovative cancer treatment which ‘can be effective in particular for highly specialised pathologies such as some eye, brain and skull cancers’ (European Commission, 2018h, p.1). As it turns out, the creation of this subgroup was requested by the European Investment Bank (EIB), which had been approached with proton therapy financing requests (p.1). Notwithstanding the importance of the availability of treatment for the patients concerned, the matter of the subgroup has no relevance whatsoever to public health promotion. The existence of this subgroup was not mentioned by any of the interviewees talking about the SGPP, and it is unlikely that health policymakers would attempt to present it as public health promotion. But this example illustrates the power of the notion of health as an innovation market leading to resource allocation towards profitable sectors, rather than focusing on creating more equal and healthy societies. This is not to say that all innovations in health exacerbate inequities, but again, it is about relative weight attributed and prioritisation rationales that the paradigm induces. It is also not to suggest that health promotion in and of itself is incompatible with profit-making: a neoliberal interpretation of health promotion has indeed led to the proliferation of a profitable lifestyle-related market, especially in dieting and exercising (Ayo, 2012), or more recently the commodification of meditation and mindfulness (see part two in Purser et al., 2016). However, the point made in this particular example, is that the SGPP was (in part) ‘hijacked’, and redirected towards researching high-tech specialised medical innovation, even though the group’s stated aim is about developing broad strategies for NCD-related health promotion.

The co-existence of the two faces of the economic paradigm of health is interesting because, while they are compatible in the short term view of improving cost-efficiency, in the long term it leads to a tension: the profit-making potential of the health sector depends on people getting sick or remaining at risk of getting sick. Of course, people will always be at risk of developing a disease no matter how wellbeing-oriented our societies become. Nevertheless, at its core and in the long term, the market creating logic of health is conflicting with the need to reduce the financial burden of disease: the aim resulting from these two logics is not to

foster a healthier society and fundamentally decrease the number of sick people, but to expand the market to deal with this burden in a cost-effective, or even better, in a profitable way.

The next section looks at how, in interaction with elements of other health paradigms, the economic paradigm of health underpins the dominant framing of NCDs, and how this does not represent an adequate ideational ground to implement HiAP.

5.1.2. The 'ageing population' NCD frame in the EU

One common depiction of NCDs and health promotion tends to portray the burden of NCDs, also often referred to as 'chronic diseases'[54], in direct relation to the fact that we live in an ageing society (European Commission, 2000b, 2013b; European Union, 2014). The mention of ageing society is present as a justification for action on NCDs and determinants of health, given the threat it will represent in terms of the financial sustainability of health systems. The main health challenge faced by member states that the third Health Programme (HP) identified, was the 'demographic context, threatening the sustainability of health systems' (European Commission, 2014d, p.1). '[B]etter levels of health across all population groups are critical in the context of an ageing EU population to contribute to the sustainability of social protection systems.' (European Commission, 2009c, p.5) Another typical example would be:

> In the context of an ageing society, well-directed investments to promote health and prevent diseases can increase the number of 'healthy life years' and thus enable the elderly to enjoy a healthy and active life as they get older. Chronic diseases are responsible for over 80 % of premature mortality in the Union. (European Union, 2014, p.86/3).

Admittedly, mentions of 'inequalities' nowadays also often accompany opening statements on NCDs[55]. The rationale of DG SANTE's 2014-2020 public health strategy (the third HP, see section 5.2.2., p.163) is based on the identification of various challenges, the first one being: an 'increasingly challenging demographic context threating the sustainability of health systems', along with the increase in prevalence of chronic diseases, as well as the rising

[54] 'Chronic diseases' refers to the usual NCD (cancer, cardiovascular diseases, diabetes, chronic pulmonary diseases) as well as neurological mental diseases and other diseases like arthritis and allergy-induced respiratory diseases. See: https://ec.europa.eu/research/health/index.cfm?pg=area&areaname=chronic

[55] The way in which the inequality aspect is interpreted and the implications of its interpretation does not invalidate the argument made in this section and will be addressed in section 5.2.2.2., p.169.

inequalities between and within member states (European Commission, 2014c, 2014d). The importance of ageing is very much emphasised, and presented as a natural, obvious causal factor for the rise of NCDs. The 'ESIF for Health' report, for example, defines 'health promotion and healthy ageing' as a single thematic category (European Commission, 2019c). Indeed, the EU population is getting older, and with this demographic change, the number of people with NCDs is also growing. This makes sense, given that NCDs such as cancer, cardiovascular diseases and type II diabetes predominantly affect middle-aged and elderly parts of the population compared to young population groups. The point of this section is not to claim that rising NCD prevalence has nothing to do with ageing. Rather, it is about digging deeper into the implications of this framing, exploring how it relates to the economic (and other) paradigms of health, and neoliberalism.

The paragraphs below will elaborate the critique of the framing of NCDs as a (inevitable) result of an ageing population. They show how this framing – like any framing – is not neutral, but is the product of health paradigms underpinned by neoliberal rationality. The argument developed here is not that the portrayal of NCDs being related to the ageing of the population is 'wrong' or 'misleading', it is not about gauging the legitimacy of this narrative itself. Rather, what is criticised is the notion that this narrative obscures other explanations for the rising NCD burden, most importantly the role of health inequities and their social, political and economic inequity roots.

5.1.2.1. Economic and security paradigms: a tsunami of elderly people as the problem

The NCD frame focusing on the ageing population is fuelled by (and reinforces) the first face of the economic paradigm of health pertaining to ill-health as a financial burden to avoid. Here, the ageing population, with its propensity to develop NCDs, is portrayed as an unavoidable threat to the financial sustainability of the healthcare system (as well as, in combination with low birth rates, the pensions system). 'European population is ageing and more exposed to multiple chronic diseases. This leads to higher demand for healthcare and increasing fiscal pressure' (European Commission, 2017g, p.1). Given that the process of the ageing population in itself is desirable, the accent is put on how to cope with this imminent threat to healthcare system sustainability. This 'threat' logic resonates with the security paradigm of health. As suggested above (p.147), global health is increasingly conceptualised as a security issue. Public and global health issues that receive the most attention have been mostly infectious diseases, likely because they fit best with a traditional conceptualisation of

security (Benson and Glasgow, 2015). In the context of NCDs, however, the security paradigm which emphasises the notion of 'threat', 'risk' and 'crisis', and which is more likely to captivate the attention of policymakers, relates to the strain caused by NCD patients on social services: the image is that of a wave of chronically sick, elderly people which will cause the health system to break down if costs are not saved. The EC talks about 'future-proofing health systems'[56] (European Commission, 2019c, p.31):

> Population ageing, technological change and growing citizen expectations are placing greater pressure on Member State health budgets. Action will be necessary to ensure the long-term fiscal sustainability of healthcare systems (European Commission, 2019c, p.31).

The focus then subtly changes from NCDs themselves to health system sustainability as a matter of economic security. The 'pragmatic' goal is not so much to create a society in which fewer people would develop NCDs, but to improve cost-effectiveness and efficiency of health systems to cope with the increase of elderly NCD patients. This 'demographic time bomb' can readily justify austerity or cost-saving measures such as the ones put forward by the European Semester (see section 4.4.1., p.133): in the closer alignment between the ESIF and the European Semester, the priority for health-related investments is put on financial sustainability of health systems, requiring modernisation, tech innovation and community-based healthcare with a view to fostering healthy, active and autonomous ageing. Member states who want to benefit from ESIF money for health need to demonstrate how the investment fits into a broader modernisation of health system strategy which improves cost-effectiveness:

> In the 2014-2020 programming period, health infrastructure investments and other investments in health in individual Member States are supported mostly as an integral part of their health system reforms in order to ensure that the system is effective and efficient. For this purpose, Member States using ESIF as a source of funding for their health systems had to present a strategic framework for health investments; every investment had to be in line with this framework. (European Commission, 2016c, p.16)

While it is difficult to argue against 'health system effectiveness and efficiency' as a desirable goal, it is important to bear in mind the underlying normative assumptions that drive the meaning of what represents 'effectiveness and efficiency'. The European Semester

[56] 'Future-proofing' is a term also used in the Better Regulation documents (European Commission, 2017d, p.149)

CSR for health are not designed by public health experts, but are designed with a view to reducing national spending on health. 'Effectiveness and efficiency', in this context, refers more to cost-saving and responsibilisation of individuals.

Portraying the growing wave of elderly people as a threat to the financial sustainability of health systems downplays and even obscures the evidence that exists on the link between NCDs and inequities, and precludes the possibility to consider structural changes to improve public health. The CSR published in 2019 in the frame of the European Semester largely revolves around three main themes: ensuring financial sustainability of the pension and healthcare system, which in many cases also explicitly means raising the age of retirement and cracking down on early retirement (see for example CSR for Austria, Portugal, Czech Republic, Poland, Romania, Slovakia, Ireland, Italy, Slovenia, Luxembourg, Finland, and Belgium)[57]. A second theme is to reduce unemployment by cracking down on incentives to remain out of work (see, for example, Finland and Germany) as well as by creating incentives specially for women, vulnerable people, low-skilled people and migrants (Portugal, Belgium, Netherlands, Czech Republic, Hungary, Ireland, Slovenia and Austria). Finally, another of the common themes of the 2019 CSRs is to create a more business-friendly environment, with recommended mechanisms like improving stakeholder consultation, reducing regulatory burden, and competition, and favouring economic investment in areas like research and innovation (see for example CSRs for Portugal, Poland, Belgium, Czech Republic, Italy, Slovenia, Austria, Luxembourg, and Bulgaria). However, the public spending cuts put forward to ensure the financial sustainability of health systems 'in an ageing population' (i.e. reducing unemployment and pension spending) is likely to increase inequities that worsen population health. As mentioned extensively in Chapter Two (section 2.2.,p. 72), neoliberal, austerity measures, such as notably ones following the Eurozone crisis, have been associated with a deterioration of population health (Karanikolos et al., 2013; Kentikelenis et al., 2011; McKee et al., 2017; Stuckler et al., 2017).

5.1.2.2. Economic and biomedical paradigms: personalised medicine as the solution

The framing of the growing NCD burden as a result of an ageing population is also driven by a biomedical paradigm of health, in which increased life expectancy is inevitably associated with more NCDs. This framing does not spark reflection on the distal, structural and political

[57] 2019 Country Specific Recommendations can be found here: https://ec.europa.eu/info/publications/2019-european-semester-country-specific-recommendations-commission-recommendations_en

determinants of health, precisely because it presents the rise of NCDs as the result of 'how well' the current system functions given the life expectancy improvements. Placing the cause of NCDs on ageing then favours technological solutions at the level of the individual rather than favouring social solutions at the level of society. This, in turn, also mobilises the 'health as a market' face of the economic paradigm, insofar as solutions are thought to lie in industry innovations – medical devices, new pharmaceuticals, but also mobile apps for self-management, to name a few.

If the NCD 'crisis' is perceived as the result of ageing population and not of a more deep-seated problem of neoliberal capitalism, then this crisis can be resolved using the usual, market-creating approach. In other words, in a framing driven by a combination of biomedical and economic paradigms of health, the solutions naturally ought to be sought in the realm of biomedical and technological innovation. This type of solution also strengthens the justification for more health innovation as a means to 'empower' people to manage themselves (for example with smartphone apps) and remain autonomous – ultimately to ensure they remain out of the hospital.

> The narrative is shifting more towards personalised medicine, using tech for kinds of personalised nutrition, personalised medicine etc. […] Nothing against personalised medicine but there should be a population approach too, it should be within a framework for the population (Quoted from interviewee 13)

This quote from a health advocate critiques precisely the trend, in relation to NCDs, to turn towards personalised medicine and personalised nutrition, i.e. effectively the creation of a new market, rather than to think about approaches to public health that put the population – not the individual - at the centre (Rose, G., 1985; McLaren et al., 2010). The absence of population-wide rationale is visible for example in the fact that the SGPP has created a subgroup at the request of the EIB to investigate the cost-effectiveness of a particular high-tech cancer treatment, despite the fact that the SGPP is supposed to be about health promotion, disease prevention and NCD management (see section 5.1.1.2., p.150).

The rationale linking ageing population, NCDs, personalised medicine and the economic paradigm of health is well encapsulated in Juncker's Commissioner for Research, Science and Innovation Carlos Moedas's publication compellingly entitled 'Better Health for All –

one person at a time' (2016[58]). The publication argues that '[w]ith an ageing population and a growing number of chronic diseases, Europe needs to change its healthcare paradigm. Personalised medicine holds the promise of bringing about change' (second paragraph). It then goes on to explain how personalised medicine can lead to better health of individuals, as well as economic growth resulting from all the potential for innovation that lies in this field. A large part of EU research funding on the topic of health is spent on developing personalised medicine, with an allocated €872 million for the 2014-2017 period[59] (European Commission, 2017m). The point is to combine health improvement in the context of NCDs and chronic diseases, with economic growth and innovation. The notion that these advancements are unlikely to address, or may even worsen, underlying health determinants – most importantly socioeconomic inequities – is disregarded.

Lastly, another EC priority in the field of NCDs is to develop and innovate in health apps (these can include healthy lifestyle promoting apps or chronic condition management apps, for example), telemedicine, and health information portals. On one hand, this is seen as a way to ensure patient/people's autonomy and minimise their burden on health systems. At the same time, it is also seen as a way to keep these people in the workforce, and keep them contributing to the economy. And finally, these tools also represent a data mine worth exploiting:

> Patient and user-generated health and care data are expected to further proliferate in the coming decade, creating continuously evolving and learning health systems. This could potentially disrupt the established status quo of health and social care delivery, opening up the ability to deliver more targeted health and social care services to citizens, and unlocking opportunities for new, data-driven economic models in public and consumer markets (European Commission, 2018i, p.45).

The point here is not to negate the desirability of keeping people autonomous as long as possible. Rather, the argument critiques the framing that emphasises the NCDs crisis as the inevitable result of an increase in life expectancy, which warrants technological innovation, self-management tools, and budget cuts. Indeed, life expectancy increases are not uniform and mask growing inequities (Burström et al., 2005; Singh and Siapush, 2006) which are left unacknowledged by this framing (and, even when acknowledged along with ageing, the interpretation of health inequality still fails to lead to thinking about societal transformation,

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[58] [Accessed 12.11.2019]. Available from: https://ec.europa.eu/commission/commissioners/2014-2019/moedas/blog/better-health-all-one-person-time_en

[59] Out of €7.4 billion (see European Commission, 2013d)

as will be outlined in section 5.2.2.2., pp.168-169). Another point that this framing brings to the forefront, is the interaction between the biomedical paradigm of health and the economic one. The biomedical paradigm of health pushes in the direction of individualised solutions, while the economic one pushes towards market innovation. Both together lead to a situation where personalised medicine is most invested in, at the expense of population-wide approaches.

Personalised solutions to NCDs also echoes the behavioural paradigm of health, given that it aims to give people (especially elder people) the tools to manage themselves independently. Admittedly, this is a desirable goal as such, only it is couched in a discourse that prioritises economic growth over population wellbeing. Therefore, it is debatable whether the actual concern the policy aims to address is people's wellbeing, or instead limit potential increases of public spending. This distinction is important because the latter is likely to be blind to differences in accessibility (in a broad sense) of innovations, and in turn risks exacerbating inequities in health. Most importantly, aiming to keep people autonomous for the sake of saving money rather than out of concern for health and wellbeing is counterproductive, because it is often accompanied with other cost-saving, austerity measures that negatively affect distal determinants of health.

The 'ageing population' framing of NCDs, in turn, can be seen as shaped by the economic paradigm of health, together with the security and the biomedical paradigm (and the behavioural one). This discursive constellation does not allow to move away from the ultimate priority, which is to foster economic growth, by producing health innovations. At the same time, it also legitimises cost-saving measures. However, disciplining people to remain autonomous by using these innovative gadgets, is not a sustainable strategy to meaningfully prioritise public health, when taken alongside cost-saving measures that tend to worsen socioeconomic determinants of health. This whole web of interaction between health paradigms and NCD frames, the thesis argues, represents part of the neoliberal background ideational structures prevailing in the EU context which undermine the possibilities for HiAP uptake.

5.2. Knowledge paradigms and frames of evidence

The previous section has looked at paradigms and frames of health in order to better understand what kinds of background ideational obstacles, related to how *health* is made sense of, stand in the way of a meaningful HiAP uptake at EU level. As the section above has suggested, the dominant paradigms, and the frames that stem from them, tend to be underpinned by neoliberal rationality, and undermine the possibility to think of a normative, social equity focused HiAP. To further investigate the background ideational structures that prevail in the EU, their relationship to neoliberalism and how they constrain or undermine HiAP, it is also worth looking at paradigms and frames of *knowledge*. As suggested in the methodology section of this thesis (see pp.20-23), the interview insights steered the attention toward the importance of knowledge in relation to implementing HiAP, and the dilemma between appealing to normative neutrality and explicit values-based advocacy. The way that knowledge is made sense of, the legitimation of certain types of knowledge over others, and the definition of what constitutes 'evidence' is normative, relates to 'power *in* ideas', and has important implications for HiAP, as will be shown in the remainder of this chapter.

Furthermore, the role of knowledge and evidence in the EC, and especially in DG SANTE, is of particular salience: given its propensity to act within the realm of 'soft governance' (see section 2.4.2., p.89), knowledge gathering, collecting and monitoring of data, commitments to evidence-based practice in public health, good and best practices, is a strong theme in DG SANTE[60]. Knowledge and evidence is a red thread that runs through DG SANTE's activities and expresses itself in different ways: in relation to the objective of protecting EU citizens from health threats, knowledge is referred to in the sense of monitoring, data gathering by member states to be compiled and processed at EC level (Flear, 2015). The health system modernisation goal also relies much on knowledge, as it taps into the scope for collaborative innovation in health tech, but also in health research, especially on rare diseases, where EU added value is perceived to be highest. When it comes to health determinants, the knowledge emphasis manifests in the facilitation of sharing best practices between member states. A common position, with respect to NCD prevention and health promotion, is that much knowledge and evidence regarding NCDs already exists, and that now it is a matter of processing it and making it accessible to policy-makers (European Commission, n.d. [d]). The role of DG SANTE in the area of health promotion and NCD prevention, in turn, has

[60] Source: interviewees 3, 7, 23 and 28

become very much targeted at supporting member states by providing them a choice of scientifically and rigorously selected best practices.

Some initiatives of DG SANTE that encapsulate its role as a knowledge broker very well include, for example, the ‘State of health in the EU’ cycle (European Commission, n.d. [e]). The ‘State of health in the EU’ is a two year cycle throughout which the EC, together with the European Observatory on Health Systems and Policies, and the member states, provides ‘health intelligence’ for member states, in order to support their evidence-based best practices implementation in the area of health (European Commission, 2017a, 2017j, 2018j). Another example would be the ECHI (formerly called European Community Health indicators, see: European Commission, 2013c) (see Annex p.250). ECHI is an initiative aimed at better integrating health data management across member states. The size of the section of the EU research budget dedicated to ‘health, demographic change and wellbeing’ also depicts the importance of the health intelligence and knowledge production role of the EC[61]. The EC research agenda is not limited to funding research and complementing the budgets of member states, but it also plays a coordination role (Greer et al., 2014). The HP funds multiple types of research projects in the area of health promotion and NCD prevention, including joint actions such as ‘JANPA’ (Joint Action on Nutrition and Physical Activity[62]) and ‘CHRODIS+’[63] on the topic of chronic diseases and which is now geared towards implementing good practices. The CHRODIS+ website links to DG SANTE’s ‘best practice portal’ for public health. Finally, the SGPP (see above, pp.150-151) can also be considered an initiative representative of DG SANTE’s knowledge broker role. One interviewee summarises the role of the EC in health promotion and NCD prevention in this way:

> They *[the EC]* are moving from member states should should should do this, to much more something like ‘here's what's working in one country’ and promoting the good practice as it is. […] it was really about identifying what is their *[the EC]* role in the determinants of health side of SANTE, what is their *[the EC]* role and how can they foster member state’s national regional local level taking up initiatives that actually work and have an impact. […] The idea was to sit down and have some criteria say how can we measure how good a practice is. And what are the priorities? So, the focus was very much on evidence of outputs, outcomes, impact. […] It wasn't for us to say for example ‘in food reformulation, industry self-regulation obviously doesn't

[61] The research budget for the 2014-2020 programming period is called ‘Horizon 2020’ and amounts to EUR 80 billion. Out of this sum, 38.53% is dedicated to the broad section called ‘societal challenges’, and within that section, almost EUR 7.5 billion is dedicated to the sub-section ‘health, demographic change and wellbeing’ (European Commission, 2013d). The largest part of the remaining subsection under ‘societal challenges’ is relevant to environmental research and sustainable future, which also relates to health.
[62] See: http://www.janpa.eu/
[63] See: http://chrodis.eu/

work, so we need to legislate or whatever'. That wasn't so much the point of our discussions. (Quoted from interviewee 23)

5.2.1. The positivist paradigm of knowledge in the EU

As suggested above, DG SANTE puts a strong emphasis on adopting and advocating for 'evidence-based' policies. The concept of evidence-based policymaking was preceded by- and aims to emulate, the principles of evidence-based medicine (EBM) (Parkhurst and Abeysinghe, 2016). EBM is embedded in the positivist research paradigm characteristic of applied natural sciences. It traditionally regards randomised controlled trials as the gold standard and most reliable type of evidence (Nutley et al., 2013). The adequacy of transposing this approach to social policy, however, is highly contentious and is being criticised in a growing body of literature (Bacchi, 2009, 2012; Bache, 2019; Greenhalgh and Russell, 2009; Marston and Watts, 2003; Neylan, 2008; Parkhurst, 2017; Petticrew and Roberts, 2003; Sanderson, 2006; Smith, 2013a). It has been argued that this understanding of evidence is not useful when dealing with complex, 'wicked' problems such as climate change (Dryzek, 1990; Parkhurst, 2017; Sanderson, 2006), and indeed public health (Kickbusch, 1989), and wellbeing (Bache et al, 2016).

The notion of evidence-based policymaking, then, is far from unproblematic. The accent put on using scientific language in politics – technocratic discourse – has been criticised for 'us[ing] the apparent objectivity of scientific discourse for […] presenting "highly contentious" statements as "uncontentious"' (McKenna and Graham, 2000, p.224; see also Fairclough, 2003). It has been associated in the UK with Blair's third way, 'post-ideological' approach to public policy (Bache, 2019; Ferlie and McGivern, 2014). This approach to policymaking needs to be contextualised in the 'new public management' reforms that occurred in the 1990s and which saw the public sector becoming increasingly closely modelled on business management, both in terms of its organisation and activity, and in terms of language used (Lane, 2000). The new public management wave has been followed by a turn to 'network governance', which facilitates the creation of multi-sectoral, multistakeholder partnerships and collaborations to reconnect the previously devolved, privatised or contracted out competencies (Bevir, 2011; Ferlie and McGivern, 2014). Both new public management and network governance can be seen as part of the neoliberal agenda as it represents a typical example of intrusion of market rationality in non-market spheres

(Bevir, 2011; Christensen and Laegreid, 2007). They echo the points raised about EU NMG and governmentality (see section 2.4.2., p.89).

Parkhurst (2017) categorises two main types of problem that follow from the transposition of an EBM approach to public policy-making. The first one relates to the risk of depoliticizing politics; the reduction of inherently political and value laden policies, to objective, apolitical issues that can be addressed in a technical way. This obscures underlying norms and values that are inevitably present in policies, and shuts down possibilities for dialogue around these norms. This is what he refers to as 'issue bias'. The second type of bias described by Parkhurst relates to the risk of politicisation of science, the instrumental (mis)use of scientific evidence for political ends – 'technical bias' (Parkhurst, 2017). An instance of technical bias was described in Chapter Four, in relation to the tobacco industry, the Better Regulation agenda, and the precautionary principle (see section 4.5.1., p.136).

This section here is more concerned with the depoliticising effects of the positivist knowledge paradigm, as representing power *in* ideas. Indeed, this knowledge paradigm implies a very narrow and limited, instrumental view of the research/policy relationship. However, possible research utilisation is far from limited to an instrumentalist view of research 'filling a knowledge gap' and providing ready-to-use solutions to problems (Weiss, C.H., 1979). The research/policy relationship can also be a more fluid one of awareness raising, where theoretical perspectives slowly inform different ways to make sense of issues, potentially redefining policy agenda in the long run (Weiss, C.H., 1977).

Evidence as conceptualised within a positivist, hypothetico-deductive paradigm of knowledge excludes these other possible relationships between research and policy, and consequently excludes a number of other kinds of evidence. Not all research evidence fits into the positivist knowledge paradigm. Some of the literature investigating the links between neoliberalism and ill-health reviewed in Chapter Two (section 2.2., p.72), for example, does not feature in DG SANTE's evidence collection and processing. This echoes Smith and Joyce's (2012) finding that while policymakers in the UK working on health inequality were familiar with the arguments put forward by Marmot or Wilkinson and Pickett, this evidence was unlikely to be featured in policy (Smith and Joyce, 2012; Smith, 2014). Furthermore, there exists evidence demonstrating the lack of effectiveness of industry self-regulation in relation to obesity in a manner that fits into the positivist paradigm (see: Ronit and Jensen, 2014), yet arguably DG SANTE cannot use this kind of evidence, because it does not fit with

the EC's official line according to which the first choice should always be to encourage self-regulation. If this type of positivist, 'objective and normatively neutral' evidence cannot be taken up by DG SANTE, it is not surprising that more normatively explicit 'politics of health' research that lies outside of the dominant knowledge paradigm – such as the literature building on Marxist and Gramscian theories, or feminist or post-modern theories – are completely absent from the debate in DG SANTE. What becomes clear is that DG SANTE's inclination to evidence-based policymaking presupposes a particular 'type' of evidence, which is deemed as obvious and objective, but it excludes research evidence that does not meet these particular paradigmatic requirements.

5.2.2. The 'SMART' evidence frame in the EU

The previous section has established that the dominant knowledge paradigm in DG SANTE (and arguably the EC), is a positivist, hypothetico-deductive one. This is visible notably through the emphasis put on evidence-based policymaking, with legitimate evidence being the one that fits the positivist paradigm. Now it is worth delving deeper and analysing the framing of this dominant 'positivist evidence'. To gain a better understanding of the dominant frame of evidence in DG SANTE, it is useful to take a look at the various EU HPs and their evolution. EU HPs outline the strategic direction of the involvement of the EU in public health for a given financial period. So far, there have been three HPs (1st HP from 2003-2008; 2nd HP from 2008-2013; 3rd HP from 2014-2020). The evolution of the HPs is quite clear: they went from putting forward a small number of broad objectives and strong normative commitments to public health, to a large number of increasingly specific, measurable objectives and with less and less reference to normative commitments (European Commission, 2007a; European Union, 2002, 2014). This evidence frame will be referred to hereinafter as 'SMART evidence'. The SMART acronym, which refers to specific, measurable, achievable, relevant and time-bound, was created in the early 80s and most prominently used in business and management to rationally guide decision making and project evaluations among other things (Britt Bjerke and Renger, 2017; Goodwin and Wright, 2004, pp.27-70). As such, the uptake of the SMART approach in public policy can be seen as a consequence of the rise of new public management in the 90s, where business approaches have been imported into the public policy sphere. The evolution towards SMART evidence is best described in the Q&A document accompanying the establishment of the 3rd HP:

The new programme is more focused towards how health can contribute to growth and to the objectives of Europe 2020 - in particular as regards employment, innovation, sustainability. It is also more focused on key issues where EU action can deliver added value and make a real difference to Member States.
Priorities are better defined and more targeted, with a focus on 23 key thematic priorities that address current health challenges.
There are clear indicators to monitor the progress made against the objectives and to regularly review the programme priorities. Improvements in knowledge and information sharing mechanisms will lead to better decision making in health policies at regional, national and European level. Better dissemination of results will help Member States and the health community to make better use of action under the programme. […]"

Box 5.1. 'How does the third health programme compare with the previous two?' (European Commission, 2014e)

This evolution towards defining narrow, measurable objectives and away from broader commitments is a result of the mid-term and ex-post evaluations of the first two HPs. Both the first and second HP evaluations identified the lack of SMART objectives as a major weakness (European Commission, 2008b, 2011b, 2011c, 2015f; European Court of Auditors, 2009). The second HP, for example, had the strongest emphasis on HiAP, but the mid-term and ex-post evaluations provided a sober account of the extent to which HiAP, as an element of DG SANTE's integrated health strategy, had been taken up in the EC (European Commission, 2011d).

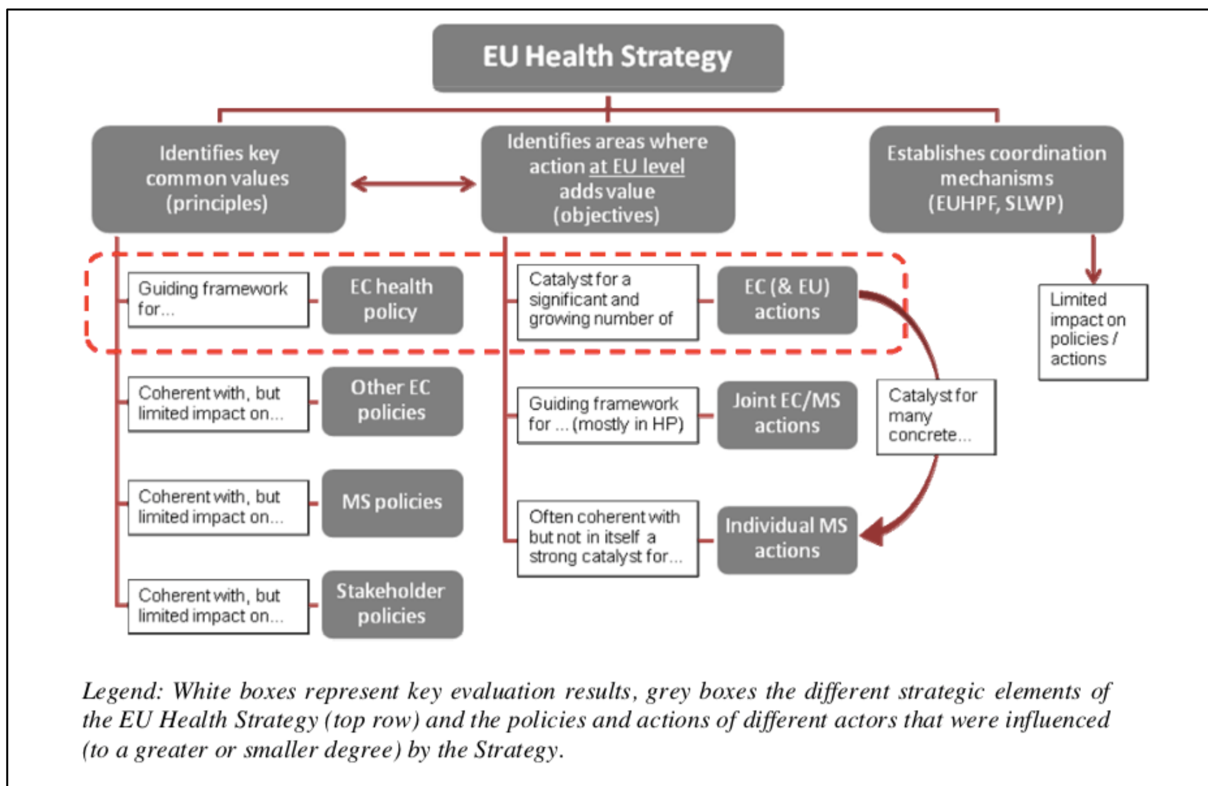

Figure 5.2. Overview of the conclusions of the mid-term evaluation of the 2nd HP. (European Commission, 2011d, p.4)

Figure 5.2. provides an overview of the conclusions of the second HP mid-term evaluation: the left-hand column shows the extent to which the key common values of the HP have impacted EC health policy, other EC policies, member states' policies and stakeholder policies. A successful HiAP in the EC should indicate transfer of the EU Health Strategy norms and key values into other EC policies. However, as seen in this chart, this was not the case.

The executive summary of the mid-term evaluation of the second HP suggested that the health strategy was not successful in mainstreaming the health norms and values in other EC policy areas (p.6). Thereafter, mentions of health-related values and norms were largely dropped, and priorities became streamlined more explicitly with the Europe 2020 strategy for growth, competitiveness and investment (European Commission, 2015f). The third HP is considered a major improvement and better value for money (European Commission, 2017k). The objectives on health promotion and NCD prevention (operational objective number 1) are still considered too broad and not clearly defined enough, and the mid-term evaluation recommends that, while this topic should not be dropped altogether, its EU added value should be made clearer and more defined, given the breadth of the topic (European Commission, 2017k, p.35). The report stresses that, in the area of health promotion, the single most important EU added value is the sharing of knowledge – very clearly recommending that this is where the EC needs to concentrate its efforts in the area of health promotion.

Over the last years, DG SANTE has put much effort into streamlining the programme's objectives and improving its coherence[64]. As the public health approach in the EC was becoming more streamlined and coherent, the language of the health programmes became increasingly oriented towards setting out SMART objectives. The most striking evolution in HPs is the shift from few, broad and strongly normative objectives in the first and second health programme, towards many, narrow and SMART objectives in the third health programme. Along with this process, normative references were dropped, as broad HiAP objectives were not perceived to produce these types of measurable results. Instead, DG SANTE became more focused on its knowledge brokering role, which is perceived as the only EU added value in the field of health promotion and NCD prevention. Relatedly,

[64] Source: interviewees 3, 7 and 8

demonstrating EU added value follows similar criteria of ‘objective measurability’. Along with focusing on SMART evidence, the notion of ‘EU added value’ as a crucial determinant of EU level action has become increasingly important (European Commission, 2017k, 2018k). CHAFEA has elaborated a formalized ‘EU added value score’ from 1 to 10 to evaluate potential funding under the third Health Programme (European Commission, 2017k). This suggests that EU added value should be objectively quantifiable, along the lines of a technical rationale. CHAFEA streamlines seven EU added value criteria: best practice and knowledge exchange; benchmarking; (multi-stakeholder) network building; addressing cross-border threats; health issues where the internal market is strongly concerned (e.g. patient mobility); innovation in healthcare; and optimising the use financial resources (avoiding duplications).

SMART evidence reflects a conceptualisation of evidence as objectively existing out there, as objectively measurable, aligned with a positivist, hypothetico-deductive knowledge paradigm. This framing of evidence also has a strong appeal to being apolitical, objective, quantitatively measurable and discrete in isolating a causal relationship (A can be isolated as the factor/one of the factors, that caused B). Going back to the State of health in the EU cycle, the emphasis is put on the neutrality of the information given. Indeed, the cycle’s purpose is stated as ‘to inform and support policy-making, not to make recommendations’ (European Commission, n.d. [e]). It is stated that ‘the report which is published every two years provides a neutral, descriptive comparison of all EU countries on the basis of publicly available data and indicators’ (European Commission, n.d. [f]).

The sections below will explore the implications of the dominant SMART evidence frame for HiAP. It will be suggested that this frame, rooted in the positivist knowledge paradigm which is itself underpinned by neoliberal rationality, precludes a focus on the social and normative dimensions of health necessary to adopt HiAP (Bambra et al., 2005; Smith, 2013a; Ståhl et al., 2006). Two problematic elements are developed in this section: on one hand, SMART evidence’s (inevitably failing) attempt to break down complexity into discrete, measurable components, and on the other hand the problematic appeal to normative neutrality of SMART evidence.

5.2.2.1. Attempts to break down complexity

While HiAP is about recognising the complexity of determinants of health, the dominant meaning of legitimate evidence as SMART thwarts any embrace of complexity by attempting to categorise health determinants into discrete variables causally related to health outcomes. Indeed, the central idea of the SMART approach in management decision-making has been described as 'by splitting the problem into small parts and focusing on each part separately, the decision maker was likely to acquire a better understanding of his or her problem than would have been achieved by taking a holistic view' (Goodwin and Wright, 2004, p.57).

Complexity of public health determinants is seen as a considerable challenge within DG SANTE. One way to illustrate these irreconcilable characteristics around complexity, is to go back to the ECHI, and look at them more closely. As one interviewee explained, it is very difficult to set out a list of discrete health indicators:

> […] when you think of the EU you think of standardised, very strict standardised data collection that applies for a limited number of indicators. A good example is if you look at employment you have four or five key indicators that are used at EU level […] In health we were never able to reach that degree of lightness, so we started with something like a couple of thousands of indicators, and now we have a short list that is under 100. But even under 100 is not four […] (Quoted from interviewee 7)

The ECHI list aims to single out HiAP as a separate 'policy area' category, which is further broken down into 'Health in All Policies (HIAP) including occupational and environmental health' (see: Appendix 1 – European Commission, n.d. [g]). Given the awareness of the importance of HiAP, the ECHI aim to include that 'variable' as a separate policy area, to which the various other indicators may have relevance. The only indicators identified as HiAP relevant, however, are those pertaining to occupational health and to environmental health. While including HiAP in the ECHI grid is likely to stem from a concern and awareness of the importance of HiAP, narrowing it to a separate, discrete variable negates the complexity that a HiAP approach is about. An indicator like 'vegetable consumption', despite its clear relevance to both agricultural and trade policies, is not marked as HiAP relevant in this particular set up. This does not mean that policymakers from DG SANTE do not recognise the relevance of agricultural policies for health, but these types of classifications contribute to shaping the meaning of HiAP. In this case, a narrow, artificial classification confines 'HiAP' into meaning occupational and environmental health. While occupational and environmental health are all relevant areas for HiAP, all other policy areas are relevant

too. Another example relates to the Best Practice Portal search engine. When selecting 'Health in All Policies' and 'Health in All Policies Actions', 12 initiatives are listed (as of 03.07.2019). Five out of the 12 projects listed as HiAP Best Practices, are projects which have as their main objective changing individuals' behaviours towards healthy nutrition and physical activity by educating and raising awareness[65]. The attempt, driven by SMART evidence, to classify what represents HiAP best practice, seems to lead back to more proximal determinants of health (such as individual behaviour). This, again, reduces HiAP and shapes its meaning in ways which obscure the complexity HiAP is supposed to take into account.

As explained by an interviewee who contributed to the 2006 Finnish Presidency priorities, HiAP cannot be thought of as a separate entity at all, because it represents 'a way of working'. Trying to isolate a discrete 'HiAP' category is problematic, because it narrows the HiAP scope and fails to adequately take into account the complexity that the HiAP concept illustrates an understanding of[66]. Attempting to isolate HiAP as a separate variable or category, which reflects a SMART evidence logic, stifles and narrows down the meaning of HiAP to associate it to what seems most easily measurable. One interviewee argued that 'there is an understanding of complexity, but complexity is used against action' (Quoted from interviewee 13). In a space where action needs to be informed by narrow, SMART evidence, it becomes easy to dismiss the areas of action that are perceived as too complex, regardless of how important and necessary the issues at hand. What this interviewee critiques are the multiple mid-term evaluations of the various health programmes, which consistently pushed the programme away from tackling the most important public health issues, i.e. NCDs (see pp.164-166).

5.2.2.2. Appeal to normative neutrality

With its root in the positivist hypothetico-deductive knowledge paradigm, the SMART evidence frame strongly appeals to normative neutrality, and this undermines the potential for an explicitly normative HiAP vision. HiAP is in essence a normative concept, underpinned by values of social justice, solidarity, human rights, and a will to prioritise population health and wellbeing over economic growth. Such a stance tends to be put 'in opposition' to a more neutral, objective and non-ideological status quo. However, normative neutrality, especially

[65] The best practice portal can be found under: https://webgate.ec.europa.eu/dyna/bp-portal/index_search.cfm
[66] Source: interviewee 32

in social issues like health, is not achievable, and any claim to normative neutrality hides underpinning values that are merely taken for granted, or seen as unavoidable.

One telling example of apparent normative neutrality and its synergy with SMART evidence is the case of health inequalities (see Smith, 2013a). The concept of health inequalities is very much present in the mainstream EC and DG SANTE debate. However the points made by critical social scientists that socioeconomic inequities are detrimental to health and wellbeing not only of the poorer population groups, but even for the wealthy, too, and therefore require a societal solution rather than a individually targeted one (Wilkinson and Pickett, 2010), are absent from DG SANTE evidence talks. Constructing SMART evidence on the topic of health inequities leads to the tendency to think of inequities as a measurable gap, with the aim to bring people from the bottom to the top, with measurable results (Smith, 2013a). The issue is that this conflates poverty and inequity, and results in targeting poor people and acting upon narrowly defined 'risk factors' rather than changing societal structures (Glasgow and Schrecker, 2016; Smith, 2013a). HiAP thinking about health inequities would identify the roots of health inequities in socioeconomic inequities and would lead to fundamental changes towards building a more equal society, which would include, at the very least, a vast redistribution of wealth. This explicit normativity clashes with the framing of SMART evidence, according to which the rationale of singling out vulnerable groups with specific measures aimed at quantifiably reducing the gap between them and the wealthier population, is (mistakenly) accepted as being normatively neutral, objective.

Steering the discussion towards the political roots of inequalities is something many health actors are uncomfortable about, precisely because it is seen as too ideological, when the expectation is that health needs to remain 'beyond ideologies':

> […] schemes targeted at poor people are not going to solve the inequality issue. They can cut some of the sharpest edges, but it still leaves you with the whole macroeconomic policy. And this is something that health actors are not comfortable talking about. […] Targeted measures should be seen as a phase-out. […] This whole discussion is something that health actors are not comfortable going into, because it's seen as too far removed. […] On the other hand, industry likes to say 'it's not an issue of tobacco/alcohol/soda etc… it's an issue of poverty' in order to shift responsibility. And proving that they, as multinational corporations, are responsible for the poverty, is very difficult: try to make that argument, you'll be labelled an ideologue, it's difficult to make a water-tight case (Quoted from interviewee 13)

The argument here is that SMART evidence is normative – rather than neutral – and that, with its embeddedness in a positivist knowledge paradigm, it is easily aligned with neoliberalism. The normatively neutral veneer of the SMART evidence frame means that the HiAP normativity appears as 'unreasonably' ideological in comparison. SMART evidence also tends to lead to the type of data gathering and evidence which relates to cost/cost-saving estimates, given that these are obvious 'measurables'. In turn, policy rationales are also geared towards what leads to easily measurable results, i.e. financially quantifiable results (Parkhurst, 2017). As put by Koivusalo (2010, p.501): 'In reporting on HiAP we tend to seek assessment on what works rather than what should be done and how to get there'.

5.3. Conclusion: HiAP and EU background ideational web

This chapter has turned towards the prevailing 'background ideational structures' in the EU. That turn has entailed a focus on the power *in* ideas, that is, the authority carried by certain ideas, and how certain ways to make sense of phenomena appear as obvious and 'objective'. In order to dig into these background cognitive and normative elements, the chapter has used the 'framework for analysing global health policy-making' proposed by Rushton and Williams (2012), specifically focusing on the relationship between the neoliberal core, paradigms, and frames.

The first half of the chapter has looked at paradigms and frames related to health and NCDs. It focused particularly on introducing the economic paradigm of health, which leads to a framing of health as an investment with good returns, as well as a profitable market in which innovation can lead to economic growth. The framing of NCDs as a result of an ageing population, the chapter argued, stems from the interactions between the economic paradigm of health, together with the security, the biomedical (and to an extent the behavioural) paradigms of health. Here, the argument was that this framing of NCDs leads to constructing the growing ageing population as a security threat, posed by a wave of chronically ill, elderly people, to the financial sustainability of health systems. This aspect of the framing justifies cost-saving measures; the goal being to decrease public spending by disciplining ageing people into managing their conditions autonomously (and, if possible, to also remain active contributors in the labour market). Solutions to this 'crisis' are not identified in the potential for changing the political system, instead they are located in the realm of more market creation, in line with neoliberal capitalism. These new market solutions, which include the

rise of personalised medicine, and the turn towards digital solutions (e-Health, m-Health), are driven by both the economic paradigm, as well as the biomedical paradigm of health.

The point made in this section is that the framing of NCDs as a consequence of an ageing society, first of all, is embedded in particular health paradigms that tend to be well aligned with neoliberal rationality: the economic, biomedical, security, as well as the behavioural paradigms. Secondly, the framing implies that the NCDs 'crisis' is (at least in part), the result of progress. This assumption tacitly endorses the prevailing system (which after all has led to said progress) and in turn prevents any fundamental questioning of the political and ideological system that in large part is responsible for the rise of NCDs – i.e. neoliberal capitalism. Rather, it embraces its methods, such as austerity and market innovation.

The focus of the second half of this chapter was on identifying the dominant paradigms and frames of knowledge in the EU, and their implications for HiAP. After justifying the necessity to look at knowledge paradigms and frames of evidence, it explained how the evidence-based policymaking approach that dominates in DG SANTE is rooted in a positivist, hypothetico-deductive knowledge paradigm typically associated with applied STEM subjects (science, technology, engineering and maths) and medicine ('evidence-based medicine'). However, issues emerge when transposing the EBM logic to policymaking. The chapter has then suggested that the emergence of evidence-based policymaking can be traced to the neoliberal agenda that pushed towards 'new public management' (and later, towards NMG). Delving further into the specific framing of evidence and how it developed along the different HPs, this chapter examined the term SMART evidence, in which the accent of legitimate evidence is put on its specific, measurable, achievable, relevant and time-bound qualities. The SMART evidence frame however, has problematic implications for HiAP. Firstly, SMART evidence pushes towards a cartesian breakdown of complex problems into sub-problems to be tackled 'separately' as a means to solve the whole problem. This is fundamentally at odds with the HiAP logic which advocates for an embrace of complexity. Secondly, SMART evidence appeals to normative neutrality and objectivity, whereas HiAP requires an explicit engagement with norms and values.

The point of the second part of the chapter was to draw attention to the importance of the politics of knowledge. Indeed, neoliberal rationality can permeate even in how knowledge is made sense of. The positivist knowledge paradigm, while it need not intrinsically be 'neoliberal', can often be aligned with this ideology and perpetuate it in subtle ways. This is

visible in the relationship between the positivist knowledge paradigm and the SMART evidence framing, and how it affects the possibility to promote HiAP. The implications of the arguments developed in this chapter raises long-standing ontological questions in public health (Mykhalvoskiy et al., 2019), and draw to attention to the mutual reinforcement and alignment between paradigms: the positivist knowledge paradigm, for example, overlaps neatly with the biomedical health paradigm. As such, paradigms and frames can be seen as parts of a cross-cutting ideational system that reinforce each other and weave the cognitive background that structures individuals' sense-making. They are not neutral, pre-existing, but as this chapter has shown, they contain normative assumptions, which, in the cases looked at herein, reproduce neoliberal rationality and undermine HiAP.

The question around the possibility to exploit the dominant paradigms and try to advocate for HiAP within these constraints, will be looked at in the next and last empirical chapter. Indeed, while certain background ideational structures dominate in a particular institutional context, it does not mean that they go unrecognised by individuals working within these institutions, who may even be critical (or not) of these paradigms and frames. Relatedly, ideational structures are not immutable, and have become ingrained, taken-for-granted over time also through active social construction and agency. In short, background ideational structures can be challenged and can evolve, even though this evolution is likely to be very slow. As such, potential spaces for contestation explored in Chapter Six may lie perhaps not so much in changing the EU institutional architecture, but in contesting dominant power *in* ideas, gradually changing their meanings, using power *over* and *through* ideas.

CHAPTER 6: Exploring the ability to (re)define HiAP

In this last empirical chapter, the focus will be on analysing DI's third element: foreground discursive abilities. As explained in Chapter Three (see section 3.3.3., p.114), it will look at both the agency in power *over* idea (the capacity of agents to define, redefine and shape what ideas mean, what defines them), as well as power *through* ideas (the power to convince of the validity of an idea). To do so, the chapter will draw on Smith's (2013a) categorisation of ideas, in particular the concept of 'chameleonic ideas'. According to this categorisation, chameleonic ideas are *strategically* formulated to become accepted in spaces where incompatible institutional set ups and background ideational structures prevail. The 'strategic' formulation here is key, as it points to the agential, foreground discursive space in which agents can articulate discourses that are critical of their institutions, and do so in a way which they perceive will maximise the potential for endogenous institutional change. Empirically, this chapter applies a critical discourse analysis lens to textual data (see pp.23-26) in a way that is informed by interview data gathered in Helsinki and Tampere, during the second round of interviews and with people involved in promoting the HiAP agenda in the EU. In order to critically analyse the power dynamics around the meaning of HiAP prevailing in the EU, and visible in the language used around HiAP in EU documents, it uses the insights provided by the Finnish interviewees, as well as the insights from EU health advocates, regarding the strategies used to get HiAP accepted in the EU, as well as their insights regarding the dangers of co-option.

This chapter argues that HiAP is a chameleonic idea and demonstrates certain ways in which it can be thought of as such. It then delves into the implications of the chameleonic nature of HiAP: that its meaning is a constant and ever-evolving political battleground. First, it looks at discursive efforts to maintain institutional continuity. This includes redefinitions of HiAP, found in EU documents, as inherently about multistakeholder involvement, as well as the use of HiAP language to promote EC priority streamlining more generally. The chapter will demonstrate how both these discursive adaptations in HiAP meaning represent attempts to fit HiAP into the NMG system. While the extent to which these particular dynamics are the result of structure, agency, or a mix of both, is impossible to tell, the chapter does point to elements that emphasise the agential role of individuals, including EU officials and industry lobbyists (for EU food and drink industry lobby tactics, see for example: Tselengidis and Östergren, 2019). The risk of HiAP being a chameleonic idea and which is pointed out in

these parts of the chapter, is that because it is couched in dominant EU language and because of its intentional normative ambiguity, it can become (easily) co-opted and watered down.

However, this does not mean that HiAP advocates (who advocate for HiAP on a normative ground) are unaware of these shifts. The following chapter section analyses documents related to the most recent (2019) Finnish EU presidency and looks at how foreground discursive abilities have been mobilised to reshape the fluid, vague and chameleonic idea that is HiAP into new versions of itself, in order to continue to promote endogenous institutional change. In the same way that HiAP is a development from the Health for All agenda from the 70s, HiAP can be further modified, rethought and rearticulated in ways that seek to address the risks of co-option in the EU institutional setting (Smith, 2013b). This chapter suggests that the 2019 Finnish EU presidency theme 'economy of wellbeing' represents an evolution of HiAP. Furthermore, the newly created advocacy coalition that promotes a health-centred economy of wellbeing, the 'All Policies for a Healthy Europe' initiative, aims to shape that concept in a way that seeks to address pitfalls faced by HiAP.

Finally, the last section of this chapter explores the potential for synergies between chameleonic ideas like HiAP, and more radical ones like degrowth. Indeed, with the shift from HiAP to economy of wellbeing, and from health to wellbeing, a greater accent has been put on the critique of gross domestic product (GDP). While the EU's position on economy of wellbeing does not challenge the economic growth paradigm (it only proposes that growth should be 'smart, sustainable and inclusive' without necessarily too much explanation of what this means concretely), the degrowth (or post-growth) idea is more radical in taking the critique of GDP further, to posit that growth itself is a problem (or 'the' problem). Surprisingly, even a radical idea like degrowth can be found in the EU institutions, albeit in a very limited number of places. Degrowth is nevertheless put forward by individuals from the JRC and from the EP. Figure 6.1. below provides an overview of this chapter's rationale and argument.

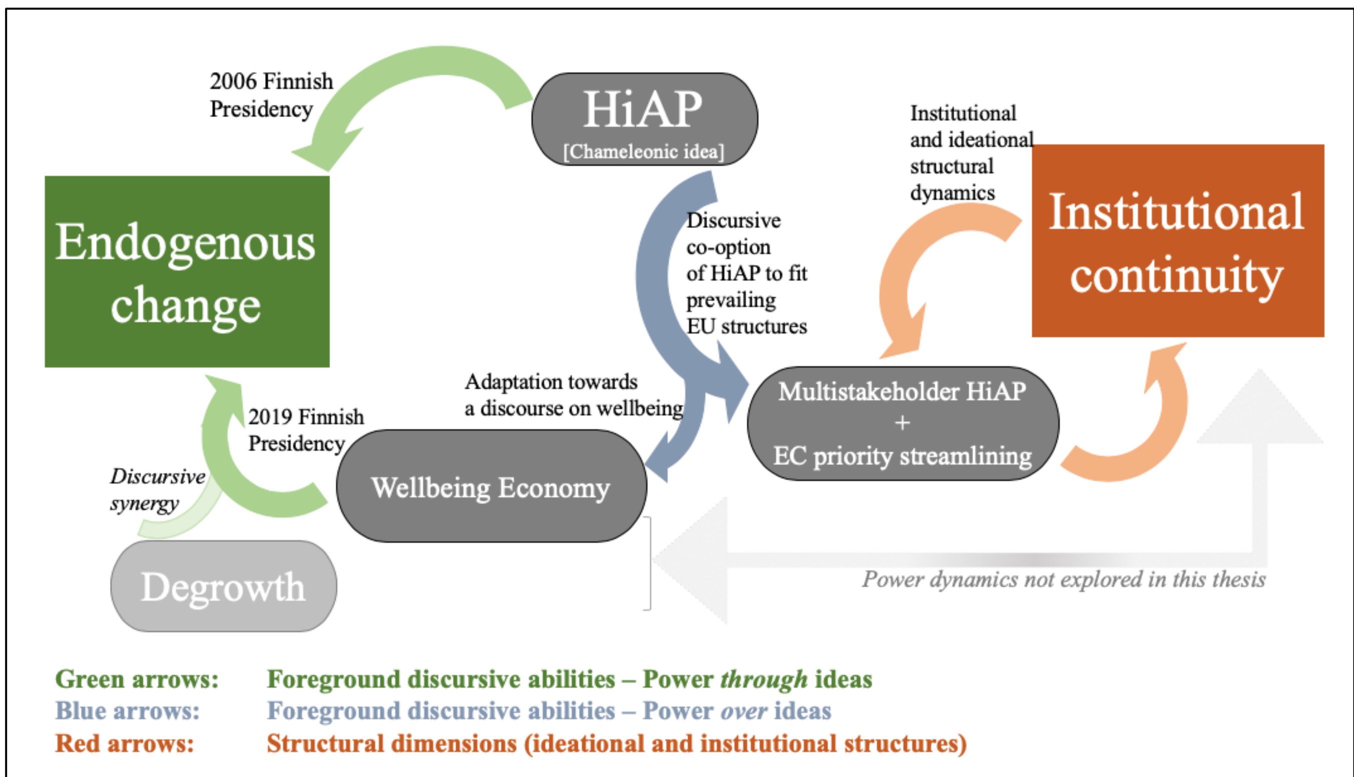

Figure 6.1. Overview of Chapter Six: Exploring foreground discursive abilities around HiAP

Ultimately, what this chapter emphasises is the space for agency and contestation. Yet at the same time, it aims to remain cautious and not overly naïve about the potential for an idea like HiAP to bring about any kind of radical change. Instead, the imaginable change considered here relates more to an endogenous change, a gradual and slow process of evolution rather than a radical game-changer. This involves a constant renegotiation and reshaping of meanings, which relates to the power struggles *over* ideas. This last chapter concludes with reflections on the possibility for synergies between chameleonic versions and more radical versions of ideas that share the same normative ground, such as HiAP and the degrowth idea.

6.1. Chameleonic ideas and endogenous institutional change

Schmidt's DI argues for the need to look at the role of ideas to understand and explain institutional change and continuity. The level of ideational power looked at in this chapter, is the level of foreground, discursively articulated idea definition, the power *over* and *through* ideas (see section 3.1., p. 97). In the vein of focusing on ideas, Smith (2013a) has argued that analysing evidence without ideational and discursive context is insufficient to understand health policymaking. She argues that, to better understand health policy, one needs to look beyond research evidence, and instead investigate the importance of ideas in shaping, enabling or constraining health policies, importance which arguably exceeds the role of

research evidence 'alone'. She identifies four types of ideas: institutional ideas, which do not aim to challenge the status quo. Radical ideas, which are too radical to actually become widely adopted in the policymaking sphere. Such radical ideas are explicitly normative and are commonly excluded by policymaking institution. These ideas are put forward, for example, through research arguing against austerity and highlighting its negative effects on population health (see the discussion on what does not count as evidence, section 5.2.1., p.161). Charismatic ideas are very rare, and represent radical ideas that have 'made it' and have become commonly accepted, without compromising their radical essence. Among those kinds of ideas and in relation to health policy, Smith (2013a) takes the example of tobacco legislation, and how health promotion related to tobacco reduction is now largely dealt with hard laws and regulations, unlike much of the rest of 'lifestyle-related' health promotion confined to voluntary, soft governance.

Finally, chameleonic ideas are ideas that may have a normative essence, and may have originally been put forward to try to change the status quo, but that have been strategically adapted, and are sufficiently vague, in order to become institutionally accepted. One characteristic of chameleonic ideas is their appeal to normative neutrality. The normative nature of these ideas is intentionally toned down to fit the language of the policymaking sphere, and the idea is vague enough to strategically allow room for interpretation. Similarly, Smith (2010, 2012, 2014) describes how the language of chameleonic ideas is adjusted to fit the academic funding bodies' language, in order to increase the chance for research to receive funding. Chameleonic ideas also result from academic peer pressures exercised in different directions: on one hand, academics who are perceived as too close to policymakers can be subject to criticism for their perceived lack of independence. On the other hand, arguments put forward by academics who are perceived as too ideological can be dismissed by some peers on the basis that they are 'too biased'.

> […] some academics described presenting their work to policy audiences (who were perceived as both potential research users and, importantly, potential funders) in ways that emphasised the aspects of their work that they felt were most likely to be received favourably and/or deliberately imbuing challenging ideas with chameleon-like qualities to ensure that they were not deemed 'too radical'. (Smith and Joyce, 2012, p. 66)

These are some of the tensions to navigate in the context of academics working on health inequalities, but these tensions also apply for advocates and researchers of HiAP: the

challenge is to find a way to put forward a normatively driven idea that changes the status quo, without being perceived as too ideological and losing credibility from policymakers and potentially even from peers and funders (Smith, 2010, 2012, 2014).

The ramifications of Smith's argument (2010, 2012, 2014) around researchers needing to appear neutral and serious in order to get funding and in order to get their ideas heard, point to the complex relationship and power dynamics between academic research and health policymaking. They also point to the dominance of the instrumental view of the relationship between research and policymaking (Weiss, C.H., 1977, 1979), a dominance which public health scholarship contributes to building (see section 5.2.1, p.161). In order to address the pitfalls of the dominance of instrumental relationships between policy and research, Mykhalovskiy et al (2019) call for more dialogue between 'social science *in* public health' and 'social science *of* public health'. The former refers to the largely positivist literature that is embedded in an institutional setting of natural science, medical public health research. Those researchers represent what Smith defines as 'facilitators' in academia; those who work very closely with policymakers and aim to see their work leading to real-life results, pragmatically setting aside 'meta-critiques' of the system within which their expertise operates and focusing on (smaller) immediate improvements (Smith, 2012). The 'social science *of* public health' literature is embedded in social sciences, social health research, and includes critical social science approaches to public health, such as post-structuralist, Marxist or critical feminist frameworks. This overlaps with Smith's 'advocates' category of academics who focus on 'the big picture', on working towards changing society more fundamentally, but who tend to fail to achieve meaningful results. They would be the ones putting forward radical ideas, and theirs would be the work dismissed in the policymaking sphere as 'too ideological'.

What Mykhalovsiy et al (2019) then suggest, is the creation of more space for 'agonistic' engagement between critical social science and public health: 'critical social science *with* public health'. This would refer to a kind of critical social science literature that would combine both worlds without merging them, not compromising on its critical stance but at the same time being useful to public health practitioners. However, it could be argued that this space already exists, and that it occupied by those researchers putting forward chameleonic ideas. This kind of researcher, which Smith (2012) refers to as 'flexians', have already been grappling with the tensions between policy relevance and normativity. Flexians seek to negotiate these tensions by putting forward chameleonic ideas, being well aware of the risk of

appearing too ideological, while at the same time identifying the need to challenge the status quo deeply and fundamentally.

6.1.1. Power *through* ideas: chameleonic HiAP

An idea being chameleonic does not mean that researchers advocating for it are unaware of the normative implications or are not driven by those norms. The question then becomes about the merits of radical ideas in research, that do not compromise on their normativity but run the risk of not being heard where they should be heard, and the merits of chameleonic ideas in research, which strategically tone down their normativity in order to reach the policymaking spheres, but which then run the risk of becoming appropriated, reshaped and lose their normative essence. Is it more useful to outright reject the economic paradigm of health, or to try to channel it towards a more HiAP-like vision? Answering this question is beyond the scope of this thesis. However, it can be argued that, while radical ideas aim for exogenous, revolutionary change, chameleonic ideas seek endogenous, evolutionary change. To put it in relation to HiAP, inequities and distal determinants of health, chameleonic ideas seek to ease into the notion that neoliberal policies are detrimental to health, rather than confront and name that system outright. An important aspect of chameleonic ideas is the notion of intentionality, of agency. Chameleonic ideas are *strategically* articulated, and while they do run the risk of becoming co-opted and watered down, those putting forward chameleonic ideas for health policy tend to be well aware of those risks and attempt to actively and critically navigate them.

As such, the use of chameleonic ideas can be conceptualised in terms of 'foreground discursive ability', of space for agents to articulate a discourse critical of their institution, or, on the contrary, to actively shape ideas to suit the overarching institutional and ideational context. The purpose of this chapter is then to identify and reflect upon different ways in which HiAP is talked about, by whom, and to assess what is being actively discursively done with HiAP (the 'politics of defining HiAP' [Koivusalo, 2019]). In that vein, this chapter is more concerned with looking at power *over* ideas (power to define ideas), rather than the power *in* ideas looked at in the previous chapter.

HiAP, this chapter argues, is a good example of a chameleonic idea. It is normatively driven and it does stem from an understanding of complex distal, political, determinants of health,

but it is also adapted to EU language, and its normative essence is acknowledged only to the extent that it remains perceived as reasonable, not too ‘ideological’. At the time of the Finnish 2006 presidency, the explicitness of the normativity of HiAP and public health more generally had to be negotiated. HiAP, from the perspective of the Finnish health policymakers and researchers interviewed, was very clearly a translation from the Ottawa Charter’s healthy public policy strategy to fit the EU, and to operationalise the EU Treaty language on protecting health in all policies. However, according to two interviewees who participated in the 2006 Finnish presidency agenda setting, negotiating the commitment to public health-related norms in the EU Council demanded discursive strategizing. For example, instead of taking a radical stance which might have led to rejection, they presented the norms underpinning EU health systems as already commonly accepted and already shared:

> The story of how the [Council] conclusions[67] put the stress on common values: In negotiating that, they got into problems when they tried to say that everybody should have equity and equality and so on, as a value. And somehow, they got into problems at the high level commission for health. But then the great idea of one of the people in charge was to present those values not as ‘we need to impose them’ but present them as ‘these are the values that we already have’. So, you avoid those problems. (Quoted from interviewee 31)

The strategy for introducing the emphasis on shared values is very interesting, because it shows how the Finnish team understood the need to avoid appearing overly ideological, and that the way to do it was to assert the value in question as a taken-for-granted assumption. This may have represented a powerful defence against the commonly held critique that HiAP is ‘health imperialistic’ (see Kemm 2001; Synnevåg et al, 2018). Additionally, they put the accent on Article 168, and the notion that HiAP is in fact nothing inherently new and radical, but merely a *return* to taking Article 168 more seriously. The strong normativity of HiAP was to an extent ‘toned down’ and made palatable to the EU (and member states) policymaking crowd, both in terms of making a strong treaty basis case (Art. 168 TFEU), as well as in terms of constructing a language of normative reasonableness compatible with the EU institutional setting.

This instance of intentionally using the discursive malleability of HiAP already points to the foreground discursive capacities of the 2006 Finnish Presidency team members that allowed

[67] The conclusions referred to by the interviewee are the 2006 Council Conclusions on Common values and principles in European Union Health Systems (EU Council, 2006b).

HiAP to even be introduced into the EU space in the first place. It represents an instance of power *through* ideas. Indeed, those individuals were acting within their own national and European overlapping institutional boundaries, and yet were able to put forward an idea that, at its core, challenges EU orthodoxy, and to make it accepted within those institutions. Arguably, and based on interviewee's insights[68], the HLG still represents a space of broadly like-minded health experts in which HiAP strategizing can take place, even though the capacity of the group to bring about fundamental change is limited (see section 4.1.2., p.125).

The power dynamics over the meaning of HiAP, however, does not stop here. The next section of this chapter analyses how some agents 'used their foreground discursive abilities' to shape or 'change the contours' (Smith, 2013b, p.82) of HiAP in a way that fits the prevailing EU (neoliberal) orthodoxy.

6.2. Power *over* ideas: institutionalised HiAP

Chameleonic ideas, by definition, are malleable, their meaning can be changed discursively and intentionally. If an idea is vague enough to be either fitted to the language dominating in a particular institutional context, or to contest the institution, then whatever happens to the idea after it has been introduced can be difficult to predict, and becomes a site of power struggle. How chameleonic ideas change and evolve, depends on both other elements analysed in DI – institutional context and ideational abilities, as seen in previous chapters. But it also depends on intentional, 'agential' discourse articulation around that idea, on what Schmidt calls 'foreground discursive abilities'. This section explores how foreground discursive abilities have been mobilised to shape the meaning of HiAP in a way that suits the prevailing EU institutional orthodoxy. More specifically, it explores how HiAP is being made to fit the NMG rationale, both by being made to be about multistakeholder engagement, and by being used to ultimately justify streamlining EU (economic) priorities.

Of course, as this section looks at how HiAP is being discursively shaped to fit existing structures, it is never entirely possible to disentangle the structural from the agential dynamics. In turn, some phenomena can be explained both in terms of structural and agential power dynamics[69]. Nevertheless, this section draws on interview material to make sense of

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[68] Source: interviewees 15, 17, 18, 19, and 27

[69] In this thesis, this is the case for the phenomenon of increased involvement of the European Semester in health: it has already been looked at from an institutional and ideational structural perspective, and this chapter will shed light onto the agential dimensions of that phenomenon.

some of the *active* and suggested *intentional,* discursive strategizing around HiAP, and how it is being made to fit existing priorities, in other words, how it risks becoming watered down.

6.2.1. Multistakeholder HiAP

As suggested throughout this chapter, the meaning of HiAP is not constant nor uniform, but it evolves according to the context in which it is introduced, depending on the active involvement of agents in the discursive meaning construction. One of the characteristic attributed to HiAP in some settings, including the EU, is that it is inherently about involving all the stakeholders. In the main documents prepared by Finland on HiAP in 2006, there is limited mention of engagement with private stakeholders (except most notably in chapters three and five in Ståhl et al., 2006). And while these chapters do encourage multistakeholder engagement to some extent, they remain cautious and emphasise the risk of conflict of interest (Ståhl et al., 2006). The 2006 policy brief does not refer to private sector engagement as an important component of HiAP at all (Ollila, E., 2006). However, the subsequent EU documents contain several mentions of the importance of involving all stakeholders (EU Council, 2006a; European Commission, 2007a). The boxes below highlight some of those instances:

> The Council of the European Union […]
>
> INVITES the Commission […]
>
> to encourage and support exchange of good practices and information on intersectoral policies between Community sectors, Member States, and other stakeholders […].
>
> INVITES the Member States […]
>
> take into account in the formulation and implementation of their national policies the added value offered by cooperation between government sector, social partners, the private sector, and the non-governmental organisations for public health

Box 6.1. Council Conclusions on Health in All Policies (HiAP) (EU Council, 2006a, p.7)

> […] HIAP is also about involving new partners in health policy. The Commission will develop partnerships to promote goals of the Strategy, including with NGOs, industry, academia and the media […]

Box 6.2. White Paper – Together for Health: A Strategic Approach for the EU 2008-2013 (European Commission, 2007a, p.6)

It is impossible to ascertain whether this change in meaning of HiAP – this instance of 'power *over* idea' – is purely the result of structures described in Chapters Four and Five, or of discursive agency, or to what extent it results from a blend of both. It would however be

naïve to think of those individuals who have interpreted HiAP as inherently multistakeholder, as people acting obliviously and purely under the subconscious effect of ideational and institutional structures. For example, in the context of HiAP in Finland, the disappointing outcomes of the 2014 meetings on a national HiAP strategy (see quotes in section 1.2.2., pp. 47-48), were, according to the interviewee[70], in large part down to the agency of a few individuals in specific positions at that particular time. It is possible to identify some specific points of discursive constructions of multistakeholder HiAP: one concrete path through which this addition to the meaning of HiAP can be made visible is the ambiguity of the term 'sector'. Indeed, 'intersectoral', including in relation to action for health, was originally meant to refer to collaboration across public sectors, i.e. the different public policy areas within governments[71]. Applied to the EC governance, this would refer to collaboration across DGs only. However more recently, 'intersectoral' has been used to refer to different sectors of society, i.e. the public, private and voluntary sectors (Ståhl et al., 2006, p.5). Echoing the research done by Smith et al (2015) (see section 4.5.1., p.136) which highlight the active role of the tobacco industry in shaping the EU regulatory landscape, it is reasonable to suspect that individuals representing industries related to NCDs (such as, for example, tobacco, food and soft drinks, and alcohol) have an interest in actively shaping HiAP as inherently multistakeholder in order to secure a seat at the table and be able to shape the HiAP implementation process in ways which do not threaten their interests (see also the point made by Tselengidis and Östergren [2019, p. 572] regarding 'constituency building' as a lobby strategy used by the EU food and drink industry).

Importantly though, according to key Finnish experts involved in setting up the EU HiAP agenda in 2006, HiAP was never meant to refer to the involvement of all sectors of society. It was instead meant to refer to the involvement and prioritisation of health in all sectors of government[72].

> In Finland there's consultation with private sector and NGOs in the beginning, in the end, but not throughout! Importantly, the HiAP concept never intended to mean 'multistakeholder' and PPPs [*private-public partnerships*], 'intersectoral' refers to the different public, government sectors, but not to private/public/non-profit sectors. That's something that was misinterpreted. (Quoted from interviewee 32).

[70] Source: interviewee 31
[71] Source: interviewee 32
[72] Source: interviewees 31 and 32

The same idea was suggested already in 2010 (Koivusalo, 2010, p.500): 'The main essence of the approach implicitly implies that the focus is on *public policies* and activities across different "policies", not, for example, between public and private sector' (emphasis in original text). The conflation of HiAP as multistakholder is problematic because it implies that the responsibility for HiAP is diffused towards other sectors of society. As such, it represents an avenue for lifestyle drift and all the problems associated with it (see section 4.1.1., p.121). Ultimately 'multistakeholder HiAP' reflects an alignment of HiAP with some of the main NMG tenets around blurring the line between private and public sector. The awareness of Finnish HiAP advocates of the consequences of the multistakeholder interpretation of HiAP, shows that HiAP proponents are driven by a normative vision that is *strategically* toned down. And while one Finnish interviewee[73] regretted that they had not defined HiAP more clearly at the time (to avoid the multistakeholder interpretation), this chapter suggests that defining it much more clearly might have jeopardised its very uptake at EU level, if it had meant straightforward normative explicitness: i.e. HiAP might no longer have been a chameleonic idea, but a radical one.

6.2.2. HiAP as streamlining EC priorities

This section looks at how HiAP language and references to mainstreaming have been used in the proposal to integrate the health programme into a wider European Social Fund + (ESF+) in the upcoming MFF, considering the ESF+'s ever-closer ties to the European Semester process. It suggests that, while HiAP initially was used to refer to the need for other sectors to work towards health, explicitly including the EC itself, there may be a risk of now mentioning HiAP in a broader sense of 'there needs to be an EC coherence, less silo thinking and therefore a better alignment of SANTE to EC priorities'. In other words, HiAP risks becoming amalgamated with (and subordinated to) a more general discourse of needing to streamline priorities, create synergies, and move beyond silo-thinking. But in the process, the notion that *health* is what needs to be mainstreamed gets lost, and instead the search for coherence revolves around typical EU priorities: growth, competitiveness, and fiscal discipline. The example used to illustrate this is the upcoming ESF+. While acknowledging the institutional and ideational dynamics explored in the previous chapters and which facilitate this kind of drift, this chapter touches upon the possible role of individual agents in this process.

[73] Source: interviewees 32

While at the time of writing, the third health programme has not yet come to term, information about the frame in which the EC will be involved in the area of public health for the upcoming financial period has already been published. The MFF for 2021-2027 suggests that there should be no stand-alone health programme anymore[74], but that instead a separate health stream will be part of the new ESF, the 'ESF+' (European Commission, 2018k). The dedicated health budget within the ESIF has always been much larger than the modest stand-alone health programme (see section 4.4.1., p.133). Nevertheless, the move to integrate the (former) health programme, along with other funds, within the ESF+ illustrates the stronger emphasis on streamlining priorities, merging programmes, shifting from a landscape of multiple fragmented programmes towards an integrated project. This is justified in terms of coherence, synergies, and a strong emphasis on avoiding duplication. One interviewee from the EC explained that streamlining works to improve resource allocation, as it allows money to move around with greater flexibility[75]. The streamlining of health into the ESF+ is justified using the language and rationale of HiAP:

> Bridging the gap that separates health from non-health sectors is important for meaningful health outcomes from the European Structural and Investment Funds. […] the inclusion of the EU Health Programme within an expanded ESF+ programme targeting implementation of the European Pillar of Social Rights (EPSR), should foster increased cross-sectoral collaboration at the strategic level (European Commission, 2019c, p.9).

The EC, through its plan to streamline health within the ESF+, also aims to deepen its involvement in member states' healthcare reforms, through the means of the European Semester. This does reflect an awareness that policy areas are interconnected, yet as already suggested in previous chapters, it suggests that health systems need to be reformed through the lens of the EU's economic and fiscal governance, rather than thinking about how economic governance could be reformed so as to work towards health and wellbeing (see sections 4.4.1., p.133; 5.1.2.1., p.153). Given its embeddedness in the ESF+, the EC's health activities will likely be even more closely coordinated by the European Semester:

[74] Importantly, this may change as a result of the Covid-19 pandemic: on 28 May 2020, the EC published a proposal for a 'EU4Health' Programme which would dedicate 9.4 billion euros to strengthening EU action in health, in particular regarding cross-border health threats, availability of medicines, and health system resilience (European Commission, 2020c). How exactly any Covid-induced changes to the planned EU health budget will unfold is not clear yet, which is why this thesis limits its analysis to the pre-Covid time. However, the impact of the covid-19 pandemic on the EU generally, and on its involvement in health specifically, is of course an important future research agenda.

[75] Source: interviewee 28

> The European Social Fund+ will be more closely aligned with the European Semester of economic policy coordination, which takes regional specificities into account. The detailed analysis of member states' challenges in the context of the European Semester will serve as a basis for the programming of the funds at the start and at mid-term of the next period. This will serve as the roadmap for the short, mid- and long-term planning and monitoring of the funds. A system of ex-ante conditionalities and macro-economic conditionality will be maintained. (European Commission, 2018m, p.42)

Theoretically, the streamlining of the health programme in the broader social agenda has been seen as an opportunity, notably for HiAP, as it could have the potential to expand the consideration of health impacts of other policy areas. In fact, worth noting is the renewed emphasis that is currently being put on making the European Semester about wellbeing and sustainability, in the context of the new Commission's European Green Deal (European Commission, 2019f) (see section 6.4., p.198). However, some interviewees[76] were mostly raising the more pragmatic concern that horizontal integration may come at the detriment of protecting institutional safeguards. This concern needs to be considered in light of the institutional and ideational power dynamics explored in Chapters Four and Five, which already suggest a push towards neoliberalisation. Horizontal integration accompanied by a weakening of health in its own right could lead to a dilution of public health concerns. In other words, these interviewees were concerned that HiAP has been serving as a rhetorical tool to gradually water down actions in the field of public health. Some of the NGO interviewees feared that referring to HiAP will end up leading to installing one health desk in each DG, but without any coordinated, purposeful health plan[77]. This threat was perceived as especially salient given the general feeling among some NGO (and industry) interviewees[78], that DG SANTE was gradually being side-lined. These concerns were not only present among NGO representatives, as indeed other interviewees from EU institutions and member states did stress the importance of institutional safeguards needed to counter potential dilution resulting from evermore horizontal integration and streamlining[79]. One interviewee from a health NGO expressed their concerns on this in the following way:

> I think [HiAP] is not necessarily a good slogan. I think it's very, very important that health is strong on its own and has the strength to go in and explain in the other policy

[76] Source: interviewees 12, 13, 24 and 26
[77] Source: interviewees 12 and 26
[78] Source: interviewees 6, 12, 13, 21 and 26
[79] Source: interviewees 8 and 27

> areas if you want to achieve certain health goals, what they need to do. (Quoted from interviewee 26)

Amplifying the concern regarding the risk of watering down HiAP, is the notion that individuals within big institutions like the EC, may not necessarily be driven by a passion for the particular branch they currently work in. While many individuals working for DG SANTE have health-specific qualifications, and have dedicated their careers to public health (as was very much the case for Juncker's health commissioner, for example), others might have other backgrounds and other aspirations. One example of this pertains to one former DG SANTE Director General. When speaking at a press event about trans fatty acid regulation in April 2018, the then DG SANTE Director General's first point mentioned, before highlighting anything about health, was whether the industry was ready to accept regulation (Jennings, 2018). This was vehemently criticised by health advocates for betraying the lack of genuine concern for public health as the central aim of SANTE, and was taken by those health advocates as a Freudian slip confirming the sentiment they had already been developing: that this Director General was not particularly driven by a concern for public health. The main point here is not to single out and criticise individual members of DG SANTE, but rather, to put the emphasis on the existence of space for agency of individual SANTE officials.

One discursive pathway though which the amalgamation between HiAP and EU priorities streamlining can occur, is the ambiguity of what the word 'mainstreaming' refers to. Differences in uses of the word mainstreaming, and their effect, have been emphasised in the context of EU gender mainstreaming, and, this thesis argues, also apply in the context of HiAP and health mainstreaming:

> The word mainstreaming itself is subject to several interpretations. The term covers multiple meanings and contents, which have been used to conform Community gender policies to the competitiveness principle at work in European employment policies (Bruno et al., 2006, p.531).

Indeed, the notion of 'mainstreaming' can invoke a sense of deep embeddedness in a 'way of working'. This is the case notably for the Better Regulation concept. Mainstreaming in the context of Better Regulation is used to convey a vision, a concept with 'a spirit' to follow[80].

[80] The word 'mainstreaming' is not invoked very often in the context of Better Regulation, but is reflected in action.

Better Regulation has been described as being part of the EC 'DNA' (European Commission, 2017c, p.2), and its scope is defined with much freedom:

> The Better Regulation Guidelines should be applied flexibly and in a proportionate manner that reflects the circumstances of each individual initiative. What matters is that *the spirit* of the Guidelines (and tools) is applied and that high quality IAs, evaluations etc. result. (European Commission, 2017d, p.8 [emphasis added])

On the other hand, 'mainstreaming' can also be used to refer to a technocratic NMG tool which buys into, rather than challenges, neoliberalism (Bacchi and Eveline, 2010). Bruno et al (2006) traced the origins of the concept of gender mainstreaming in the EU back to the 80s. They then identified a change in the use of the word mainstreaming in around 1995, when a group of individuals not immediately tied to gender-related work defined it in terms of an NMG tool. That means, mainstreaming became about flexibility, soft methods around knowledge sharing on a topic, thereby eliminating the possibility to think about gender mainstreaming in more binding, legislative terms. This kind of meaning of mainstreaming is relevant also to the case of HiAP. Mainstreaming in relation to HiAP is narrowly delineated in the way, space and scope it is supposed to be applied, and most of all, it remains a very soft, aspirational concept, unlike other mainstreamed concepts like Better Regulation.

6.3. Power *over* ideas: recycled HiAP

Both subsections above have provided some insights into potential pathways through which agents' discursive foreground abilities can act to align HiAP with the prevailing EU institutional orthodoxy. More specifically, to align HiAP with the NMG rationale, and as such confine it to a 'soft' space: on one hand, its discursive construction as inherently about multistakeholder engagement, and on the other hand, its use to justify streamlining EU priorities more generally. These drifts are perhaps not surprising. Meanings are not fixed, and as such the struggle to define HiAP is a continuous one. In turn, proponents of a more transformative HiAP have responded and are responding to these challenges by constantly reforming and redefining HiAP. In the same way as HiAP can be seen as an evolution from the Health for All idea (see section 1.2.1., p.43), HiAP also evolves into new, chameleonic versions of itself. This section explores different ways in which HiAP has been 'recycled' (see Smith, 2013b, p.81), rephrased and newly presented in response to risk of institutional co-option and watering down.

6.3.1. From HiAP to the wellbeing economy

From July to December 2019, Finland held another EU presidency. The umbrella theme for its health and social sector was the 'economy of wellbeing' (Koivisto, 2018). The Council adopted conclusions on the economy of wellbeing, which it defined as 'a policy orientation and a governance approach, which aims to put people and their wellbeing at the centre of policy- and decision-making' (EU Council, 2019). Furthermore, the conclusions reference HiAP and state that:

> The need to engage with cross-sectoral action is embedded in the Treaty on the Functioning of the EU and in the European Social Charter, and was referenced as part of the *Health in All Policies* approach in previous Council conclusions (2006). Pursuing the concept of Economy of Wellbeing *does not require new competences or structures* for EU-level actions, but it does necessitate coordinated and improved use by the Union and its Member States of their respective powers. (EU Council, 2019, p.2, emphasis in original)

The presidency also commissioned the Organisation for Economic Co-operation and Development (OECD) to publish a conceptual framework on 'Creating opportunities for people's well-being and economic growth', which was used as a basis for the EU Council's adoption of the economy of wellbeing (All Policies for a Healthy Europe, 2019a; OECD, 2019). The framework categorises four areas to act upon in order to build a so-called wellbeing economy: education, healthcare, social protection and redistribution, and gender equality. Underlying the economy of wellbeing idea, is the explicit mention that GDP is not an adequate measure of countries' performance (see for example: Fioramonti, 2013), and that the prosperity and wellbeing of society should be evaluated based on other criteria, such as health broadly defined, and equity.

This section is interested in acknowledging the strategic shift from HiAP towards economy of wellbeing, and the shift from the word 'health' to the word 'wellbeing', as the discursive adaptation and response to some of the challenges to implement HiAP in the EU. As put by Smith (2013b), ideas which are essentially the same can be recycled and reappear as innovative, even though they have been around for a long time. This chapter section proposes that the 'economy of wellbeing' theme was put forward as a response to the difficulty to implementing HiAP. In the same way that 'multistakeholder HiAP' can be seen as the product of discursively modified HiAP, the 'economy of wellbeing' can be seen as a discursively modified HiAP, one that was strategically formulated to try to counter the risk of

watering HiAP down. Making any predictions on whether this will or not be successful, and how 'success' should be defined in this context in the first place, is beyond the scope of this thesis.

Arguably, the timing of the last Finnish presidency in the second half of 2019, was not propitious to really focus on the economy of wellbeing: it occurred shortly after the election of a new EP (May 2019) and the Finnish parliamentary elections (April 2019). The new von der Leyen Commission also took office during that presidency (December 2019). And of course Brexit, the withdrawal of the UK from the EU, was being negotiated. This constellation of exceptional circumstances meant that the 2019 Finnish EU presidency was perhaps not as high-profile as the one in 2006. It is nevertheless interesting to reflect upon the evolution from HiAP to economy of wellbeing in terms of foreground discursive abilities, and strategies to 'recycle' and rephrase the broad aims put forward by HiAP, in a renewed way. This timeframe of change and renewal was used by a network of EU health advocacy groups to launch an initiative called 'All Policies for a Healthy Europe', which advocates for a health-focused wellbeing economy. All Policies for a Healthy Europe is multistakeholder advocacy initiative led by NGOs, not-for profit organisations, think tank, trade organisations and companies. It is funded by Johnson and Johnson, Microsoft and Randstad. This chapter does not argue that All Policies for a Healthy Europe somehow represents a radical paradigm shift. As a privately funded multistakeholder initiative, it is likely to present the same fundamental weaknesses described in Chapter Four in relation to the EU Diet Platform. An in-depth critique on the initiative is beyond the scope of this thesis. Instead, this advocacy initiative is drawn upon as an illustration of how the HiAP idea is continuously adapted. All Policies for a Healthy Europe explicitly builds on HiAP:

> All Policies for a Healthy Europe builds on the EU 2030 Agenda for the Sustainable Development Goals (SDGs), on the OECD's framework for Inclusive Growth, and on the work of the Finnish EU Presidency for the "Economy of Well-being" (2019) and for "Health in All Policies" (2006). (All Policies for a Healthy Europe, n.d.)

Its advocacy is based on the premise that GDP is an inadequate way to assess the performance of a country, and that goals should be directed towards fostering equity, societal wellbeing and health. It highlights the interactions between healthy people, healthy environments, and healthy care systems, before proposing governance mechanisms that would strengthen the European Social Pillar and the inclusion of wellbeing and health across governance sectors. As such, it represents a kind of differently formulated HiAP or 'reverse

HiAP', to quote one interviewee[81]. The phrasing is meant to invoke a broad vision for societal health. Substantially, it is no different from HiAP, yet it aims to close off the risk of being interpreted as 'health to be added onto each governance area', an interpretation that falls prey to both health imperialistic critiques and to a narrow conceptualisation of health.

Like HiAP, the 'economy of wellbeing' as present in the EC, is a chameleonic idea, and looking at the co-option dynamics of it is beyond the scope of this thesis[82]. Indeed, much needs to be said about how the economy of wellbeing discourse does not challenge the economic paradigm of health, for example (see section 5.1.1., p.147). Background documents from the 2019 Finnish EU presidency emphasise how healthier people are more innovative, productive and pay taxes (Niemi, 2019). Similarly, the OECD conceptual framework on wellbeing economy encourages the creation of public-private partnerships and stresses the important role of the private sector. As such, the economy of wellbeing is not a radical idea that challenges the prevailing orthodoxy. Instead, it should be seen as a chameleonic idea too, which therefore does not fundamentally challenge prevailing orthodoxies, but which aims to act within these constraints.

From the 2006 to the 2019 Finnish presidencies, the language shifted from health to wellbeing, and there was a stronger emphasis on 'economy'. While the economy of wellbeing does not challenge the mantra that wellbeing is necessary to promote economic growth, one advantage of this kind of phrasing, one could argue, is that it targets non-health governance areas more efficiently. This very point of strategically harnessing the economic paradigm of health, but to make it work genuinely for health, was something that some Finnish interviewees[83] were far from downplaying. They did however caution against the risk of getting caught up in negotiations with more powerful interests, and losing sight of the health goal:

> […] your responsibility is to bring health to the table and not just bring yourself there as an assistant for the other sectors. When you play with the more powerful people,

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[81] Source: Interviewee 7

[82] An in-depth exploration of the politics of wellbeing is beyond the scope of this thesis. However, it is worth acknowledging that a shift from 'health' to 'wellbeing', while it makes strategic sense for the reasons argued in this chapter, does not come without its own pitfalls. Wellbeing is now often also being proposed as an indicative tool to measure countries' performance. This, of course, comes with its own challenges on how (if possible at all) to 'measure' wellbeing. The commodification of wellbeing and wellbeing as governmentality, can also be mentioned as processes worth critically reflecting upon. For more on the politics of wellbeing, see for example: Bache and Scott, 2018; Binkley, 2011; Davies, 2015.

[83] Source: Interviewees 27 and 31

> you need to know your stuff and not forget the essence of what it is your message should put forward. (Quoted from interviewee 31)

An issue with HiAP which has been described at length in this thesis, is its difficulty to resonate in non-health policy areas, its difficulty to reach distal determinants of health. This is despite the notion that HiAP is precisely about broad definitions of health and distal determinants of health. The word 'health', arguably, is a double-edged sword: on one hand it conjures up a kind of 'incontestable scientific tone', but on the other hand and for exactly these reasons, it also tends to be boxed into a narrow scope of disease treatment and prevention, along the dominating pathogenic approach to public health. This is where discursively enacting a shift towards the word 'wellbeing' might be interesting, as it could offer some openings into non-health policy areas and distal determinants of health. The main idea around the 'economy of wellbeing' concept, is to convince that the goals and priorities of governance should be the attainment of societal wellbeing rather than economic growth[84]. The use of the word 'wellbeing', rather than health, allows for other sectors of government to feel more involved in it[85]. Similarly, it may be possible that the word 'wellbeing', because unlike 'health', it is not as strongly embedded in biomedical sciences, might lead more naturally to a political discussion around norms and values (see section 5.2.2.2., p.168).

The economy of wellbeing idea, as suggested above, is a chameleonic idea and as such it does not challenge the economic paradigm of health. That means that, while it aims to shift priorities towards social, wellbeing goals, it does so without challenging the basic assumption that the EU needs to generate 'sustainable and inclusive' growth. Despite the structural constraints, and despite the inability to fundamentally challenge ideational structures like the economic paradigm of health and even the 'multistakeholder' discourse, the economy of wellbeing idea can be seen as a continued adaptation of HiAP which seeks to respond to some of the challenges faced by HiAP. While it does not explicitly do so, it can be argued that the All Policies for a Healthy Europe initiative seeks to shape the wellbeing economy idea so as to offer solutions to some of the issues faced by HiAP (All Policies for a Healthy Europe, 2019b). Some concrete examples of these are illustrated in the table below.

[84] Source: Interviewees 27 and 31
[85] Source: Interviewee 32

Challenges faced by HiAP[86]	Solutions put forward by 'wellbeing economy'[87]
Difficulty to reach distal (political) determinants of health	- Shift from health to wellbeing - Proposal to appoint a vice-president for health - Explicit critique of GDP, the economy as a starting point
Constitutional asymmetry	- Proposal to appoint a vice-president for health - Develop a 'social imbalance procedure', in contrast to the 'macroeconomic imbalance procedure' - Include health expertise (health ministers) in the European Semester
Narrow definition of health	- Shift from health to wellbeing - Relating human, environmental and social health
Risk of watering down health on its own right	- Proposal to 'maintain a home for health within the Commission' (manifesto 1, p.16)

Table 6.1. Responses to HiAP challenges offered by the 'wellbeing economy' idea

What this section has shown, is the resilience of chameleonic ideas that seek to generate endogenous institutional change. This does not mean that chameleonic ideas are necessarily successful[88] at changing institutions. However, proponents of chameleonic ideas like HiAP, despite their strategic discourse formulation that adopts the dominant language, are aware of the political challenges they face, such as the risk of their idea becoming co-opted and/or watered down. As a result, different discursive variations of what is essentially one same idea (Health for All, HiAP, economy of wellbeing, all propose a normatively identical agenda) are actively and continuously recreated, reshaped and re-presented so as to push for gradual institutional change, evolution 'from within'.

6.3.2. Wellbeing and the degrowth discourse

As mentioned above, the economy of wellbeing questions the usefulness of GDP as a measure of countries' performance. That GDP is an inadequate measurement is not a radical claim, in fact even institutions like the OECD have stated it (OECD, 2019). The orthodox

[86] Based on the analysis in this thesis
[87] Based on the All Policies for a Healthy Europe manifesto
[88] What defines 'successful', is of course also contingent

institutional position with respect to GDP and economic growth in the EU, does not question the absolute necessity of economic growth, but claims that it should be 'smart, inclusive and sustainable'. The current full name of the overarching EUROPE 2020 strategy is 'EUROPE 2020: A strategy for smart, sustainable and inclusive growth' (European Commission, 2010). Another version of this newly packaged discourse of growth is the concept of 'green growth', which is put forward by the OECD and the World Bank as a project to 'mak[e] growth resource-efficient, cleaner and more resilient without slowing it' (World Bank, 2011, p.2). These kinds of rebranded growth models have been criticised. 'Inclusive growth' for example, is a term that has been criticised for bearing little meaning. While it refers to growth that promotes employment, how exactly this 'inclusive growth' leads to poverty reduction is left unexplained (Daly, 2012). There is also a lack of clear definition of what 'green' refers to exactly in the 'green growth' concept (Rosenbaum, 2016).

In the same vein, one can also fundamentally question the 'sustainable' element of growth, and reflect on whether growth is *by definition,* unsustainable, 'green growth' representing merely capitalist green-washing (Dale, 2015). A rejection of the economic growth imperative is the basic premise behind the degrowth (or 'post-growth') idea and movement. This section will highlight how, even in the EU institutional context, spaces for articulating a degrowth discourse exist, even if they certainly remain marginal. This suggests that, not only do chameleonic ideas make their way to the EU institutions, but so do – to a considerably more modest extent – some radical ideas, even though they do not resonate as loudly as chameleonic ones.

In the current climate emergency context, where planetary boundaries are impossible to ignore, degrowth proponents challenge the idea that economies need to grow *ad infinitum*. Degrowth has been defined as

> […] an equitable downscaling of production and consumption that increases human well-being and enhances ecological conditions at the local and global level in the short and in the long term (Schneider et al, 2010, p.511).

As such, the degrowth idea closely relates to a normative vision in which human and environmental wellbeing are inseparable, and that the economy should work towards achieving 'harmony', rather than unlimited growth. The idea is based on the long-term view that continued growth is not sustainable and will lead (or is already leading) to a breakdown of the ecological basis of human existence. Additionally, degrowth stresses the notion that,

beyond a certain threshold, economic growth no longer correlates with improved life quality and wellbeing (Easterlin et al, 2010). And finally, degrowth advocates for the need to redefine 'wellbeing' (Büchs and Koch, 2017). Neoclassical economic theory tends to reduce wellbeing to consumption opportunities (World Bank, 2006). A degrowth agenda would entail a need to completely rethink our wants and needs, our aspirations and how we spend our free time (i.e. develop ambitions other than accumulating wealth, and spend our free time doing things that do not involve consuming). All these deeply taken-for-granted ways of living would need to be rethought entirely, and it is not clear how such radical changes would be accepted and perceived as positive by society. Degrowth would also not be imaginable without a radical rethinking of state institutions, like the welfare system, given that currently they are engineered to function on an assumption of economic growth. Redistribution would need to be completely different for degrowth to work without jeopardising wellbeing. Degrowth is then often found alongside complementary radical ideas like universal basic income (Andersson, 2012; Kallis et al, 2012).

6.3.2.1. The degrowth discourse in the EU

Degrowth and HiAP are not the same idea. However, this chapter argues that they share common norms and values. It suggests that, if political, distal determinants of health are taken seriously, and, going back to Chapter Two, if neoliberalism is considered a determinant of ill-health, then degrowth and HiAP have a lot in common and can be seen as belonging to a similar type of idea in terms of content, but with differing levels of boldness. HiAP is about recognising the effects of other policy areas on health. As seen throughout the chapters, this also includes the effects of macroeconomic policies on health, in large part indirectly through their impact on inequities. Implicit in the critique of inequity-exacerbating macroeconomic system leading to ill-health, is indeed the idea that a growth-centric model is both unsustainable and unfair. Instead, what HiAP stands for is a prioritisation of population health and wellbeing as more important goal, towards which the economy needs to work (rather than the other way around). Therefore, even though they are not the same ideas, HiAP and degrowth can share a common vision – depending on how HiAP is interpreted[89].

What is perhaps surprising to see, is that even radical ideas like degrowth can be found in a few spaces within the EU institutional and ideational constraints. Individual research papers originating from the EC's own JRC have explored and endorsed the degrowth idea. Andreoni

[89] HiAP as interpreted and advocated for in this thesis, shares a common vision with degrowth.

and Galmarini (2013, 2014) have explored conceptualisations of the relationship between degrowth, social capital and wellbeing. Weiss M. and Cattaneo (2017) published a scoping review of the degrowth literature and its evolution from 2006 to 2016. The purpose of the review was to devise a degrowth research agenda, and ultimately facilitate degrowth implementation solutions. The existence of these articles is interesting in and of itself, as it shows the ability of researchers in the JRC to put forward ideas that are outside their institutional orthodoxy, ideas that are in fact critical of it. Another point worth making about these papers, is the accent put on formalising and modelling degrowth to provide concrete plans for implementation. Weiss M. and Cattaneo (2017) highlight the evolution of the literature: they state that earlier work was mostly very philosophical, very 'social scientific', whereas 'research on degrowth has been recently branching out into more *formal* economics, material and energy flow accounting, and empirical case studies' (Weiss, M. and Cattaneo, 2017, p.222, emphasis added). The authors welcome this evolution, stating that '[…] the academic discourse could benefit from rigid hypotheses testing through input-output modelling, material flow analysis, life-cycle assessments, or social surveys.' (p. 220). Andreoni and Galmarini (2014) provide an attempt at modelling the effects of degrowth on wellbeing. These JRC studies take a pragmatic approach to studying degrowth and do not engage as much with the philosophical debate underlying the idea. Note that is aligned with the dominance of the positivist knowledge paradigm, and is yet still radical content-wise. However they do very much represent an instance of discursive ability mobilised against the dominating ideational and institutional structures that take the necessity of economic growth for granted.

Another space in which the degrowth discourse is present is the EP. In September 2018, a conference on 'post-growth' was organised by ten MEPs representing five different political groups[90]. The rationale for organising the conference was to face the problem with the growth paradigm head on, and explore alternatives:

> We are surrounded by the attractive visions of 'sustainable growth', 'green growth' and promising technological solutions to environmental problems and other negative outcomes our societies produce. However, we don't dare to name the one we should blame – growth. (Post-Growth 2018 Conference, n.d.)

[90] Three MEPs from the Greens, three members of the Progressive Alliance of Socialists and Democrats (S&D), two members of the European United Left–Nordic Green Left (GUE), one member of the European People's Party (EPP), and one from the Alliance of Liberals and Democrats for Europe group (ALDE).

15 panels were organised around four key themes: the economy, the financial sector, the environment, and society. Panels included topics like basic income, tax evasion and avoidance, sustainable fiscal consolidation, to name only a few. These kinds of spaces can provide the possibility for foreground discursive articulations of dissenting ideas, even though they are located within the institutional boundaries. Arguably, the EP, given its political (in the traditional sense) nature has more freedom to explore radical ideas than a technocratic institution like the EC. Equally, the JRC, because it is a research centre, also enjoys the same kind of relative freedom.

The point made here is not that the end of the economic growth paradigm is near. Rather, what is suggested is that, despite the structural constraints, there are spaces for dissenting discourses, even in a rigid institution like the EU: they can take place through chameleonic ideas, which become more widely accepted and referred to, but are less radical. But there can also be smaller pockets of more radical ideas, which will likely not become part of the EC's agenda, but the existence of which still matters. Degrowth is only one example of a radical idea which can be found in rare and limited spaces in the EU, and it is one which relates to the economy of wellbeing and HiAP. Together, chameleonic ideas like HiAP and economy of wellbeing, and radical ideas like degrowth, can be seen as forming a body of agential, contesting discourses existing within the institutional boundaries and which perhaps could lead to gradual, endogenous change.

6.4. Conclusion: Joining discursive forces for change

This final chapter has explored DI's third element: foreground discursive abilities. More specifically, it has looked at the power *over* ideas, the agential power to define and attribute meaning to ideas, whether those meanings are intended to maintain institutional continuity, or whether they seek to foster endogenous institutional change. This chapter drew on the notion of chameleonic ideas to analyse the malleability of the meaning of HiAP. The first agents analysed here were the Finnish HiAP advocates who, back in 2006, shaped HiAP in a way to ensure it would become accepted in the EU space in the first place (and not be seen as 'too radical'). Subsequently, HiAP has been reinterpreted by EU officials (as found in the EU documents) to refer to something that is inherently about multistakeholder involvement. The multistakeholder interpretation of HiAP is likely to have been promoted by industry lobbyists, too, in the same way they have been shaping the Better Regulation agenda in ways

which secures them a powerful seat at the table. 'Multistakeholder HiAP' has been criticised for putting too much emphasis on involving the private sector and leading to the lifestyle drift. Additionally, HiAP-like language is also used by the Juncker Commission to justify the need to streamline EU (economic) priorities. This tendency has led to concerns that HiAP as a slogan can be used to justify dismantling the institutional safeguards that DG SANTE represents, and instead install the equivalent of 'one health desk in every DG'. Both these instances of power *over* ideas can be argued to contribute to the preservation of institutional continuity, in particular the continuity with the NMG that prevail in the EU health policy and governance area.

At the same time, HiAP is also being redefined and re-adapted to continue to foster change. In the same way that HiAP is the continuation of the 'Health for All' agenda from the 70s, this chapter suggests that the theme of the 2019 Finnish EU presidency, the 'economy of wellbeing', is a continuation of the HiAP idea. The 'All Policies for a Healthy Europe' initiative advocates for an economy of wellbeing that is strong on health, and its agenda seeks solutions to challenges that HiAP has been facing in the EU. Policymakers who 'get it' can choose to advocate for a chameleonic version of this normative vision, through HiAP or the economy of wellbeing. This is another instance of power *over* ideas, where HiAP becomes constantly reshaped to address the challenges it faces.

HiAP is a very broad concept, and ultimately it is a deep-seated political vision that embraces complexity and a holistic approach to fostering wellbeing, equity, and social and environmental justice. As such, it would not be coherent to consider HiAP in isolation from other, similar ideas that share broadly the same purpose, but through different avenues. The shift from HiAP to economy of wellbeing and from health to wellbeing arguably allows for more focus on the macroeconomic determinants of health through, for example, the critiques of GDP as a measurement of countries' 'performance'. This is where the chameleonic HiAP idea connects with more radical ideas like degrowth. The last part of the chapter has highlighted how, even in an institutional setting like the EU, limited spaces for radical ideas like degrowth exist, albeit not in the EC *per se*. The extent to which degrowth and HiAP can, together, form a body of critical discourses that gradually lead to institutional change, is impossible to predict or observe without a considerable amount of hindsight. As mentioned in Chapter Three (pp.101-102), background ideational structures and ingrained systems of meanings change very slowly.

However, to finish on one last potentially promising development that resulted from agential power, one might cite the European Green Deal drafted by the new von der Leyen commission (European Commission, 2019f). Far from claiming that it represents a radical paradigm shift, it is fairly safe to suggest that the European Green Deal is more sustainability- and wellbeing-oriented than the previous Juncker priorities. How this agenda will unfold, remains entirely to be seen. There is however a much stronger focus on aligning EU action with the sustainable development goals, and while it does not challenge the economic growth paradigm, it aims to decouple economic growth from resource use (European Commission, 2019f, p.2). It also states 'put[*ting*] sustainability and the well-being of citizens at the centre of economic policy' as a goal (p.3). The European Green Deal also contains concrete policy examples, timelines, an investment plan and dedicated funds to work towards these goals (European Commission, 2019f, 2019g, 2020a, 2020b). Analysing the ins and outs of the European Green Deal is beyond the scope of this thesis, and would be an interesting next step in this thesis' research agenda (Haines and Scheelbeek, 2020). However, what could be suggested here is that the agency of the individuals in power positions in the EU, such as for example the presidents of the EC, can shape the political priorities for their term[91]. While this remains speculative, one can reflect on whether the establishment of the European Green Deal represents an outcome of slow, endogenous institutional change, and whether the discursive weight of ideas like HiAP, degrowth and the economy of wellbeing has contributed to this slow change.

[91] Of course, this does not mean that the appointment of an EC president is not determined by structural factors.

CONCLUSION

In this thesis, I have conducted a critical analysis of HiAP at EU level, focusing particularly on how neoliberal rationality prevailing in the EU prevents a normatively meaningful HiAP uptake. Rather than just looking at particular policies and evaluating the scope to technically mainstream health within it, I have focused on the normative, ideological and political dimensions of HiAP and what stands in the way of its effective uptake and implementation. I started by arguing that neoliberalism is an important constraint which undermines a normatively meaningful HiAP. At the same time, I sought to avoid overly deterministic (and pessimistic) accounts of the EU as a rigid, immutable neoliberal monolith, exploring the emergence of HiAP in the first place, as well as the spaces for agency to redefine and continue advocating it. The focus has been first and foremost on HiAP in relation to so-called distal determinants of health, in particular in relation to health promotion and NCD prevention. The main puzzle that I posed was: if HiAP is indeed adopted at EU level (which in theory is supposed to be the case), how come it has not led to a fundamental change in which distal determinants of health are taken into account? Overall, the thesis aimed to analyse *the possibilities and limitations of HiAP* in the EU context.

Chapter summary and argument highlights

In this section, I will start by presenting the three main arguments that guide the stages of the thesis, and then expand on the content of the various chapters in relation to these arguments, and how the arguments address the initially formulated research questions. The first part of the thesis served to establish the need for a broad conceptualisation of health promotion, in which neoliberalism is defined as a determinant of ill-health. I then highlighted the implications in terms of the scope of HiAP, and in terms of the relevance of EU competencies to health promotion. This was the first main argument of the thesis, which I developed in the first and second chapters, and which set the scene for answering the overarching research question, one sub-question at a time.

The second main argument related to how I conceptualised 'institutions', and thus how I approached the task of exploring neoliberalism in the EU institutional setting as an obstacle to HiAP. Here, I took a DI approach to institutions as both constraining structures and as resulting from active social construction (see Chapter Three). The focus of the second

argument was on the *limitations of HiAP*, the constraining structures which perpetuate a 'neoliberal bias': pertaining to sub-question 1[92], institutional architecture conceptualised in a conventional sense were shown to systematically prioritise economic integration over social integration, undermining the possibility to take up HiAP. However the crux of the second argument of the thesis, pertained to sub-question 2[93]: in order to get a better sense of how neoliberalism is reproduced in the EU, one needs to look beyond conventional definitions of institutional structures, and additionally analyse how frames and paradigms shape worldviews and perceptions of social realities in a way that is driven by an underlying neoliberal 'deep core'. Importantly, these frames and paradigms were not seen as 'inevitable consequences of institutional architecture', but rather as power dynamics in their own rights, i.e. power *in* ideas.

The third and last main argument of this thesis, pertained to sub-question 3[94]: the space for contestation, the 'active social construction' part of DI as the driver of endogenous institutional change, *the possibilities of HiAP*. Here, I explored how the meaning of HiAP is a contested and ever-evolving terrain, especially given its chameleonic nature. On one hand, I highlighted how discursive agency is used to maintain institutional continuity, watering down HiAP by fitting it into the NMG agenda. On the other hand, I argued that HiAP advocates are well aware of these dynamics and as such, can find ways to constantly redefine, reshape and adapt the HiAP in response. This was visible for example in the shift from HiAP towards the 'economy of wellbeing'.

Radically broad health promotion and neoliberalism as a determinant of health

The first main argument in this thesis, developed in the first two chapters, concerned the need to adopt a radically broad conceptualisation of health promotion. It started with explaining the 'complexity turn' in NCDs, in which a growing body of research emphasises the inappropriateness of narrow biomedical and behavioural paradigms of health, especially in relation to NCDs. The political root causes of the NCD burden are increasingly well understood, and so are the links between neoliberalism and health inequities. It then argued

[92] Sub-question 1: 'How does the EU institutional architecture, particularly its neoliberal bias, limit the possibility for a meaningful HiAP uptake?' (pp.16-17)
[93] Sub-question 2: 'How do neoliberal background ideational structures in the EU, limit the possibility for a meaningful HiAP uptake?' (pp.16-17)
[94] Sub-question 3: 'What are the various discursive power struggles at EU level around the meaning of HiAP, and how do active redefinitions of HiAP promote institutional change?' (pp.16-17)

that HiAP represents an attempt to translate this understanding of complexity into a policymaking agenda. However, HiAP has been predominantly researched from a technical angle rather than a political, normative one. The latter, in turn, required an ontological and analytical approach which differs from traditionally positivist natural scientific public health investigations. What the first two chapters of the thesis stated, is the incompatibility between (a normatively meaningful) HiAP, and neoliberalism. This point implicitly made the case for more emphasis on studying the political, normative, ideological and ideational aspects of HiAP and its uptake (or lack thereof), from a critical social scientific perspective. If neoliberalism is considered a determinant of ill-health and health inequity, then health promotion needs to be radically redefined to encompass more explicitly normative commitments to health, as well as social and environmental equity. This also broadened the realm of HiAP and the areas HiAP has relevance to.

The next step of this argument was to consider how a broad conceptualisation of health promotion brings out the vast (and largely underestimated) extent to which the EU has relevance to health: The importance of the EU in relation to public health tends to be either completely ignored, or limited to health as pertaining to *healthcare* systems and healthcare delivery. The institutional neoliberal biases of the EU, as described in the concept of constitutional asymmetry, underlie the argument that the EU's involvement in healthcare is driven by a market rationality and pushes a neoliberal agenda onto social issues. Arguably, this is the dominant position among critical EU health scholars: the view that the EU's involvement in health represents illegitimate spill over, and that it affects member states' health systems governance negatively, by pushing for health system liberalisation and marketisation. This thesis was sympathetic to this argument, but saw it as both too narrow and not nuanced enough. 'Too narrow', because a broad conceptualisation of health promotion, and a correspondingly broad and explicitly normative HiAP scope entails analysing neoliberalism in and of itself, as a determinant of health. This is why the thesis argued that the repercussions on public health of EU governance as a whole needs to be scrutinised, rather than focusing only on EU intrusions into healthcare systems and healthcare delivery. 'Not nuanced enough', because the EU health literature tends to take a rigid institutionalist view which does not leave space to acknowledge endogenous institutional change and evolution. Their theoretical standpoint tends to invariably lead back to the pre-determined, inevitable reproduction of neoliberalism. However, as Chapter Three explained, this thesis conceptualised institutions in a less rigid way.

Neoliberal EU from a discursive institutionalist perspective

The second main argument of this thesis went right into the main substance of the empirical analysis: it pertained to how neoliberalism is reproduced at EU level in a way that undermines HiAP, and it was the object of Chapters Four and Five (and parts of Chapter Six). As Chapter Three explained, DI is concerned with the role of ideas and discourses, and how various kinds of ideational power shape institutional change and continuity. DI however does not ignore 'conventional' *institutional* power altogether, and Chapter Four was concerned with first mapping the institutional context, looking at how the EU constitutional asymmetry undermines HiAP. This chapter touched upon various EU governance areas situated within various governance types, and for each area it looked at one example in relation to HiAP. Overall, it became visible that governance areas that are perceived as being relevant to HiAP tend to be situated in the realm of EU soft governance, and pertain mostly to proximal determinants of health often associated with the behavioural paradigm of health. This was exemplified notably through the EU Diet Platform and the HLG. On the other hand, those governance areas that impact distal determinants of health (such as social inequity, or the food system), are perceived to be less relevant to HiAP and are dealt with through harder governance competencies. This was visible through the very limited policy space for health in Single Market regulations, in the CAP, and in EU economic governance. Finally, the EU meta-regulatory landscape also reflects constitutional asymmetrical biases, as illustrated through the example of the Better Regulation agenda and DG SANTE's Strategic Plan for 2016-2020.

The second part of this main argument, was about looking beyond institutional power and investigated the role of EU (neoliberal) ideational power in structuring how social reality is made sense of. The main overarching point here, was that neoliberalism does not only manifest through institutional structures in a conventional sense, but also ideationally, through 'background ideational structures'. Chapter Five was concerned with power *in* ideas, that is, the authority and 'taken-for-granted' character that certain kinds of ideas possess, and their exclusionary power towards dissenting ideas. To analyse this dimension, Chapter Five drew on the framework for analysing global health policymaking. It analysed how a neoliberal deep core underpins paradigms within which policy issues are framed. Here, two kinds of paradigms were investigated: health paradigms and their impact on the framing of

NCDs, and knowledge paradigms and their impact on the framing of evidence[95]. In both cases, the chapter drew the links between frames, paradigm, and the neoliberal deep core. The economic paradigm of health, overlapping and interacting with other paradigms of health (security, biomedical, and behavioural), was seen to be reflected in the framing of NCDs as problems systematically associated with the 'ageing of populations'. Notwithstanding the link between demographic change and NCD prevalence, the issue with this framing, is that it obscures the social and inequality dimensions of NCDs by portraying them as the inevitable result of increased life expectancy, i.e. of progress. On one hand, the framing draws on both the security and economic paradigms of health to present the NCD 'crisis' as a matter of threat posed by 'a tsunami of elderly people' that may lead to the collapse of member states health and pension systems. This then serves to justify austerity measures and budget cuts, as well as pressures to come up with individual self-management solutions. At the same time, the ageing population framing also mobilises solutions from the economic and biomedical paradigms of health, centred around personalised medicine, eHealth, mHealth and biomedical innovation: health as a profitable market. In terms of knowledge paradigms, the chapter critiqued the dominant, positivist knowledge paradigm which calls for evidence-based policymaking as the best way to design public policies, and how it has led to the framing of evidence as SMART evidence in DG SANTE. The issue with SMART evidence, in relation to HiAP, is that it does not allow for neither complexity nor normativity to be taken into account.

Ultimately, compared to some of the existing critical EU health literature, this thesis' investigation into how neoliberal rationality is reproduced aimed to go deeper and offer greater nuance. It pointed to both the non-inevitability and the perniciousness of neoliberal reinforcement: on the one hand, it highlighted how neoliberalism goes far beyond constitutional asymmetry and is found in spaces like the biomedical paradigm of health, or the framing of evidence as SMART. On the hand, it highlighted the room for change, for evolution and avoided falling into determinism because it saw institutions as socially and discursively constructed. This room for change pertained to the third main argument, and was developed in Chapter Six.

[95] Knowledge and health paradigms are not unrelated, either. As a typical example, one can mention, the relationship between the biomedical health paradigm and the positivist knowledge paradigm.

The permanent struggle to redefine chameleonic ideas

To avoid falling into determinism, and in line with DI, this thesis conceptualised institutions as both constraining and socially (actively, discursively) constructed. So far, the focus had been on neoliberalism as structure manifested institutionally and ideationally. The third main argument, however, looked at the space for agency, for active resistance and contestation – as well as active maintenance of institutional continuity. Together, these tensions represent the constant and ever-evolving struggle to propose HiAP and then define it, they represent instances of power *through* and *over* ideas. Chapter Six started by suggesting that HiAP is a chameleonic idea, that is, an idea that seeks to change the institutional status quo, but which is strategically packaged to nevertheless become accepted in the policy sphere it targets. A chameleonic idea is phrased ambiguously enough and normatively neutral enough, to not be perceived as 'too radical', or 'too ideological'. However its meaning is particularly unstable, very malleable. This was illustrated in how HiAP is becoming actively redefined in the EU space, so as to fit the NMG agenda: on one hand, through the ambiguity of the term 'sector', the EU interpreted HiAP as inherently about engaging all stakeholders, an interpretation vehemently contested by the Finnish HiAP advocates interviewed. At the same time, there was a worry among some interviewees, that HiAP language was being used to justify dismantling the institutional safeguards for health, and further streamlining EC economic priorities. This relates to the ambiguity of the term 'mainstreaming', and how it refers to a technocratic NMG tool in the case, for example, of gender mainstreaming, whereas it refers to something much more all-encompassing and deep seated in the case of, say, Better Regulation. These, the thesis stated, are some of the dangers faced by a chameleonic idea like HiAP in the EU, the risk of becoming watered down and redefined to maintain institutional continuity.

The second part of this agency-centred argument, was about the ability to continuously respond to the co-option challenges, by continuously redefining and recycling HiAP. One of the last points made in this thesis, was that the 'economy of wellbeing' agenda of the 2019 Finnish EU presidency represents a continuation of the HiAP agenda, which seeks to address some of the challenges faced since 2006. One example in which this adapted continuity is visible is through the 'All Policies for a Healthy Europe' initiative which was launched in the frame of the Finnish presidency, and advocates for a health-heavy economy of wellbeing. The argument suggested here was that the shift from using the term 'health' to using the term 'wellbeing' – while not without its own challenges – can allow other governance areas to be

more invested in taking it up, as wellbeing is a broader goal to which more governance areas will perceive they have relevance. Similarly, by being less directly associated with the biomedical realm, 'wellbeing' may allow for a more explicit discussion around politics, norms and values. Finally, the 'economy of wellbeing' phrasing also leads to a discussion of the inadequacy of the current macroeconomic model, for example critiquing the GDP measurement. The economy of wellbeing, like HiAP, is a chameleonic idea, and therefore does not fundamentally or radically challenge the institutional orthodoxy. The last part of Chapter Six pointed to the presence of more radical versions of the 'economy of wellbeing', i.e. the degrowth movement. Interesting was that, even within a conventional and rigid institution like the EU, spaces for the degrowth idea do exist, notably in the JRC and the EP. While degrowth is unlikely to become widely accepted in the EU (at least in the foreseeable future), this thesis' last main argument was to suggest that the presence of radical, marginal ideas, together with chameleonic – more widespread but much less radical – ideas, may lead to gradual endogenous institutional change, even though this change may be very slow. Arguably, the European Green Deal, while it is at a very early stage, and without suggesting that it embodies a radical paradigm shift at all, does look like progress compared to the Juncker priorities. This gradual slow change may be attributable to, on one hand the agency of the individuals making up the new commission, and on the other hand, the presence of discourses (within and outside the EU institutions) that push for the prioritisation of wellbeing, social justice and environmental sustainability.

Contributions of the thesis

This section spells out and reflects upon the specific contributions of this thesis, and how they fit into various relevant literatures. It identifies two primary contributions and one secondary contribution.

Primary contribution I: a novel empirical study

Altogether, the thesis has provided a novel analysis of HiAP in the EU, with new empirical data. Unlike the majority of studies on HiAP, which tend to look at its implementation challenges from a technical perspective, this thesis offered an in-depth investigation into the political, normative and ideational obstacles and opportunities for HiAP at EU level. The thesis in itself was a normative project, the goal of which was to contribute to the body of research that promotes a normative vision of social and environmental justice and

sustainability through the channel of public health and wellbeing. That is the concern of much of the politics/sociology of health research, and it is within these disciplines that my thesis aimed to offer a main contribution.

This HiAP analysis' novelty lies in part in its EU focus. But mostly, the novelty lies in its use of DI as the overarching theoretical framework to analyse HiAP. This framework allows us to look at different kinds of manifestations of power within a sophisticated conceptualisation of institutions that balances structure and agency. In turn, the empirical analysis in this thesis provided multifaceted insights into how the EU institutional setting affects HiAP: institutionally, ideationally, and discursively. To the critical EU health literature, this thesis added the discursive, ideational, constructivist insights. To the literature on neoliberal governmentality in health promotion, this thesis added the institutional architecture element, as well as the scope for discursive contestation and slow endogenous change.

While the thesis focuses on HiAP, on health mainstreaming, the radically broad way in which 'health promotion' was conceptualised also means that the thesis has relevance beyond health mainstreaming, and to the broader literature on economic versus social Europe. The critical approach to EU studies adopted in this thesis points to the need to look beyond constitutional asymmetry when investigating the failures to promote a more social Europe. An important point made in this thesis was to draw attention to the need to look beyond the soft/hard governance asymmetries and 'conventional' institutional factors. This is where Chapters Five and Six provide a novel contribution to the EU studies literature, by delving into how discourses and meanings reproduce the dominant neoliberal rationality and the spaces to challenge it.

Overall, this thesis sought to provide a well-rounded, *multifaceted* yet coherent analysis of the neoliberal obstacles to HiAP in the EU, and how these are being challenged discursively. This novel empirical analysis contributes to making the case that the EU is indeed relevant to public health and health promotion, an angle which tends to be neglected in EU studies. It did so by emphasising the political, normative nature of health promotion, and advocating for a more holistic approach to understanding what constitutes health promotion. At the same time, this analysis served to highlight the need for more critical, post-positivist approaches to EU studies, precisely to better understand the *subtle*, indirect impacts of the EU on aspects of life other than immediate EU exclusive competences (health, for example, or social inequities).

Primary contribution II: a novel combination of literatures

Another of the thesis' claims to originality is that it brought together different literatures in novel ways. The main research object was HiAP, however it was researched in the EU case study, which has generally neglected engagement with health promotion and public health. Additionally, the way in which it was researched was through a critical social science approach, which investigates power manifest institutionally, ideationally and discursively. In terms of bringing literatures together in useful ways, this thesis offers two different contributions:

Firstly, it brought together the literature on EU health, with the literature on neoliberalism and health. As already mentioned above, this thesis critiqued the most common critical take on the EU's involvement in health for being too narrow and not nuanced enough. With exceptions (for example: Flear, 2015; Stuckler et al., 2017), this literature has tended to be mostly focused on legal perspectives to EU health policy and law (see for example: Hervey et al., 2017; De Ruijter, 2019) and/or on political perspectives that take an neofunctionalist approach and look at it from a spill over perspective (for example: Greer, 2014a).

The reason EU health promotion is an under-represented study area relates to the way in which 'health promotion' is normally defined in a restrictive way, which leads many EU researchers to dismiss it, given its formal status as primarily a member state competence. However, when one considers the complexity turn in NCD prevention and health promotion, the relevance of HiAP at EU level and the relevance of EU public health promotion as a research object makes much more sense. In turn, one of the contributions of this thesis to the EU studies field is to draw attention to the need to broaden the scope of EU studies, to look beyond the obvious EU competencies and to investigate how EU governance affects society in more indirect, subtle ways. This was done precisely by bringing in the vast literature on health and neoliberalism. By bringing together the EU health literature, with the broad and diverse literature on neoliberalism and health, this thesis broadens the way in which we can make sense of the relevance of the EU to public health and health promotion. In turn, combining those literatures shows that the EU governance's impact on public health should be traced back not only to health systems and healthcare, but to all EU competencies and policies, as they have a potential influence on reducing or exacerbating inequities. This is ultimately what HiAP is about.

Secondly, two further literatures that have been brought together in this thesis, were the HiAP literature, and DI. One shortcoming identified in the HiAP literature (and more generally in those academic public health circles more closely affiliated with biomedical sciences and positivist ontology), is the lack of engagement with and research on the politics, i.e. the study of power, in relation to HiAP (and in relation to public health policymaking more generally). As mentioned in Chapter One (section 1.3., p.51), HiAP has mostly been researched from a technical rather than a political angle. This thesis is a contribution to the research looking at HiAP from a critical social science angle, and it does so drawing on DI, which has not yet been applied to HiAP research. Smith (2013b) has applied DI to a very similar topic (health inequalities) and in a broadly comparable setting (the UK), albeit in a different way. She mentions HiAP as a 'more radical response' in relation to health inequalities, suggesting however that HiAP's success in fostering considerable institutional and policy change had yet to be demonstrated (Smith, 2013b, pp.95-96). This thesis represents a contribution to this specific research agenda, as it has looked specifically at HiAP from a DI theoretical approach.

<u>Secondary contribution: a structure-heavy use of discursive institutionalism</u>

A secondary contribution of this thesis pertains to its use of DI. As mentioned in Chapter Three (section 3.2.1., p.106), the majority of studies that self-identify as using Schmidt's DI tend to take an agency-focused starting point, looking more heavily at agents' discursive abilities (*how* they communicate, depending on who they address), and how these are underpinned by – or challenge – ideational paradigms (*what* do they say, which normative views do they articulate). These studies are mostly concerned with power *through* and *over* ideas. Schmidt's DI, however, is a large family of frameworks which can include various different ways of approaching the structure/agency scale. This thesis has aimed to use DI in its own, adjusted way, by focusing more heavily on institutional and ideational structures, and then on how these structures can be challenged (or reinforced) discursively. While it did analyse power *through* and *over* ideas, it did so looking at these two kinds of ideational power dynamics alongside each other, as both related to the chameleonic nature of HiAP. The two other empirical chapters, on the other hand, were more heavily concerned with structural manifestations of power: institutional and ideational structures respectively. Using DI in such a way, this thesis has combined it with other conceptual tools: Rushton and William's (2012) framework for analysing global health policy-making, allowed us to delve

into the ‘power *in* ideas’ dimension prevailing in the EU, in particular in DG SANTE. This exposed the relationship between the EU and neoliberalism beyond constitutional asymmetry, and as deeply embedded in health and knowledge paradigms, shaping how NCDs and evidence are framed.

Future research agendas

There are three potential future research agendas that I would like to discuss here: the first results from the limitations of the thesis; the aspects left unexplored due to time and resource constraints. For example, certain kinds of ideational power in relation to HiAP in the EU have not been looked at in as much detail, most notably the various power dynamics across member states, and member state–EU relationships more generally. Secondly, some research avenues put forward by the findings of this thesis are not new ones *per se*, but they remain relevant and this thesis contributes to highlighting their importance. This includes the need for more critical perspectives in EU studies, more research on EU health, as well as generally more engagement with the ontological diversity in public health scholarship, not limited to NCDs and health promotion. These are not new research agendas, but their importance remains salient, and this thesis contributes to highlighting this. Thirdly, the thesis is also carving out a more novel research avenue as a result and implication of its findings. Specifically, research around the salience of the ‘degrowth’ (or post-growth) concept in connection to public health and wellbeing, which is relatively underdeveloped. Another important development to keep a close eye on, is the unfolding of the European Green Deal agenda, and the extent to which it successfully socialises and ‘environmentalises’ EU economic governance tools and other EU competencies. Whether we will be able to witness some broader changes in political rationality will be particularly interesting to watch in the context of the post-pandemic world ahead. These are some ways to think about the implications of this thesis, of its findings and limitations, and where these can lead future research.

HiAP in EU member states and beyond

A continuation of this thesis would be to further investigate the details of HiAP advocacy, and how HiAP is being talked about in different EU circles, at different events and across different member states. Chapter Six has looked at what kinds of meanings are attributed to HiAP, and how HiAP is being recycled into newly formulated chameleonic ideas that have

the same essence. In terms of power *through* ideas, it focused on the 2006 and, to a lesser extent, the 2019 Finnish presidencies, and how they were the site for convincing to adopt ideas for change. However, investigating the deliberative spaces and dialogues between the various member states among each other and with the EU was not the main focus of this thesis. This was due in part to the lack of access granted[96]. Researching those more in detail would provide a better picture of the obstacles and opportunities for HiAP not only at EU level, but importantly also at the level of member states. In terms of member states and HiAP, this thesis only considered Finland in opposition to the EU, but researching the role of other member states would provide additional analytic depth, and would add to the complexity of the discursive and ideational landscape in the EU around HiAP, health promotion and NCD prevention. In the same vein, researching HiAP in DGs other than DG SANTE will be crucial to get a fuller picture of HiAP in the EC, given that HiAP is precisely about non-health policy areas. It would also be interesting to look more closely at the fate of the 'economy of wellbeing' idea in the EU in the context of the 2019 Finnish EU presidency, as well as the unfolding of the European Green Deal agenda, especially in a post-pandemic context. Finally, the study of the politics of HiAP could also be extended beyond the EU case study, especially as this concept has been gaining traction internationally. Looking at HiAP in LMIC, for example, would perhaps bring to the forefront interesting differences in forms and meanings that HiAP take on, as well as differences in obstacles and opportunities for HiAP, compared to the EU.

Developing critical approaches to the EU and health

Given the vast understanding of complexity of health determinants, it is necessary to start talking about public health promotion in a way that automatically includes the health impacts of governance areas which are not directly related to health. In turn, health should feature more prominently in EU studies, not only because of spill over effects, but also because we now understand much better where distal determinants of health are shaped. EU studies do not neutrally observe the EU as a pre-existing entity. Rather, EU studies, how the EU is theorised, talked about, researched, and criticised, shapes the EU as a social construction. In turn, challenging orthodox conceptualisations of what the EU is and what it does (Ryner, 2012), exposing the subtle, overlooked power dynamics and political effects from a critical perspective, is in itself political – and necessary for promoting institutional change.

[96] I attempted to gain access to a series of joint and separate meetings of the HLG and the EU Diet Platform, without success.

Beyond the EU focus, this thesis contributes to the call for more work using critical, post-positivist approaches in public health, to continue to broaden, and add complexity to our understanding of how power operates in health promotion and public health governance. Such approaches are likely to present a more holistic picture of the complexity and interconnectedness between public health determinants, and politics. While this thesis focused on NCDs and health promotion, this point applies beyond those health topics. To give a timely example, more critical approaches applied to pandemics can highlight the political-economic roots, the inequality dimensions, of the increased likelihood for epidemics and pandemics to break out and differentially affect populations (Rushton, 2019). Ultimately, this can push towards slow changes of how, collectively, issues are made sense of.

Exploring ‘degrowth’ through the political sociology of health

While this thesis has looked at the resonance of HiAP as an idea at EU level, it has not delved into exploring what the EU could look like, concretely, if HiAP was meaningfully implemented (from a normative project perspective rather than from a technical perspective). In order to develop this kind of research agenda, it is fundamental to work towards redefining what counts as ‘health promotion’. Exploring the connection between such radically broad conceptualisations of health promotion as put forward in this thesis, and the idea of degrowth (or post-growth) would be an interesting future research avenue to explore. What this thesis really brought to the forefront throughout the chapters, is the normative and vast scope of ‘health promotion’ as a vision that goes far beyond promoting the absence of disease in humans. Radical ideas like degrowth, that challenge the dominant macroeconomic model are driven by what is ultimately the same vision for a more just, and equitable world, one that strives for a meaningful purpose beyond consumption, capital accumulation and economic growth. However, degrowth has yet to be researched from a political sociology of health perspective: how to ensure the theoretical link between degrowth and wellbeing actually holds in practice. This is far from obvious, given that current structures like welfare states in Western countries are built on the premise of economic growth (Büchs and Koch, 2017). At the same time, cultural and social perceptions of what represents wellbeing, aspirations, goals and beliefs regarding how to achieve wellbeing, are also deeply embedded in a capitalist worldview.

Finally, it is worth reflecting more broadly, on the impact that the current pandemic might have on the importance given to health on political agenda, but also and importantly, *how* this renewed attention on health might occur. Will the current pandemic lead to a focus onto the broad political economic root causes of public illness, the 'distal determinants of health'? Will it make it impossible to ignore the connections between neoliberal capitalism and health? Despite NCDs and infectious pandemics being two very different public health problems, they are not unrelated in terms of one of their main underlying political determinants: inequity. Political economic models, climate change, the global food system, NCDs, the increased likelihood of pandemics, are related issues that need to be viewed holistically and normatively. At a time when individual responsibility narratives in relation to 'healthy lifestyle promotion' are under ever-growing criticism, when solutions to the destructive consequences of political decisions continue to be pushed into the realm of individual action, the Covid-19 pandemic is blatantly exposing the limits of disembedded free market economies, and underscoring the importance of a strong welfare state. Trying to make sure these relationships do not go unnoticed, trying to make sure they become politicised and contested, is both an implication of this thesis, and a long-term future research agenda.

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List of interviewees

Interviewee number	Interviewee type	Date	Location
1	EU NGO representative	08/03/2018	Brussels
2	Representative for an EU food and drink industry	09/03/2018	Brussels
3	EC official	22/03/2018; 04.06.2018	Luxembourg, Luxembourg
4	Industry representative	26/03/2018	Brussels
5	NGO representative	26/03/2018	Via Skype
6	Industry representative	27/03/2018	Brussels
7	EC official	06/04/2018	Luxembourg
8	EC official	06/04/2018	Luxembourg
9	EU NGO representative	10/04/2018	Brussels
10	Industry representative	13/04/2018	Brussels
11	EC official	16/04/2018	By telephone
12	EU NGO representative	05/04/2018	Brussels
13	EU NGO representative	01/06/2018	Brussels
14	EU NGO representative	04/04/2018	Brussels
15	Member state health ministry representative	12/04/2018	Email exchange
16	Former EC official	17/04/2018	Brussels
17	Member state health ministry representative	18/04/2018	By telephone
18	Member state health ministry representative	19/04/2018	Luxembourg
19	Member state health ministry representative	19/04/2018	Luxembourg
20	EU health advocate	20/04/2018	Luxembourg
21	Member of the European Parliament assistant	28/05/2018	Brussels
22	EC official	04/06/2018	Luxembourg
23	Research and evaluation company representative	11/06/2018	Brussels
24	Member of the European Parliament	19/06/2018	Brussels
25	Former MEP assistant	22/06/2018	Luxembourg
26	EU health organisation representative	04/07/2018	Brussels
27	Member state health ministry representative	04/07/2018; 23/04/2019	Via Skype; Helsinki
28	EC official	09/07/2018	By telephone
29	EC official	09/07/2018	By telephone
30	Finnish NGO representative	18/04/2019	Helsinki
31	Member state health ministry representative	23/04/2019	Helsinki
32	Finnish public health researcher	29/04/2019	Tampere
33	Finnish health policymaker	17/04/2019	Helsinki
34	Finnish health policymaker	17/04/2019	Helsinki
35	Finnish health policymaker	17/04/2019	Helsinki

Annex: The European Core Health Indicators

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See full page below:

THE EUROPEAN CORE HEALTH INDICATORS ECHI

SHORTLIST OF 88 HEALTH INDICATORS IDENTIFIED BY POLICY AREA*

Area	No.	Indicator	HEALTH SERVICES AND HEALTH CARE: Sustainable health care systems	HEALTH SERVICES AND HEALTH CARE: Health system performance, Quality of care, Efficiency of care, patient safety	HEALTH SERVICES AND HEALTH CARE: (Planning of) health care resources and health care cost	AGEING AND POPULATION: Healthy ageing, Ageing population	AGEING AND POPULATION: Maternal & perin. health	AGEING AND POPULATION: Child health	HEALTH DETERMINANTS: Health inequalities (including accessibility of care)	HEALTH DETERMINANTS: Preventable health risks and lifestyle health behaviour (including young adults)	DISEASES AND MENTAL HEALTH: Non-Communicable diseases (NCD), Chronic Diseases	DISEASES AND MENTAL HEALTH: (Preventable) Burden of Disease (BoD) and health threats, communicable diseases	DISEASES AND MENTAL HEALTH: Mental health	HIAP: Health in All Policies (HIAP) including occupational and environmental health
DEMOGRAPHY AND SOCIO-ECONOMIC SITUATION	1	Population by sex/age	X		X	X								
	2	Birth rate, crude	X				X							
	3	Mother's age distribution		X			X	X	X					
	4	Total fertility rate	X				X							
	5	Population projections	X		X	X								
	6	Population by education							X					X
	7	Population by occupation							X					X
	8	Total unemployment							X					X
	9	Population below poverty line and income inequality							X	X				X
HEALTH STATUS	10	Life expectancy	X						X			X		
	11	Infant mortality		X			X	X	X					
	12	Perinatal mortality		X			X	X	X					
	13	Disease-specific mortality; Eurostat 86 causes		X						X	X	X	X	
	14	Drug-related deaths							X	X		X	X	
	15	Smoking-related deaths		X					X	X	X	X		
	16	Alcohol-related deaths		X					X	X	X	X	X	
	17	Excess mortality by extreme temperatures (formerly 'by heat waves')							X					X
	18	Selected communicable diseases										X		
	19	HIV/AIDS							X	X		X		
	20	Cancer incidence	X	X	X	X					X	X		
	21	(A) Diabetes, self-reported prevalence (B) Diabetes, register-based prevalence	X	X	X						X	X		
	22	Dementia/Alzheimer	X		X	X					X	X	X	
	23	(A) Depression, self-reported prevalence (B) Depression, register-based prevalence			X						X	X	X	
	24	AMI		X	X						X	X		
	25	Stroke		X	X						X		X	
	26	(A) Asthma, self-reported prevalence (B) Asthma, register-based prevalence			X			X			X	X		X
	27	(A) COPD, self-reported prevalence (B) COPD, register-based prevalence	X		X	X				X	X	X		
	28	(Low) birth weight		X			X	X				X		
	29	(A) Injuries: home/leisure, self-reported incidence (B) Injuries: home/leisure, register-based incidence			X	X		X		X		X		
	30	(A) Injuries: road traffic, self-reported incidence (B) Injuries: road traffic, register-based incidence			X			X		X		X		X
	31	Injuries: workplace			X				X			X		X
	32	Suicide attempt			X							X	X	
	33	Self-perceived health			X	X			X			X	X	
	34	Self-reported chronic morbidity			X	X			X			X	X	
	35	Long-term activity limitations			X	X			X			X		
	36	Physical and sensory functional limitations			X	X			X			X		
	37	General musculoskeletal pain										X		
	38	Psychological distress			X	X			X			X	X	
	39	Psychological well-being				X			X				X	
	40	Health expectancy: Healthy Life Years (HLY)	X		X	X								
	41	Health expectancy, others	X		X	X								
DETERMINANTS OF HEALTH	42	Body mass index			X	X		X	X	X		X		
	43	Blood pressure			X	X			X	X		X		
	44	Regular smokers			X			X	X	X		X		
	45	Pregnant women smoking		X			X		X	X		X		
	46	Total alcohol consumption			X			X	X	X		X		
	47	Hazardous alcohol consumption			X			X	X	X		X		
	48	Use of illicit drugs						X	X	X		X	X	
	49	Consumption of fruit							X	X		X		
	50	Consumption of vegetables							X	X		X		
	51	Breastfeeding					X	X	X	X		X		
	52	Physical activity				X			X	X		X		
	53	Work-related health risks							X	X		X		X
	54	Social support				X			X	X		X	X	
	55	PM10 (particulate matter) exposure						X	X	X		X		X
HEALTH SERVICES	56	Vaccination coverage in children		X				X	X			X		
	57	Influenza vaccination rate in elderly		X		X						X		
	58	Breast cancer screening		X	X	X					X	X		
	59	Cervical cancer screening		X	X	X					X	X		
	60	Colon cancer screening		X	X	X					X	X		
	61	Timing of first antenatalvisits among pregnant women		X	X		X	X	X			X		
	62	Hospital beds	X	X	X				X					
	63	Physicians employed	X	X	X				X					X
	64	Nurses employed	X	X	X				X					X
	65	Mobility of professionals	X		X				X					X
	66	Medical technologies: MRI units and CT scans	X		X				X					
	67	Hospital in-patient discharges, limited diagnoses		X	X									
	68	Hospital daycases, limited diagnoses		X	X									
	69	Hospital day-cases as percentage of total patient population (in-patients & day-cases), selected diagnoses	X	X	X									
	70	Average length of stay (ALOS), limited diagnoses	X	X	X									
	71	General practitioner (GP) utilisation			X				X					
	72	Selected outpatient visits			X				X					
	73	Surgeries: PTCA, hip, cataract		X	X				X					
	74	Medicine use, selected groups		X	X				X			X		
	75	Patient mobility	X	X	X				X					
	76	Insurance coverage	X						X					
	77	Expenditures on health	X	X	X				X					
	78	Survival rates cancer		X					X					
	79	30-day in-hospital case-fatality AMI and stroke		X					X					
	80	Equity of access to health care services	X	X					X					X
	81	Waiting times for elective surgeries		X	X				X					
	82	Surgical wound infections		X						X		X		
	83	Cancer treatment delay		X					X		X			
	84	Diabetes control		X		X			X	X	X			
HEALTH PROMOTION	85	Policies on ETS exposure (Environmental Tobacco Smoke)										X		X
	86	Policies on healthy nutrition						X	X	X		X		
	87	Policies and practices on healthy lifestyles						X	X	X		X		
	88	Integrated programmes in settings, including workplace, schools, hospital						X	X	X		X		X

*The Joint Action ECHIM suggested 17 relevant policy areas for the ECHI indicators shortlist. DG SANCO has reviewed the allocation to policy areas and in order to make the ECHI shortlist more user friendly has merged some policy areas and set the ECHI shortlist up in a table with 12 policy areas. Both tables have been presented to the Expert Group on Health Information (EGHI). The main aim of the lists is to support policy makers in their choice of indicators for measuring and/or setting of policy but is not intended to be prescriptive for users.