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Global Health Expertise in the Shadow of Hegemony

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Abstract

What enables actors to shape norms in global health governance? Scholarship on global health has highlighted the role of experts and expertise in operationalizing norms across a variety of issues. The degree of expert consensus or dissensus and the negotiation processes between expert communities—for example, in international organizations, NGOs or academia—are commonly identified as centrally important for explaining these processes. In this article, we posit that norm-making in global health governance occurs in the shadow of hegemony; a system of status and stratification that is centered on economic and security concerns and maintained by countries at the core of the world system. These countries—notably the USA and other major economies in the Global North—project their hegemonic position in the world system across areas of global organizing, including in global health. We explore the relationship between epistemic consensus and hegemonic interests as parameters that shape the outcome of norm-making processes. To pursue this argument, we examine this relationship in the context of the development of policy norms to counter non-communicable diseases in developing countries and to pursue the securitization of global health.

Keywords Global health expertise · Hegemony · Global norms · Non-communicable diseases · Global health security

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Introduction

Experts and expertise permeate global health. At the transnational level, networks of experts and professionals provide the knowledge on which global health initiatives are based (Dalglish et al. 2015). Such transnational networks not only dominate debates at global venues and health summits but also commonly inform country-level action, as experts translate and modify global policy norms into national policy (Chorev 2012; Hanrieder 2019; Harris 2015, 2017). Such global policy norms define what are seen as appropriate and authoritative policy responses on particular issues, thus framing priorities and shaping the contents of policy (cf. Halliday 2009, 268). But despite the centrality of expertise in shaping policy norms on global health, underlying global power dynamics behind it are often relegated to the margins of analyses. To be sure, scholarship does point to the political nature of expertise and the political struggles underpinning the development and implementation of global norms (Block-Lieb and Halliday 2017; Kentikelenis and Seabrooke 2017). The factors that underpin which global health initiatives are given political priority have been primarily discussed as actor and issue-level attributes (Shiffman and Smith 2007). But less attention is paid to the social structure of the world system, and the unequal power relations within it, that shape whether, when and how expertise feeds into global health policies and priorities.

At heart, the distribution of power in the world system, and the epistemic authority on which global health measures are based, bring out two conflicting principles for policy making: Claims to scientific authority are often cast as universal, transcending national borders. The logic of international politics, by contrast, suggest that particular (state) interests prevail, trumping claims to universal, scientific authority. Explaining the contents and changes of global health by reference to transnational health expertise, then, risks ignoring the systemic-level political context of hegemonic powers.

In this article we posit that global health expertise lies in the shadow of global-level hegemonic dynamics. By the "shadow of hegemony" we mean that global health expertise is articulated with reference to status and stratification dynamics imposed by hegemonic interests, namely the USA and—to some extent—other powerful countries in the Global North. A hegemon—typically understood as the polity with a preponderance of power on economic and security issues in the international order (Musgrave and Nexon 2018)—seeks to replicate their dominance by favoring global governance initiatives compatible with their public and private interests. In other words, while epistemic communities in global health can agree or disagree on the contents and priorities of global health governance, they must also keep an eye on the hegemon's interests (Haas 1992: 2-4; Kapstein 1992). This is important if the hegemon has a strong interest in what issues are considered integral to global health governance. To pursue this argument, we build a bridge between scholarship on expertise and hegemonic orders, with a specific focus on global health.

We argue that hegemony has multiple manifestations in its interactions with expertise in global health. We advance a model where a hegemon's power is a

structural constant in what policies are given priority in global health, making the hegemon's interests, especially on economics and security, a central explanatory factor together with the role of expertise. By analytically separating variation in hegemonic interests, on the one hand, and degrees of epistemic consensus among health experts, on the other, we can explain variation in norm-making across different issue-areas in global health. This variation in norm-making follows the extent to which activity in global health governance follows interaction from high or low epistemic consensus and if the hegemonic interest is for or against the inclusion of an issue as important to global health governance. This combination of epistemic consensus/dissensus plus hegemonic interest/disinterest leads to four possibilities, which we characterize as *compatible*, *incoherent*, *conflictual*, and *strategic*. We focus on two cases that demonstrate conflict (hegemonic interest against a high epistemic consensus) and strategy (hegemonic interest for an issue amidst low epistemic consensus). The first case highlights how global health governance has stalled on failed to operationalize and institutionalize norms on how to combat obesity, as strong public and private corporate interests from the Global North diluted relevant epistemic attempts at norm-making on this issue. Our second case demonstrates how on pandemic preparedness hegemonic interests, steered by the USA, exploited epistemic dissensus to propel health security in global norm-making. Notably, the Bill and Melinda Gates Foundation's support for different norms reflects what we can understand as hegemonic action that replicates status and stratification dynamics between the Global North and the Global South. As pointed out by recent literature on the need to decolonize global health, it is important to specify the practices that reinforce power asymmetries and affirm colonial remnants (Kwete et al. 2022). Understanding how expertise in global health governance operates in the shadow of hegemony supports this aim.

The Role of Expertise in the Making of Global Health Norms

Global health is reliant on experts and practitioners tasked to define policy norms that countries, intergovernmental organizations (IGOs), international non-governmental organizations (INGOs) and other actors put into practice (Noy 2021). This process is often determined by both a mix of science and politics (Block-Lieb and Halliday 2017; Kentikelenis and Seabrooke 2017), with scientific expertise provided internally by technocrats (Hanrieder 2015; Littoz-Monnet 2017), and through arrangements with established epistemic communities formally at arm's length from politics. These "networks of knowledge-based experts" (Haas 1992, 2) can foster an epistemic consensus on what is best scientific practice to inform norm-making, especially when connected to IGOs that can legitimate the mix of science and politics. The role of experts in the articulation of global health governance has been a noteworthy feature in the development of the concept and policy field, which is commonly linked to the 1990s influence of economic and political globalization on what was an established field of international health governance dominated by IGOs like the World Health Organization (WHO) (Ng and Ruger 2011; Chorev 2012).

IGOs in the 1970s and 1980s discussed the need for new international health policy priorities that included economic and social development issues, as well as health as a human right. Realizing these aims required both the creation of a body of international law, such as the International Health Regulations that became binding in 2007 (Kamradt-Scott 2019), as well as the inclusion of INGOs and private actors, such as foundations and firms. Greater complexity also led to clashes between North and South in IGOs, and a stronger reassertion of state interests with, for example, the USA seeking control over policy direction in the WHO (Chorev 2012, 2013). "Global" health governance indicates a move away from "international" as really meaning "low-income country" and a focus on what health lessons are also important for securing the health of the North (Janes and Corbett 2009, 168). This includes the professionalization of health experts from the Global North through activities in the South, including the reimportation of some practices (Hanrieder 2019, 310).

With a greater diversity of organizations and agendas, global health governance has centered on the principle that "policy decisions should be informed by evidence-based science" and the norm that "high-income countries should provide health-related assistance to low-income countries" (Morin and Blouin 2019, 2). Along with key funders, experts sit at the center of this complex organizational field, focusing on the advocacy for and translation of scientific advances and the establishment of professional criteria for health care as key factors in norm-making (Inoue and Drori 2006, 211). Views from competing IGOs—such as the WHO, World Bank, and UNICEF—over whether global health priorities should reflect cost-efficiency or socio-economic development are articulated via expertise and who is recognized as authoritative (Sending 2017). Large philanthropic organizations—like the Bill and Melinda Gates Foundation and historically the Ford and Rockefeller Foundations—have been instrumental in developing and funding a transnational network of experts on health issues (Sending 2015; cf. Moran and Stevenson 2013). Private-public partnerships, such as the GAVI alliance, rely on experts to create "vertical" systems of global best practices, which have been criticized for showing little concern for national health systems, and sometimes undermining them (Eggen and Sending 2012). This vertical system is affirmed by the production of metrics for global health, which become policy focal points (Adams 2016).

The production of global health expertise relies on "circularity and exclusivity" (Littoz-Monnet 2022), meaning that expertise is assembled through expert groups, research clusters and scientific venues that affirm particular science-based policy norms. Of course, the boundaries of this epistemic world are not fixed, but malleable: "policy entrepreneurs" in the global health field seek to institutionalize policy ideas and particular solutions to real or constructed policy problems (Béland and Katapally 2018). However, while epistemic communities are not static, they are also shaped by their broader political environment. This has meant that, in recent decades, the activities of expert groups have often privileged health norms tied to Western medicine, often to the marginalization of Southern voices (Littoz-Monnet 2022, 16). In this sense, experts can be used as tools for the promotion of norms in line with transnational and imperial projects, as has been well-documented in the literature on economics and law (Dezalay and Garth 2002; Fourcade 2009).

In the health context, the leading force legitimating certain types of expertise was the advent of neoliberalism—a set of policy ideas that was highly skeptical of the role of governments in steering economic activity and delivering a range of public goods, and favored market solutions to a range of policy problems (Chorev 2012; Kentikelenis and Babb 2019; Kentikelenis and Rochford 2019; Keshavjee 2014; Sparke 2019). This opened up space for experts that were not drawn from a traditional medical or public health background, but were trained in economics, which became the dominant frame for devising policies. Correspondingly, the field of global health became more fragmented, with powerful new entrants trying to shape the development of relevant policy norms. The most prominent instance of this was the rise of the World Bank as a highly consequential actor in global health (Noy 2021; Kaasch 2015). In a telling example of the transformation of hitherto tightly controlled global health expertise, the World Bank became the leading advocate in promoting the marketization of public health services around the world, advocating for the introduction of public-private partnerships and user fees for health services (Noy 2017). This is policy entrepreneurship in action: the World Bank saw an epistemic opening in the mid-1980s and worked hard to redraw the boundaries of what is considered relevant and appropriate knowledge in the making of global policy norms.

But expertise at the transnational level (encompassing IGOs, INGOs, epistemic communities and professional groups) is only part of the story. There is also a recursive process for norm-making that relies on links between global and local expertise, as there is a realm where norms are placed into policy practice. In this context, there can be competing claims to knowledge and expertise—i.e., epistemic dissensus. For example, in Thailand's attempts to implement universal health coverage (UHC), the World Bank was adamantly opposed to it, while the WHO and International Labor Organization were in favor. Local experts could leverage the sympathetic international experts to counter opposition experts (Harris 2015). Recent research has found that link between the local and global rely on a "power-trust cycle" that includes faith-based organizations (Anderson, Considine, and Patterson 2021). Experts are enrolled into making not only scientific claims but also moral and ethical claims (Littoz-Monnet 2017).

Given this context for expertise in global health governance, it is not surprising that epistemic consensus and dissensus interact with broader state and private interests. Powerful interests can enroll experts in attempts to legitimate their activities and to foster an epistemic consensus that matches other priorities, such as economic and security objectives. Such drives can even separate what are often allies in the North. For example, Baccini et al. (2022) find that in health aid allocations there is a distinction between "like-minded" and "single-minded" donors in global health governance that is tied to their use of epistemic communities, with rallying effects around specific diseases, such as HIV (Benton 2015). "Like-minded" donors are the Nordic and Western European countries that often provide funding for global health governance, while the USA stands out as "single-minded" in its use of epistemic communities. This single-mindedness follows a hegemonic conception of interest that casts a shadow over expertise.

Bringing Hegemony in

Within international relations scholarship, hegemony is generally understood in terms of the power of one state to define and support the institutional infrastructures regulating international interactions. Explanations of hegemonic influence within the (predominantly North American) literature concentrate on how a hegemon is able to generate consent and support from other states through a combination of coercion, incentives, and through references to shared norms or "soft power" (Ikenberry and Kupchan 1990; Nye 2003). Typically, the effective functioning of hegemonic power is understood to rest upon the ability to take responsibility for, and invest resources in, public goods from which other states benefit, as the USA is assumed to have done with the Bretton Woods institutions in the post-war period (Keohane 1984). Hegemonic interests can also be distinguished at the regional level, as is clear from studies of oil politics (Colgan 2021). These views on hegemony tend to place experts and the diffusion of expertise as either epiphenomenal, being inconsequential in explaining policy outcomes, or as equated with the dominant position of a hegemon within structures of globalization and global governance.

In contrast, more critical scholarship—often pioneered by scholars in the Global South—views hegemony as inextricably tied to relations of material as well as ideological domination. The binding thread across this strand of work—commonly identified with the dependency and world systems theories (Cardoso and Faletto 1979; Palma 1978; Wallerstein 1979)—is the focus on the polarizing nature of the global economy: powerful capitalist states at the "core" of the world system shape the behavior and policy space of countries in the "periphery," because the latter are structurally dependent on the former to achieve higher levels of growth and development (Kvangraven 2020). This focus on core-periphery relations also enables expanding the remit of hegemony away from a unipolar conception that solely focuses on the role of the USA (or other hegemonic powers in the past) and toward a fuller integration of advanced capitalist countries in explanations of international affairs. That is, the USA is not the sole hegemonic power, but other countries in the global core can—whether individually or in coalitions—also materially shape the conditions in (parts of) the global periphery. In relation to expertise, the critical accounts foreground its instrumental nature: hegemonic powers try to impose their interests and worldviews on other countries, and this entails not only using material resources to forward their strategies but also legitimating certain kinds of expert knowledge that is compatible with their preferences in order to compel or facilitate compliance (Mallard and Sun 2022). We can expect to see hegemony supported by policy planning networks that allow public and private interests to maintain dominance through continuity, regardless of what political party is in power (on the USA, see de Graaff and van Apeldoorn 2021).

A more sociological strand of scholarship on hegemony, meanwhile, draws attention to differentiated social "fields" within which hegemonic powers can wield influence through a range of both material and more symbolic resources

(Go 2008; Nexon and Neumann 2018). In this scholarship, hegemonic actors are able to construct orders and subordinate others not only through coercion, but through providing public goods—such as military support and development aid—in exchange for political loyalty from subordinate states. This is not to say that hegemonic powers have a monopoly on the definition of what constitutes a public good, or the contents of services provided (cf. Reus-Smit 2017), but to draw attention to the power relations that underpin the institutionalization and legitimation of some policy choices over others. New research on hegemony has opened up to examine cases where expert knowledge is central (Ikenberry and Nexon 2019). The opportunity here is to consider how expertise and hegemony interact to produce variation in how issues are treated within global health governance. As the "third wave" of hegemony studies has documented, hegemonic interest is expressed "when a single actor garners a large-enough quantity of (some combination of) military and economic capital...to reshape fields" (Musgrave and Nexon 2018, 599). This logic extends to expert groups as well, so that a hegemon may support or promote certain forms of expertise in distinct policy areas—or fields—to advance its core interests, and to undermine expert groups that advance policy norms that do not align with the hegemon's interests. The upshot of this is that we should also consider the hierarchy between expert groups in light of hegemonic core interests: Expertise on economic growth and trade, or on security matters, will typically stand above other expert groups in the hierarchy or professional "pecking order" to shape global policy norms (Sending 2015; Pouliot 2016). This includes issue treatments across social fields, so that hegemonic interests in economic and security matters may well override some policy content and practices. We would thus expect that global health governance is not solely driven by epistemic consensus among experts in global health but depends on the degree of overlap or alignment with hegemonic economic and security interests. This variation should be specified. Doing so requires a differentiated conception of how hegemonic power may operate (Barnett and Duvall 2005), ranging from overt forms of coercion to indirect "soft" power. The more direct form of power entail direct control. In the context of global health, the most obvious example is donor-recipient relations, which enable countries in the Global North to directly shape the policies of countries in the Global South (Anderson, Considine, and Patterson 2021, 427). For example, the USA is not only the largest global health donor, but is also "single-minded" in its global health pursuits, opting against cooperation with other countries that might dilute its priorities (Baccini, Heinzel, and Koenig-Archibugi 2022; Pfeiffer et al. 2017).

Additionally, countries in the core of the world system can also exercise indirect influence over those in the periphery. Within global governance, this process often operates through IGOs that respond to the priorities of the major donors—countries in the Global North—and then diffuse relevant models to countries around the world. For example, the World Health Organization serves as a key vehicle for developing and spreading norms that are consistent with the views of its largest donor, the USA (Chorev 2012; Sending 2017). Beyond IGOs, multilateral forums—like the Group of 20—are also key spaces where hegemonic interests are transmitted and negotiated settlements reached.

But hegemonic power can be even more diffuse in the way it shapes the interests and capacities of actors. Social scientists have long noted that power has several faces, ranging from direct influence over decisions to shaping the decision space altogether (the "second face") and to creating misleading interpretations of the world that blind participants in decision-making from alternative, preferrable equilibria (the "third face") (Bachrach and Baratz 1962; Lukes 2005). For example, education curricula taught as "global health"—commonly operationalized as health in lower-income countries—tend to mirror hegemonic worldviews of experts (academics, health professionals, and development workers) in the USA (Hanrieder 2019), thereby leading to this type of education becoming "an instrument for a new era of scientific, programmatic, and policy imperialism" (Horton 2014, 1705).

Overall, the implication here is that the shadow of hegemony from public and private interests in countries in the core of the world system provides clear markers of status, stratification, and what is "thinkable" in obtaining access to resources (Hopf 2002). But sociological research has also shown that epistemic consensus or dissensus does not directly track onto funding from dominant interests, but varies according to issue areas and can exhibit "spiral" (clear growth), "circular" (back and forth), or "flat" (stagnant) trajectories (Shwed and Bearman 2010). Such variations in epistemic consensus matter for how hegemons plan to execute their preferred policies and forms of governing. Knowing that the shadow of hegemony matters for what is likely to be articulated as global health governance, there is variation to be explored between epistemic consensus and the intensity of hegemonic interest.

The Role of Experts and the Multiple Manifestations of Hegemony in Global Health

Bringing together the literatures on expertise and on how hegemonic power manifests can open up new analytical windows into how global health norms are developed and modified. In this section, we conceptually distinguish the multiple manifestations of hegemony in global health, and how they relate to expertise. This analysis has two starting points. On the one hand, we distinguish between policy areas where the hegemon is supportive or opposed to a particular policy in global health. Hegemonic support means to prioritize the issue in policies, while opposition is to ignore or downgrade the issue's importance. On the other, we account for different possibilities vis-a-vis expertise: whether epistemic consensus is high or low on an issue. The combination of these elements yields four types of relationships between hegemony and expertise in global health, summarized in Table 1.

Table 1 The relationship between global health expertise and hegemony

		Hegemonic interest	
Epistemic consensus		Supportive	Opposed
	High	*Compatible*	*Conflictual*
	Low	*Strategic*	*Incoherent*

The first, and analytically simplest, possibility is that one of *incoherence*: there are no support from the hegemon and low epistemic consensus on an issue, thereby leaving much space for other actors to feed into global norm-making. For example, the concept of "spiritual health" is not widely recognized among global experts as a key dimension of health, although it is seen as important by countries in South East Asia and the Eastern Mediterranean—this led to the topic being picked up by the relevant WHO Regional Offices, even though the issue did not get wider traction beyond these regions (Hanrieder 2017).

Second, the relationship between hegemonic interests and epistemic consensus may be *compatible*, and there are several cases in global health where we find evidence of this. A clear example can be found in initiatives for global immunization programs. There is broad epistemic consensus that immunization is a cost-effective measure in global health (Yoon 2015). These have been supported by the WHO, UNICEF, and the World Bank with strong US support on the individual and population-level health benefits of immunization. This has also crystallized into Gavi, the Vaccine Alliance, which is a public-private partnership that supports extensive vaccinations of children in low-income countries. Gavi is recognized by core donors in the Global North as a highly effective and autonomous in operationalizing norms (Lall 2017). We see a similar pattern of compatibility between US interests and epistemic consensus on maternal health from the mid-1980s onwards, where the formation of an epistemic consensus on the broader importance of maternal health was an integral part of US policy prioritization. The USAID, the World Bank, and a range of US philanthropic foundations were central in funding, for example, the "Safe Motherhood Initiative" and other research and programmatic initiatives that helped place maternal health higher on the agenda in global health (Rosenfield and Maine 1985; AbouZahr 2003). As Secretary of State, Hillary Clinton also pushed for maternal health as an integral part of the Obama administration's global health agenda.

There are two additional possibilities for the relationship between hegemon interest and expertise, and these provide ample analytical leverage to unpack the power dynamics underpinning global health norm-making. When manifest hegemonic interests and high epistemic consensus are at odds, we term this relationship as *conflictual*. This means that norm-making is marked by battles between expertise drawing on scientific consensus and attempts by hegemonic powers to institutionalize a different set of norms or fend off potential threats to the normative status quo. Such conflicts typically develop over longer stretches of time, where competing expertise is mobilized to advance a particular set of interests. This can result in continued stalemate, but it can also lead to key states—including the hegemon—changing its policy. This was arguably the case with the US position on property rights on HIV-AIDS drugs, where the USA was initially opposed to relaxing property rights but gradually changed its position due to an epistemic consensus forming around the need for accessible medicine. But there are also cases where there is a low epistemic consensus, as experts cannot agree on a common definition of a problem and the development of policy norms to respond to it. If this happens while there are also strong hegemonic interests, we understand the relationship between hegemony and expertise to be strategic: the hegemonic power strategically supports amicable

expert groups to spiral knowledge production and thwart challenger groups to influence the direction of global norm-making.

We stress that these four possibilities are not fixed arrangements for interactions between epistemic consensus and hegemonic interests. Movement between these four possibilities occurs. For example, the US investment in maternal health became—from the 1980s onwards—a springboard for the emergence of a transnational network pushing for reproductive health to challenge the official US position on abortion (Dunlop 2004). In this way, epistemic consensus in one area—maternal health—can be mobilized to re-frame policy concepts in adjacent fields that may or may not go against hegemonic interests (Sending 2015).

A case of *conflictual* relations between an apparent epistemic consensus and hegemonic opposition to policy prioritization in global health governance can be seen in obesity in the Global South, which we provide detail below. We can also consider a *strategic* case, where the hegemonic has a clear interest in pushing how policies are framed amid low epistemic consensus—and our example here is the framing of pandemic preparedness as health security. We provide a diagnostic case study, seeking to identify generative mechanisms on how norm-making in global health governance is constrained. Case selection in diagnostic case studies is informed by pragmatic considerations about the prominence of known cases in the literature (Gerring 2017). There is a significant body of work on non-communicable diseases, focusing on obesity as a global health problem (Swinburn et al. 2011) with specific recommendations on policies to support new norms in global health governance. Similarly, global health security has re-emerged as a clear intervention into global health governance (Fidler 2015). Both cases are delimited in comparison to other much broader issues, such as poverty, allowing us to trace the integration or rejection of these issues as new norms in global health governance in a more targeted fashion. We trace these two cases drawing on secondary literature in the two subsequent sections. In doing so, our focus is solely on the relationship between hegemonic powers and expertise and how this shapes norm-making, rather than broader inputs into such processes (see Halliday and Carruthers (2007) on such broader methodological approaches).

Conflict Between the Hegemon and Experts: the Case of Fighting Obesity in the Global South

Global health experts have long been drawing attention to non-communicable diseases, which are increasingly prevalent in the Global South (Islam et al. 2014; Gómez 2022, 2023) yet receive limited attention by global health donors—that is, aid and development agencies from the Global North (Nugent and Feigl 2010). The case of obesity provides a case in point (Swinburn et al. 2011). Overweight and obesity linked to diabetes, ischemic heart disease and some forms of cancer, which are leading causes of death worldwide. In 2010 the WHO estimated that more than three-quarters of obese and overweight children live in low- and middle-income countries (WHO 2010). To be sure, this framing is not neutral, as it neglects the harmful health consequences of weight stigma, that disproportionally affects women

(Puhl and Heuer 2010; Boero 2007; Saguy 2012). However, we analyze it here as the dominant frame in order to highlight the relationship between scientific expertise and hegemony.

Scientific advances on the causes and consequences of obesity have led to the advocacy of a range of policies by the epistemic community. Most importantly, there is clear recognition of the role of high fat, salt or sugar foods, and the role of "Big Food" companies in expanding market access to their products, especially given that most of the market growth for these companies is in the Global South (Stuckler and Nestle 2012). Global health experts have drawn attention to these issues already since 1998 (Baker et al. 2017), calling for tighter regulation of these industries, limits to marketing, "sugar taxes" and other public health interventions to curb the reach of unhealthy foods (Stuckler et al. 2012; Ruhara et al. 2020). This effort has also been supported by major IGOs (Gómez 2023), like the WHO where the World Health Assembly passed a (non-binding) resolution in 2010 to "take active steps to establish intergovernmental collaboration in order to reduce the impact of cross-border marketing" (WHO 2010, 4).

However, this policy area is one that directly intersects with major commercial interests in countries in the Global North, and—in turn—with the political advocacy by these countries for lax regulation of Big Food and for limiting the development of global policies that might impede market access or profitability of these businesses. Despite clear evidence that obesity is linked to a range of co-morbidities that will produce "social and economic costs that no country, least of all developing countries with limited resources, can afford" (Rigby, Kumanyika, and James 2004), policies recommendations focused on the amount of physical activity needed to offset heightened calorific intake rather than curtailing obesity-creating products. This points to how hegemonic powers can block the institutionalization of norms that are advocated on the basis of expert consensus in the field of health, and the central role of corporate actors—commonly, multinational companies—therein.

What tactics do hegemonic powers use to counter and bypass conflicts with an established epistemic consensus? Drawing on our secondary literature search on overweight and obesity, we elaborate on three such strategies. First, hegemonic powers can directly intervene in norm-making processes. For example, the US administration in the mid-2000s pushed organizations like the WHO and the World Bank to dilute their policy advice to countries on limiting the sugar intake of their populations (Magnusson 2010, 493). The relevant events surrounding the WHO are illustrative: the US Sugar Association lobbied the US health minister with the request to curtail funding to the WHO if perceived anti-sugar recommendations were not removed from policy recommendations (Lauber, Rutter, and Gilmore 2021). Such direct interference by the USA (on behalf of powerful Big Food companies) against the established epistemic consensus point to one of the most powerful tools available to a hegemon: the power of the purse. This grip on funding is especially pertinent to international organizations that rely on extensive voluntary contributions (most notably, the WHO), as their ability to deliver on their broader mandate and to grow is contingent on high-income countries providing additional resources.

Second, hegemonic countries can also marginalize the role of public health expertise in global norm-making that has direct or indirect impacts on public health.

The most prominent case of this is the 1994 North-American Free Trade Agreement (NAFTA) between the USA, Mexico, and Canada, which—among other provisions—removed tariffs on trade in food containing high-fructose corn syrup, which is linked not only to obesity but an impaired ability to tolerate glucose and the onset of diabetes (Hattori et al. 2021). Public health experts early on raised alarm about the health implications of this type of trade liberalization (Labonté and Schrecker 2007; Hawkes 2006; Barlow et al. 2017), yet such concerns were brushed aside as trade policy experts advertised the multiple economic benefits of increased trade (Fairbrother 2014). This case is not only indicative of health concerns being neglected in the face of business interests in hegemonic countries, but also points to a hierarchy of epistemic communities. Those closely aligned to the material interests of hegemonic states (here, trade experts) enjoy recognition and rewards from their close orbit to political power, while opposing expert communities that act on the basis of scientific consensus (here, public health experts) are marginalized or ignored in providing meaningful input to relevant norm-making processes (here, trade negotiations).

Finally, hegemonic powers and private interests therein can pursue the fragmentation of expert consensus (Gómez 2022, 2023). In tactics that resemble those of the tobacco industry, recent evidence reveals that when Mexico tried to introduce measures to reduce the consumption of sugary drinks, lobbying organizations representing Big Food "paid scientists to produce research suggesting that the tax failed to achieve health benefits while harming the economy" (Pedroza-Tobias et al. 2021). In another example, Coca-Cola—concerned that the WHO director-general linked sugar-sweetened beverages to obesity—leveraged its contacts in the US government to lobby the director-general: in correspondence secured through Freedom of Information requests, Coca-Cola liaised with the US Centers for Disease Control to expand the involvement of Big Food-linked experts to engage with any relevant norm-making and for a "famous scientist […or] a US government scientist" to meet directly with the director-general in an effort to change her position (Maani Hessari et al. 2019).

But even beyond direct actions by public authorities in hegemonic powers, private concerns within their borders can also help entrench hegemonic interests within norm-making in global health. For example, the Bill and Melinda Gates Foundation Trust's investment portfolio features prominent investments in Big Food, with McDonald's, Coca-Cola, and Mexico-based Coca-Cola FEMSA ranked 2, 4, and 9 in their 2010 stock portfolio. In the case of McDonald's and Coca-Cola, the Foundation invested more than half a billion US dollars in both (Stuckler, Basu, and McKee 2011). It is hardly surprising then that the Bill and Melinda Gates Foundation would shy away from throwing its weight and funding power behind tackling issues like obesity, despite their heavy toll on countries in the Global South—a search on its webpage for programs and projects on overweight and obesity did not yield any results.

In sum, in the case of obesity, despite the presence of clear epistemic consensus on its drivers, actions by powerful countries in the Global North to protect big business interests reveals the potentially conflictual nature of the relationship between hegemonic powers and experts. While such conflicts often end up with the expert consensus failing to influence policymaking or donor priorities against hegemonic power opposition, this process brings to surface tensions between scientific advances and hegemonic interest—as well as the hierarchies of expertise—in global norm-making.

The Strategic Use of Expertise by Hegemonic Powers: the Case of Pandemic Preparedness

In many cases, there is epistemic dissensus where there is no commonly agreed-upon definition of policy problems and solutions to them, often because of unsettled or ambiguous scientific knowledge on these topics. When this situation overlaps with clear interests by hegemonic powers, we expect the latter to strategically employ favorable expertise in order to shape the parameters of global norm-making processes. The securitization of global health issues—especially on pandemic preparedness—presents a case in point. This is an issue area with epistemic dissensus, but strong preferences by countries in the Global North to frame health issues through a security lens to advance foreign policy objectives (Kentikelenis and Seabrooke 2022).

In defining pandemic preparedness, the lack of epistemic consensus is immediately apparent, as there are multiple and occasionally conflicting definitions (Aldis 2008; Rushton 2011). In the broadest terms, pandemic preparedness policies are related to the prevention, detection and response to potential transborder infectious disease threats (Wenham 2019). Accordingly, global health activities are to be focused on influencing the activities of states vis-a-vis infectious diseases that have the potential to cross national boundaries and spread in other countries and regions. The list of issues included in pandemic preparedness is extensive, including zoonotic diseases, food safety, and laboratory infrastructures, among others. Demonstrations of health emergency preparedness are centrally important for countries to comply with the relevant global norms that are themselves codified into international law through the International Health Regulations. Supporting these objectives is a community of experts, primarily based in institutions in the Global North: this is composed of scholars, practitioners, and policymakers who sought to embed a security frame into discussions of global health priorities, and contributed to the development of relevant policy norms (Fidler 2015; Kentikelenis and Seabrooke 2021). The best example of this is the Global Health Security Initiative, established in 2001, which included practitioners from high-income countries, Mexico, and the WHO (Rushton 2011).

This state responsibility-centered global health frame focuses on security over improving universal health. Universal health coverage and universal social protection are both policy pathways focused on ensuring access to appropriate and effective health without incurring financial hardship. These frames have been championed by experts in international organizations (like the WHO, the International Labour Organization and UNICEF), civil society, and academia (Shriwise, Kentikelenis, and Stuckler 2020; Wenham et al. 2019). Yet, the policy issues they prioritize—for example, access to healthcare and medicines, and treatment for both communicable and non-communicable diseases—are in tension with global health security frames that are focused on risks to countries from inadequate preparedness measures in other countries (Wenham et al. 2019). In short, competing frames in global health uneasily coexist, and there is no epistemic consensus that has coalesced around a single model for underpinning pandemic preparedness.

While there are disagreements among experts, many countries in the Global North have been more unified in supporting the security lens on pandemic preparedness issues

that focuses on state obligations and compliance to them. This is because these countries have strong perceived interests in advancing security-based arguments (Wenham 2019). The Covid pandemic shows, for example, the economic interests at stake in setting up a system that can help prevent and mitigate pandemics, as trade has slowed and global supply chains have been disrupted, which—ceteris paribus—undermines the position of a hegemonic actor which to a large degree depends on being seen as a guarantor for global trade infrastructures (Cooley and Nexon 2020). This is not a new development, as it echoes earlier fears in imperial capitals about infectious diseases spreading from colonies to the colonizers (King 2002).

In recent years, powerful countries in the Global North have actively shaped the pandemic preparedness norms to match the security framing on the issue. An initial win for these countries and allied group of experts was the encoding of security norms into the International Health Regulations (IHR) in the mid-2000s that specifically focused on health issues of "international concern." These regulations built on the norms developed through expert initiatives via the Global Health Security Initiative and were "enthusiastically pushed" by the WHO (Rushton 2011, 787).

Despite the success of institutionalizing security norms with the IHR, countries in the Global North still considered that this agenda had not gone far enough, as countries around the world were lax in complying with their IHR-derived obligations to report on their pandemic preparedness infrastructures. Consequently, more active monitoring was seen as the appropriate way forward. This was spearheaded by the USA and Finland through the Global Health Security Agenda (GHSA), which was tasked with developing enhanced monitoring procedures for the health systems of—primarily—low-income countries (Kentikelenis and Seabrooke 2022). This initiative spearheaded the development of a template for country evaluations, which was trialed in 2015 in Georgia, Peru, Uganda, Portugal, and Indonesia (Sillanaukee 2015). This model explicitly relied on global health experts assessing countries on the basis of policy norms on global health security that were developed in the Global North to more fully operationalize the IHR. The rollout of GHSA, underpinned by US policy, ultimately morphed into the WHO's Joint External Evaluation. The WHO was then tasked with organizing visits to countries by groups of experts to assess IHR compliance, thereby facilitating the implementation of global health security norms. To do so, the WHO relies on a roster of experts, who are drawn overwhelmingly from public health authorities from high-income countries and from the WHO and other international organizations (Kentikelenis and Seabrooke 2021). The Bill and Melinda Gates Foundation provides funding in support of these evaluation processes, in line with its general strategy to influence global health governance (McGoey 2016).

Conclusions

Hegemony has multiple manifestations in its interactions with expertise in global health. In this article we analytically separated the role of hegemonic interests and consensus among experts in global health to elaborate on variation in the establishment of policy priorities integral to norm-making processes. Drawing on theoretical arguments in sociology and international relations and on secondary

literature on two case studies, we demonstrate the long shadow that global hegemonic dynamics cast onto expertise in global health governance. We contend that interactions between epistemic consensus and hegemonic interest can produce four types of relationships (*compatible*, *incoherent*, *conflictual*, and *strategic*), with issue areas able to move across these types over time. What are the implications of this argument for our understanding of how norms and rules are created in global health?

Our focus on centripetal hegemonic dynamics does not imply that we understand hegemonic actors as static. Their position relies on providing goods to others, be it in the form of security guarantees, safeguarding global trade routes, or serving as the "anchor tenant" of large international organizations such as the IMF or the World Bank. Through the predominant position across a wide range of policy fields, a hegemon can shape—directly and indirectly—the playing field within which health governance takes place. It is in this regard that the policy influence of expertise on health issues is conditioned by hegemonic interests and actors that advance these interests. We have highlighted that in recent scholarship on hegemony the social fields of economics and security are paramount. The hegemon has preponderance in these social fields and likely to export their policy preferences into what it considers relevant in other fields (Musgrave and Nexon 2018). This is the "shadow" of hegemony. While global health is generally an issue area of lesser importance to a hegemon compared to economics and security, the effects of hegemony on global health are still significant. In the case of US hegemony, the sheer scope of US involvement in global health—a function of the size of its aid budgets—makes it the central actor in global governance for health, and gives it the ability to export its economic and security strategic priorities, like the securitization of global health described above, into global health governance. Our findings raise the question of how we should understand the role of expertise in the making of global health norms in contexts where there is explicit rivalry between contending hegemons, or where it is unclear which actors is hegemonic. In the context of increased competition between the USA and China, one can aver that the same dynamic plays out, with core interests of the USA and China as defining the parameters within which health expertise operates. But we have to add a new dimension, which is that China may not so much seek to challenge the USA directly, mobilizing expertise strategically to engage in norm-making that counter US interests. Rather, China may seek to undermine the position of the USA through indirectly by offering up alternative institutions, staffed with different forms of expertise, which engage in developing norms that run counter to those advanced by the USA (Benabdallah 2020). A case in point is the concept of "civilizational diversity" which China and Russia promote to dilute liberal norms backed by the USA and its allies (Cooley 2015). This is supplemented by the setting up of organizations to "monitor" and engage in research and analyses of cases where such diversity is not recognized. Another example is China succeeding in placing a Chinese national at the helm of the Food and Agricultural Organization (FAO), against US criticism. If China will deploy the same rulebook as the USA in shaping global policy fields—and these examples suggest that they are doing so—we are likely to see the field of global health becoming characterized by more strategic use and deployment of expertise to advance its interests.

Our analysis points to how interaction between epistemic consensus and hegemonic interest produces positional roles and structural constraints. Hegemons seek to affirm status and hierarchy in ways that reflect and consolidate their power. This includes both public and private interests within the hegemon. Actors seeking to change policy priorities for global health have to keep this "international pecking order" on their radars, including in what they publicly recognize as authoritative and achievable in different policy fora (Pouliot 2016; Sending 2017).

Analytically tracing the shadow of hegemony in global health governance offers important theoretical and empirical payoffs. First, this approach explicitly foregrounds how global health is part of a much broader calculation for hegemonic powers, insofar as it is directly linked to their economic and security considerations. Therefore, it should not come as a surprise that the USA worked to give the World Bank—the world's premier multilateral bank and where the USA holds most decision-making power—a remit on advancing its own vision of neoliberal global health (Chorev 2013), and to embed security considerations into this policy area (Wenham 2019). Second, the focus on the interaction between hegemonic interest and expertise is readily applicable to other important areas of norm-making. For example, climate governance is driven by the degree of epistemic consensus in conjunction to what threatens hegemonic interests. Climate breakdown as an "existential threat" that will force asset revaluations in a systematic manner relies on a high epistemic consensus plus hegemonic support (Colgan, Green, and Hale 2021).

Global norm-making around issues, like migration, critical infrastructures, plastics management, and many others, rely on how epistemic consensus and hegemonic interests push and pull each other. While the Global South continues to be underrepresented or excluded from major norm-making processes in global health governance (Anderson and Patterson 2017), there are also counter-hegemonic ideas being developed and championed by important policy actors. Most notably, the attempts to achieve universal health coverage and universal social protection—increasingly prominent, but underfunded and opposed by powerful commercial interests—present a clear path forward. This path would require "a set of reforms that would institute progressive taxation, re-commit to the public provision of basic necessities, including UHC, and to the de-commodification of goods and services such as water, education, and healthcare" (Sell 2019, 8). How likely is this to happen? In the context of a still-raging global pandemic and global economic destabilization, prospects do not look very promising. What is more likely is the propagation of monitoring in global health governance that supports the economic and security concerns of the hegemon. We can see this already in attempts to use pandemic preparedness indicators reflecting the priorities of the Global North into regular IGO decision-making (e.g., on financial assistance) (Kentikelenis and Seabrooke 2022). To address ongoing unfairness in global health governance it, is important for counter-hegemonic actors, especially those from civil society, to support progressive epistemic consensus that has a chance of withstanding predictable attacks from above.

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Declarations

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