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Fragmentation in Global Policy-making: Mapping the Problem and Exploring Coordination Mechanisms

Why do global health organisations take on the governance structures that they do? A framework for examining the legacies from the "Golden Era" of global health policy?

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Introduction

There have been various attempts over the past 20 years to establish and maintain novel governance mechanisms to sustain political priority in global health. These include multi-stakeholder funds with large capital throughputs; coordinating bodies that work within and between multilateral organisations; market-adjusting public private partnerships; and knowledge communities linked together through formal decision making structures (Kickbusch & Cassar Szabo, 2014; Lee et al., 2009; Lidén, 2013; McInnes et al., 2012; Ng & Ruger, 2011; Ruger, 2012). In each case, the establishment of new organisations can be seen as a response to a recognised need to moderate the process of cooperation in dynamic political environments where health and medical knowledge is advancing, resources are scarce, interests are dispersed and priorities are contested (Aginam, 2005; Aginam, 2013; Castells, 2008; Cometto et al., 2009; Fidler, 2010; Frenk & Moon 2013; Gostin & Mok, 2009).

The so called 'golden era' of global health, spanning approximately 1998 – 2008 was marked not only by a dramatic increase in funding and political attention for global health, but arguably radical change in the *processes* of global health policy making (Kickbusch, 2016). One area of innovation was in the administrative, executive and oversight structures of newly established global health organisations; which can be seen as both a response to, and a part of, an evolution in the global health architecture (Fidler, 2010). There was been considerable academic interest in the governance of global health organisations emerging during this era, in particular membership in their Boards (or equivalent) and the extent to which they represent a shift away from multilateral towards public-private governance (Brugha et al., 2004; Buse & Harmer, 2007; Rittberger et al., 2008).

The establishment and consolidation of global health organisations of this era has thus been documented in terms of the key influencers and the historical context of the period; including the activities and political constraints in the World Health Organization at the time.(Lidén, 2013) Further scholarly focus has been on the apparent mutual constitution with a 'private turn' in global health (Williams & Rushton, 2011a) and an ongoing debate over legitimacy (Bartch, 2011). Most of this work has been aligned with broader questions surrounding government beyond the state, with strong influences from fields of international relations (Bartch, Huckel Schneider & Kohlmorgan, 2009; Benford, 2011; Bexell, Tallberg & Uhlin, 2010; Finklestein, 1996; Gordenker & Weiss, 1995). There has been far less attention paid to the reasons for, and influence of, these new organisational structures; in particular in terms of setting new standards of organisational governance and management in global health.

A decade on, new questions emerge surrounding the legacy of these innovations and whether new norms of global health organisation have become established. This discussion paper for the 3rd International Conference on Public Policy, aims to put forward a framework for scoping the different

organisational standards and norms that may now be manifested in global health organisations as a legacy of the 'golden era'. The aim of this paper is to explore potential elements for a cross-disciplinary framework, bringing together insights from business management, organisational sociology, public policy and international relations for a richer understanding global health organisations.

The significance of formal governance structures for global policy making

Global health policy is dynamic and highly politicised. Goals, priorities and the broader conceptual frames that guide global action are contested. Global cooperation in health is concerned with the mechanisms for negotiation and mediating this contestation (Fidler, 2010; Kickbusch, 2016; Schrecker, 2017).

Global health governance is defined in many ways, often dependent on the context and nature of the surrounding discourse in which the term is used (Lee & Kamradt-Scott, 2014). A descriptive approach to global health governance is focussed around the architecture of the global health landscape, including the actors playing various roles, the power that they wield, their interests and how they are linked through various networks (Møgedal, Alveberg & Pereira, 2011). A more institutional approach focusses on the 'rules of the game', both formal and informal, and how they are cemented. The focus of institutional approaches has been on norms and conventions that persist through time; determining logics of appropriateness that explain patterns of behaviour and cooperation that can appear to defy self-interested pursuits of interests or even the search for self-preservation within a recognised world of complex interdependence (Fidler, 2007; Hanrieder, 2014; Inoue & Drori, 2006). Global health governance can also be defined broadly as the politics of global health, including the political determinants of the health of people and populations (Gill & Benatar, 2016). This definition is more frequently used in discourse as a juxtaposition to bio-medical, investment and social determinant approaches to global health, to emphasise the impact of factors such as participation, representation, oppression, conflict, discrimination, political identity and self-determination on health.

This paper takes on a tighter definition of governance as the *conditions under which actors agree to cooperate* (Lee & Kamradt-Scott, 2014). The focus here is on structural elements that organise global health policy making creating a reciprocal relationship between input into policy processes, and acceptance of its outputs. The conditions under which parties agree to cooperate may be implicit, in the forms of conventions or social norms, or explicit, in the form of treaties, or organisations. This paper puts the focus on organisations for three reasons:

First, the history of global cooperation in health has been dominated by the creation, role and effectiveness and critique of organisations. Most significantly this has been the World Health

Organisation, but also its regional arms (including the Pan-American Health Organisation); it's predecessors including the League of Nations Health Organisation and Office I International d'Hygiène Publique (OIHP) and that various other organisations (states, multilateral agencies, corporation, civil society organisations) they interact with, from both within and outside health (Hanrieder, 2014; Lidén, 2014).

Second, empirically we have seen a continuation of new organisation for global health forming not just during the 'golden era' described earlier, but also well beyond it. This suggests that, even in instances where informal networks have flourished, there is a need, real or perceived, for formalised structures that enable cooperation, including reaching agreement and taking decisions.

Third, the study of organisations can be useful analytical unit to make sense of the complex global health architecture; and are often taken as such in studies of global health governance, although usually without explicit acknowledgement. With an ongoing academic debate over the meaning and relevance of structure and agency, framing and norms, interests and power and deep ideological cores, the majority of literature on global health still refers to organisations as the various parties may influence, or be influenced by these such constructs.

Legacies from the 'golden era'

The era from 1998 – 2008 has been described as a golden decade in global health (Fidler, 2009; Lang & Rayner, 2015; Lidén, 2013). This label is based not only on advancements in health outcomes during this time (in particular the reversal in global trends of rates of new HIV/AIDS infections) but also the dramatic increase in the amount of global financial aid that was channelled towards health during this decade (multilaterally and bilaterally) (McCoy, Chand & Sridhar, 2009; Ravishankar et al., 2009) and the apparent elevation of health as an issue of concern in the realm of 'high politics' (Williams & Rushton, 2011b; Zacher, 2007). This was also a period during which there was dramatic change in processes and institutions of global health policy making (Kickbusch, 2016; Lidén, 2013).

Among the most studied innovations in governance during this era include the formation and establishment of the two major health funding organisations, the Global Fund to Fight AIDS, Tuberculosis and Malaria (henceforth Global Fund) (see for example, (Bennett & Fairbank, 2003; Lu et al., 2006; Ravishankar et al., 2009; Vitoria et al., 2009)) and the Global Alliance for Vaccines and Immunisation (now GAVI Alliance) (see for example (Clemens et al., 2010; Marchal, Cavalli & Kegels, 2009; Storeng, 2014)). Founded around the turn of the century, these organisations focused around raising the profile of specific diseases and technologies and procuring and dispersing funds to affected populations. They came to have an organisational structure centred around a governance board with diverse representative style membership, including UN organisations and representatives of the governments of leading donor as well as recipient countries. Both organisations also included

board seats for representatives from the private sector (both for and not-for profit) including philanthropic organisations (in the early years dominated by the Bill and Melinda Gates Foundation) (Huckel Schneider, Gillespie & Thow, 2017). Other new organisations linked to the era include the Roll Back Malaria and Stop TB Partnerships, each located within the World Health Organization but with specific independence structures that included formal ties with key non-state stakeholders (Lidén, 2013; Lidén, 2014; Vitoria et al., 2009); UNITAID, a financing organisation which collects contributions from airline ticket taxes (Atun et al., 2012); and the International Health Partnership+, which provides funds and in-kind support with the aim to improve health aid effectiveness (Shorten et al., 2012).

It is notable that the establishment and success of global health organisations of the type and scale of the Global Fund and GAVI have not been repeated. With the global financial crisis of the late 2000s, there were concerns that the period of generosity in global health would end (Leach-Kemon et al., 2012) – with some directly declaring the end of the golden decade (Fidler, 2009; Fidler, 2010; Woods, 2010). Accordingly the hurdle of the exceptionally high level of political and financial attention and support required to get organisations such as the Global Fund and GAVI was not expected to be met again. Some scholars have described the last 10 years as a post-golden era period, marked among other aspects as one of less innovation in global health governance (Kickbusch, 2016).

There has however been a continuation, and evolution of organisations for global health governance since the end of the 'golden era'. Over the past 10 years, as different issues have come dominate the global health agenda, notably non-communicable diseases (NCDs) and universal health coverage (UHC), there has been renewed activity forming new, or reforming existing, organisations to garner political attention, advocate for action, share resources and determine policy actions (De Cock et al., 2013). The NCD Alliance was formed in 2009 as a conglomerate of four large global NGOs for diabetes, heart health, cancer and lung disease and has since evolved its organisational structure to include executive and non-executive members on its board and regional representatives. In 2016, the International Health Partnership+ morphed into UHC2030 for the advancement of Universal Health Coverage; accompanied by changes to its organisational structure. More broadly we also see more policy networks formalising into global organisations such as the Bone and Joint Decade formally becoming the Global Alliance for Musculoskeletal Health in 2015. From 2014, despite a still unresolved debate over global NCD Governance, the WHO Global Coordinating Mechanism on the Prevention and Control of NCDs became established as the eminent global organisation for global NCD policy (Huckel Schneider, Gillespie & Thow, 2017).

The legacies from the 'golden era' are therefore unlikely to be found in repeats of the formation of major funding institutions like the Global Fund and GAVI. However, there are indicators that more

global health organisations have adopted characteristics that appear remarkably similar to those found in the 'major' forerunners. Examples include board compositions that combine regional representatives with individuals from various sectors, separate financing oversight boards, structured roles and relationships between boards and advisory/scientific committees, structured modes of stakeholder engagement and certain structures of the executives.

This paper therefore explores how to determine the legacy of governance innovation from the "golden era" in terms of global health organisation governance and structure; specifically whether certain organisational norms have been cemented in the culture of global health organisations. To do this, the following framework is intended to assist with the initial task of scoping the different organisational standards and norms that may now be manifested in global health organisations; as well as the different theories that could explain why global health organisations take on the governance structure that they do.

The framework

Over the past 15 years, global health governance scholarship has explored many international norms and their role health governance. These include norms relating to sovereignty, hegemony, multilateralism, cosmopolitan democracy, accountability, complex interdependence, liberal institutionalism, responsibility, and legitimacy (of the input, throughput and output kinds). This scholarship forms the basis of the framework.

There has been a notable separation between this scholarship and that of organisational sociology; in particular, the sub-disciplines that relate to the corporation, the non-for-profit organisation, bureaucratisation and specialisation (See for example (Chhaochharia & Laeven, 2009; Coffee Jr, 1998)). This is somewhat surprising as recent work on transnational networks, epistemic communities and public-private partnerships have demonstrated that global health governance today need not follow precedents of international relations (Shiffman, 2009; Shiffman & Smith, 2007). Many global health organisations have no intrinsic obligation to operate as multilateral organisations in terms of being standing bodies to ease negotiation between states on mutually recognised matters of concern. While there is a clear link between global politics and global health organisations, norms of international relations might therefore only tell part of the picture of why global health organisations take on the structures that they do.

Experiences of evolving health governance within industrialised states have increasingly shown that:

> "Historically, the traditions of governance in private, public and voluntary organisations are rather different. However, with the government reforms of the public sector, and the growing introduction of management practices derived from business into the public and voluntary sectors, the

> boundaries between the sectors have become blurred. Increasingly, it is relevant to ask what the similarities and differences are between the different sectors" (Cornforth, 2003, p. 6).

Organisational stability, integrity, efficiency and reputation amongst certain stakeholders (including funders) are therefore plausible key considerations in deliberations on how to structure a new, or reform an existing, global health organisation. The framework therefore includes insights from corporate governance (including not-for-profit governance), scientific management and organisational behaviour. Key elements from corporate governance include rules of transparency and reporting, financial disclosure and fiduciary responsibility, independent audit, ability of boards to deliberate separately from executives and risk management. An example is the Global Fund repeatedly emphasizing its principles of fiduciary responsibility (Banati & Moatti, 2008)

Scholarship on non-for-profit governance has developed parallel to that of corporate governance; and has focused around the characteristics of board membership that contribute to overall performance of the organisation. In particular, the focus is membership and dynamics of a board that allow it to effectively lead policy debate, contribute to organisation strategy, hold management accountable and be responsive to external demands (Coombes et al., 2011; Cornforth, 2001; Cornforth, 2003; Mordaunt & Cornforth, 2004).

At third field of organisational science rarely studied in terms of global health organisations is public management. Again, this is surprising as principles of so called 'new public management' are frequently discussed in domestic public policy scholarship in conjunction with trends towards privatisation, marketisation and monetisation of health. (Dickinson & Sullivan, 2014) This debate is paralleled in the global health literature (Bexell, 2013; Kay & Williams, 2009; Rushton & Williams, 2012), however the extent to which these principles are built in to global health organisations is rarely discussed. The framework therefore includes elements of public administration as well as new public management (see figure 1).

Finally, the context and circumstances within which organisational structures are determined are also incorporated into the framework. History of public policy suggests that innovation and change may be less a result of measured deliberation of available options and but arise from 'muddling through' key decisions, on the basis of historical precedents, limited information, time constraints, personal preferences and dynamics of the group (Birdsall, Graham & Pettinato, 2000; Lindblom, 1959). Context and precedent is therefore also built into the framework as a moderating factor; acknowledging that not every instance of an adoption of a norm or standard is a deliberate calculation to do so.

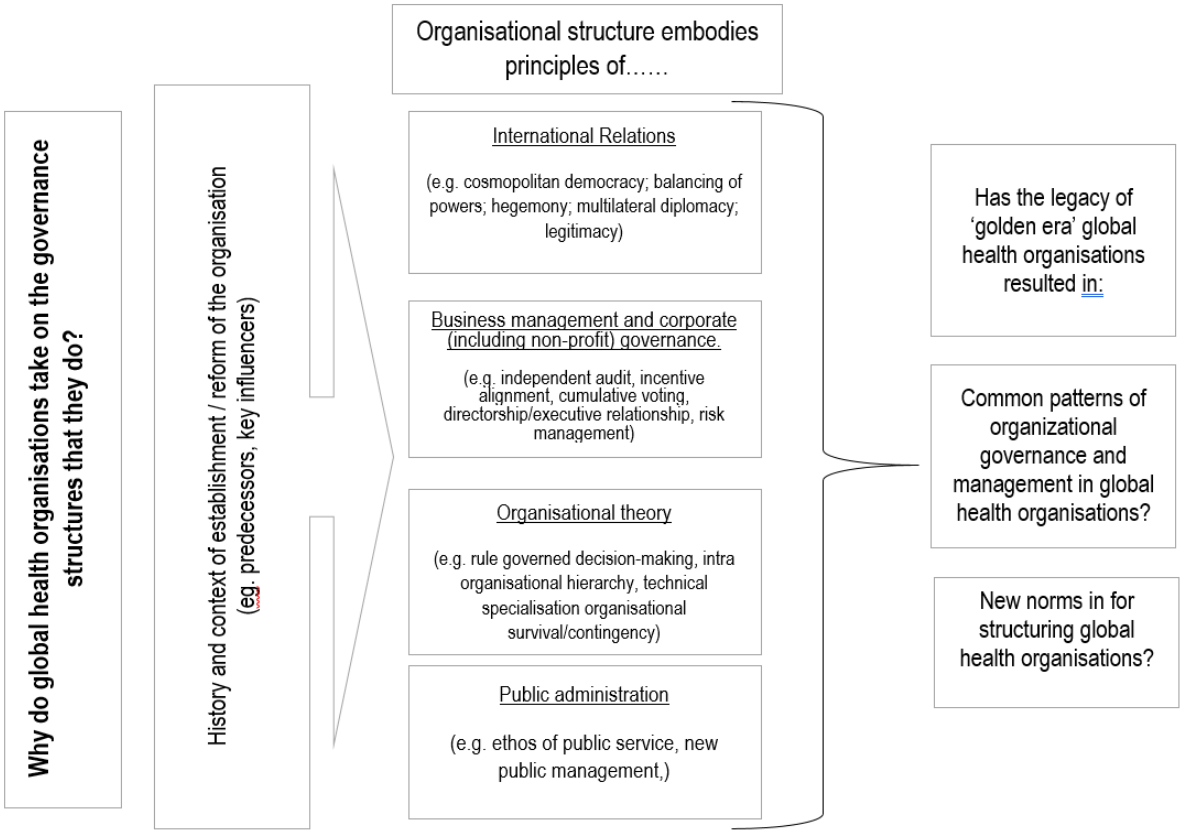

Figure 1 Framework examining organisational governance legacies from the "Golden Era" of Global Health Policy?

Conclusion - Application of the framework

Despite considerable interest in the history, legacy and nature of global health governance during the so called 'golden era' spanning approximately 1998 – 2008, there has been little scholarship examining global health organisations from public policy, public administration and corporate governance perspectives.

The presented framework invites a qualitative historical methodology and comparative analysis between global health organisations from historical and current eras. The framework is designed to interpret, from what is known about the formal structures of global organisations and the principles on which operational models are based, the norms that guide decisions, actions and strategic directions of the organisations as a whole.

The framework includes norms drawn from mainstream international relations as a starting point, but the focus is on 'bringing in' an examination of principles from business management, corporate governance and new public management. Including this in the framework promises to also shed

further light on mechanisms through which principles associated with a 'private turn' in global health manifest and embed themselves in health policy development and implementation.

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