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WHO orchestrates?

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Coping with competitors in global health

Tine Hanrieder

ABSTRACT

This chapter examines how the WHO's orchestrating role has been reshaped by the proliferation of actors in the international health field. Lacking the material capabilities to perform its technical functions on its own, WHO traditionally draws on its formal authority and convening power to mobilize other international organizations and non-governmental associations for research, surveillance and technical assistance activities. Yet as this chapter demonstrates, the growing density of the health field since the 1980s has played out differently on WHO's ability to orchestrate. Comparing the domains of epidemiological surveillance and technical assistance, I argue that IGO focality is critical for recruiting new actors as intermediaries. As WHO's recent empowerment in health surveillance demonstrates, new intermediaries can become powerful allies that allow a focal IGO to engage in orchestration, and even to gain greater autonomy from member-state oversight. By contrast, as WHO lacks focality in the developmental domain, its attempts to orchestrate health assistance are increasingly frustrated. Additionally, states have used new exit options to strengthen their oversight over WHO through project-specific contracts. Thus, this within-case comparison not only illuminates the inter-organizational dynamics underlying orchestration, but also points out how focality, intermediary availability and state oversight interact to either reinforce or undermine IGO orchestration.

Introduction

The WHO was created to be an orchestrator. Its constitution provides that WHO shall "act as the directing and co-ordinating authority on international health work," thereby granting it the formal legitimacy to assume

I thank the convenors and participants of the orchestration workshops, Philipp Pattberg and two anonymous reviewers for helpful comments on earlier drafts of this chapter.

a leading role in its organizational field.¹ Indeed, since its creation in 1946, orchestration has allowed WHO to compensate for its limited operational capacities, for example by coordinating health research performed by other research institutions, or by providing technical guidance to health assistance delivered by other IGOs and NGOs. The evolution of its orchestrating role has not been uniform, however. Over its lifetime WHO has witnessed a massive influx of new actors into the international health field, as other IGOs such as the World Bank became more active in health, new health-related NGOs were founded and philanthropists discovered health as a main field for international charity. Yet while the growth of its organizational field offered WHO many opportunities to recruit new intermediaries, only in some domains such as disease surveillance could WHO also assume an orchestrating role. In other domains such as health aid, rival orchestrators increasingly detracted intermediaries from WHO, or actually transformed WHO into their intermediary. This intertemporal and cross-issue variance provides the basis for the present analysis, which will demonstrate the fundamental role that focality played for WHO's authority and thereby for its ability to "bypass" states in governing global health (see Abbott et al., in this volume).

I will argue in this chapter that an IGO's focality, i.e. its unrivalled competence in a given issue-area, is an advantageous position at both levels of the orchestration model: focal IGOs are more attractive orchestrators for potential intermediaries, and they are more powerful agents vis-à-vis their principals. First, as pointed out in the introductory chapter, intermediaries are particularly attracted by focal IGOs because these offer consistent governance schemes that lower the transaction costs involved in establishing collaborative ties. What is more, to work with a focal IGO also bears a distributional advantage for intermediaries in that they gain access to broader governance networks, their legitimacy and resources. Reversely, IGOs that are not focal tend to be less successful in attracting intermediaries. Second, I will argue that an IGO's focality also affects its relationship with principals and thereby another condition of IGO orchestration advanced in the framework chapter: the degree to which states exercise *oversight* over the IGO's activities. A focal IGO is in a relatively strong position to shape the conditions of its service, given that there are few or no organizational substitutes available to states. Moreover, granting an IGO the discretion to orchestrate may be the sole possibility for states to reach out to intermediaries that are beyond their formal control. By contrast, IGOs lacking focality experience stronger

¹ This role is specified in Article 2 (a) as the first of WHO's constitutional functions. See WHO 2006: 2.

pressure to adapt to their principals' demands, given that states could more easily exit to rival orchestrators. Where states can attach conditions to their organizational choice, state oversight over an IGO's activities is tightened. Thus, focality is a core condition of an IGO's authority, both toward its principals and toward its organizational peers.

These causal pathways will be illustrated with observations from WHO and its orchestration attempts in two sub-domains of international health: health assistance and epidemiological surveillance. Both domains have seen an increase in intermediary availability, but only in the surveillance field could WHO retain its focality. The analysis will show that in epidemiological surveillance, the information revolution and the concomitant rise of professional surveillance networks in the 1990s did more than allow WHO to recruit new intermediaries. The emergence of non-state informants also led states to grant WHO greater discretion in clearing and disseminating epidemiological information through a major revision of the International Health Regulations in 2005. In the domain of health assistance, by contrast, beginning in the 1970s a strong issue-linkage between health and development and the concomitant rise of rival orchestrators has eroded WHO's focality. The ensuing inter-organizational competition has not only compromised WHO's ability to orchestrate the increasingly complex field of health aid. It has also weakened the organization vis-à-vis its member states, which have amplified their oversight through the use of "earmarked," that is conditional, budgetary contributions. Here, the blurring of issue boundaries has left WHO considerably weakened.

By carving out these diverging pathways, the chapter makes several contributions to this volume. First, the WHO case lends support to core claims of orchestration theory, illustrating how IGO capability gaps, IGO focality and intermediary availability jointly condition orchestration in the field of international health. Second, the analysis brings to the fore the dual impact of focality that affects IGO orchestration and IGO autonomy alike. It thereby contributes to specifying the causal status of, and interrelations between, the working hypotheses that underlie this volume. And third, by highlighting the ambiguous effect of actor proliferation, which can both enhance and erode IGO orchestration, this chapter suggests a more nuanced view of the historical trend toward orchestration that the framework chapter postulates. For WHO, orchestration is an old, rather than a new, mode of governance. With the growth of the international health field, it became better equipped to orchestrate in some domains while losing this ability in others. This finding suggests that orchestration can diffuse, but also recede, as global institutionalization proceeds. In particular, interlinkages and overlaps

between issue-areas may well create demand for orchestration, but at the same time make it more difficult to establish focal points for inter-organizational cooperation.

I will proceed in three main steps. In the first section I introduce WHO in light of the framework hypotheses and show that its orchestration-prone *properties* are contrasted by considerable historical variance regarding the *positional* prerequisites for orchestration, given the proliferation of potential intermediaries and orchestrators over time. The second section analyzes the negative impact of WHO's loss of focality in health assistance on its authority vis-à-vis states and intermediaries, and the third section examines how its focal position in epidemiological surveillance allowed WHO to harness its authority by recruiting new intermediaries. The conclusion addresses the implications of this analysis and suggests research avenues for future studies of IGO orchestration.

WHO's orchestration prerequisites: favorable dispositions in a challenged position

With the creation of WHO in 1946, for the first time a single organization became the leading agency for international health work.² Established as a United Nations specialized agency, WHO was given the broad mandate to work toward health in the most encompassing sense: as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."³ Among the many constitutional functions that enable the organization to attain this goal, the competence to direct and coordinate international health work is ranked first, followed by the mandate to establish collaborative relationships with its IGO and NGO peers (WHO 2006: 2). This historical mandate makes WHO an ideal case with which to study orchestration under shifting environmental conditions. I will lay out in the following section that in the light of those orchestration hypotheses that refer to an IGO's properties – its principal-agent design, bureaucratic entrepreneurship and capabilities – WHO is a likely orchestrator. By contrast, the conditions that specify the IGO's position in its organizational field – focality and intermediary availability – vary over time, making the WHO case suitable for analyzing the inter-organizational dimension of orchestration.

² WHO succeeded, and incorporated, several major health institutions, including the Paris-based Office International d'Hygiène Publique, the League of Nations Health Organization and the Pan American Sanitary Bureau. See Lee 2009: 2.

³ Preamble of the WHO Constitution. See WHO 2006: 1.

Favorable predispositions

From the viewpoint of its organizational properties, WHO is a likely orchestrator. First, as a multilateral organization with a quasi-universal membership of 194 states,⁴ WHO is steered by a large and heterogeneous collective principal. In accordance with the goal divergence hypothesis, WHO's member states have proven reluctant to agree to binding international health law. WHO mostly acts as a "service organization" that engages in soft governance: it develops non-binding standards and guidelines, provides technical advice to countries, and gathers and disseminates epidemiological information and health statistics (Cox and Jacobson 1973: 372). These activities are mostly performed beneath the principals' radars and do not require formal member-state consent – thus leaving considerable leeway for orchestration initiatives that are barely impaired by *state oversight*.⁵

Second, and in line with the orchestrator entrepreneurship hypothesis, WHO is an administratively strong organization. It has a sizeable administrative apparatus of more than 8,000 staff, and most of its technical staff members are medical professionals (Lee 2009: 27). This specialized workforce imbues the organization with a strong professional identity and independent expert authority – sources of bureaucratic agency that allow WHO to engage in proactive behavior.⁶

Finally, WHO's organizational resources match the capability deficit hypothesis. On the one hand, we have seen that WHO enjoys formal legitimacy as the leading UN agency in international health, and that its Secretariat imbues it with independent expert authority. These capacities are complemented by a widely recognized "convening power," which is based on official working relationships with ministries of health through which WHO can set agendas and diffuse policies, but also on WHO's role as a central platform for epistemic communities (Yamey 2002: 1296). An affiliation with WHO confers prestige on health professionals and institutions, and can be a door-opener vis-à-vis public and private donors. In the words of a former WHO adviser, "[f]ew hesitate to come when WHO calls" (Nossal 1998: 376). Thus, since its creation, WHO regularly convenes consultative bodies to generate expert consensus on a wide array of public-health topics.

⁴ As of August 2012, see www.who.int/countries/en (accessed August 8, 2012).

⁵ Formally, WHO is authorized to conclude health-related international treaties. Yet apart from the 2003 Framework Convention on Tobacco Control, it has not made use of this authority. See Burci and Vignes 2004: 124–155.

⁶ On IGO expert authority see Barnett and Finnemore 2004: 24–25; on WHO's professional identity see Cortell and Peterson 2006: 263–265.

Yet on the other hand, WHO also lacks important governance capacities, above all the operational capabilities that are needed to implement its technical advice. For example, it can define global research priorities, but not conduct research by itself. Even though its constitution lists the conduct of research as a WHO function, in fact member states have never granted it the necessary resources, such as laboratories, to perform this task.⁷ Thus, since 1949, the organization has relied on a network of “WHO Collaborating Centres,” national research institutions or parts thereof, which engage in health research, offer research trainings or prepare WHO manuals.⁸ But also with regard to technical assistance, WHO mostly acts as an adviser, but cannot provide financial aid or operational services to member states (Burci and Vignes 2004: 195). Therefore, other IGOs with stronger country-level presences such as the UNDP or UNICEF are crucial for implementing WHO’s technical advice, for example by constructing the water supply systems, or conducting the medical trainings designed by WHO (WHO 1958: 355; WHO 2008a: 256).

Challenges to WHO’s position

Given its organizational profile, orchestration is a natural strategy, through which WHO can exert its constitutional leadership while compensating for capacity gaps (see also Blauberger and Rittberger, in this volume). However, orchestration not only depends on an IGO’s *dispositions*, but also on a favorable *position* in its organizational field. As laid out in the introductory chapter, potential *intermediaries* must be available, and the IGO should be *focal* in its issue-area to be able to attract them (Abbott et al., in this volume). These conditions have been considerably reshaped by the historical growth of the international health field.

Since WHO was created in 1946, health has been transformed from a rather technical and specialized issue into a priority concern of international politics, mainly through its close interlinkage with the developmental agenda. This is prominently reflected by the fact that three out of eight UN Millennium Development Goals are directly related to health, namely: reducing child mortality, improving maternal health and combating major diseases such as AIDS and malaria. It also shows in financial terms.

⁷ On member states’ early reluctance to fund WHO laboratories see Ascher 1952: 28–29. In the 1960s, attempts by the Secretariat to establish a “world health research centre” with about 1,200 professional staff were again declined, as member states insisted that WHO should limit itself to coordinating existing research activities (WHO 2008a: 89–91).

⁸ Today more than 800 such centers exist in over 80 countries. See WHO 2010a.

According to one estimate, health assistance funds rose from \$5.6 billion in 1990 to \$21.8 billion in 2007 (Ravishankar et al. 2009).

The concomitant influx of actors into the health sector has been equally dramatic. After a first wave of institutional creation in the late nineteenth century, the field of international health organizations exploded after World War II (Inoue and Drori 2006: 205–207). Thus since its creation in 1946, WHO has been joined by a plethora of IGOs such as the World Bank and UNAIDS, and NGOs such as Doctors without Borders and Save the Children. In addition, around the year 2000 myriad public–private partnerships for health have been established, for example the GAVI Alliance (for Vaccines and Immunization, launched in 2000) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (created in 2001), mobilizing enormous resources and attention for global health challenges (Bull and McNeill 2007: 65–68). Many of these new actors are potential intermediaries with important complementary capacities, for example, grassroots NGOs bringing in local expertise and credibility. Other actors such as the World Bank, however, have themselves become viable health orchestrators, and thereby undermined WHO's historical focality.

Hence, to grasp how shifts in intermediary availability and focality have interplayed with WHO's organizational predisposition to orchestrate, the following analysis will contrast a domain of eroding WHO focality, health aid, with one of sustained WHO focality, disease surveillance and response. Both are core areas of WHO activity. Health aid designates technical assistance to developing countries in improving their health conditions through material services and advice. Epidemiological surveillance and response refers to the containment of disease outbreaks through epidemiological intelligence, timely information and advice and emergency measures.⁹ Only in this second area is WHO still the focal agency.

A comparison of WHO's orchestration attempts in both domains will reveal that differences in focality not only impact on the success of its orchestration initiatives, but also affect its very organizational prerequisites for undertaking such initiatives. I will first analyze WHO's changing role in health aid and then turn to the domain of epidemiological surveillance.

⁹ In the words of Zacher and Keefe (2008), these areas of international health work can be described as “disease control” and “disease containment” respectively. Note that these domains of activity are interrelated. Emergency interventions often imply material assistance, and so does the build-up of national surveillance capabilities in countries with underdeveloped health systems.

Health aid: growing un-orchestrated

It is in particular WHO's leadership in technical assistance that has been undermined by the expansion of international health. This is mainly due to the ever-stronger linkage between the issue areas of health and development, a nexus that began to be established in the 1960s. The inter-linking of those two issue-areas has created institutional overlaps that blurred the competencies of issue-specific lead agencies. In this section, I will first lay out how WHO's initial focality in health aid allowed it to engage in limited orchestration of the available intermediaries, then retrace how this focality was increasingly undermined by rival orchestrators, and finally analyze the dual negative impact that this loss of focality had on WHO's ability to orchestrate, as well as on its autonomy from state oversight.

Early orchestration of international health assistance

Technical assistance has always been a central part of WHO's work. From the beginning, WHO acted as the guiding expert agency in health assistance, being mainly concerned with the control and eradication of epidemic diseases in the 1950s and 1960s (Black 1996: 8). Yet given that WHO cannot operate large-scale field activities or resource transfers on its own, its activities were mainly of an advisory nature. For policy implementation, it depended on the operational support of other agencies. Such support was provided, for example, by the UNDP that acted as a founder of WHO field activities (WHO 2008a: 11–17). Most importantly though, WHO was supported by UNICEF, an agency that had been founded as an emergency organization for children and early on focused on improving child and maternal health. In contrast to WHO, whose work was mostly based in its global and regional offices, the main part of UNICEF's work was located in its country offices (Black 1996: 9). UNICEF disposed of the financial means and operational capacities – “vehicles, vaccines, injectors” (Black 1996: 9) – that WHO lacked, and the two organizations indeed became close collaborators, with WHO acting as the lead agency.

The collaboration between these organizations was put on a formal basis with the establishment of the Joint WHO/UNICEF Committee on Health Policy in 1948, where the respective roles of the two organizations were specified: UNICEF was to act as the supply agency for programs that WHO prepared and approved. Such joint projects made up the main part of UNICEF's field activities by the 1960s, absorbing about two-thirds of its operational budget (WHO 2008a: 33; WHO 1958: 353–354).

That UNICEF accepted this division of labor may be due to the fact that in its first years it was preoccupied with lobbying for its organizational survival. Before 1953, it only had a temporary mandate to engage in postwar relief operations, and was keen to demonstrate its comparative advantage as a hands-on agency (Black 1996: 8). WHO, by contrast, could draw on its recognized sector-wide authority and provided technical guidance for vaccination campaigns, health trainings, or training stipends that were operated by UNICEF (Lee et al. 1996: 303; Lee 2009: 19). This division of labor would only be temporary, though.

The development turn: mainstreaming health, dethroning WHO

WHO's initial status as the lead agency in health assistance was closely tied to the disease-focus of health aid in the first decades of its existence. Indeed, WHO's flagship program of the 1950s and 1960s was the (unsuccessful) campaign to eradicate malaria; and the eradication of smallpox by the end of the 1970s is one of the organization's main success stories.¹⁰ However, the content and purpose of health aid was considerably redefined, beginning in the 1970s, when "development" became the primary concern of multilateral cooperation. This developmental turn reoriented health work away from the preoccupation with infectious disease toward the broader socio-economic conditions of health and well-being, thus challenging WHO's sectoral focality.

Notably, WHO was itself spearheading this redefinition through its campaign for a turn to "Primary Health Care" (PHC). The PHC movement originated in the 1970s, in conjunction with calls for a "New International and Economic Order." PHC should prioritize prevention over treatment by empowering local communities and reducing their dependence on Western aid and high-tech medicine. This conceptual shift was endorsed by more than 130 states at the 1978 PHC conference in Alma Ata, Kazakhstan, which WHO convened in cooperation with UNICEF (Cueto 2004; Magnussen et al. 2004). The PHC approach, with its emphasis on social justice and bottom-up development, made health an integral part of the international developmental agenda, resonating well with the "basic needs" approach that had gained ground in the 1970s (Hanrieder forthcoming: Chapter 4).

The development turn not only transformed the understanding of health assistance, but also widened the issue area towards other IGOs'

¹⁰ On the history and eventual failure of WHO's malaria-eradication program see Siddiqi 1995: 123-182. On the smallpox-eradication program see Henderson 2009.

sphere of authority, in that it justified a greater involvement by development agencies such as the UNDP or the UN Population Fund (Lee et al. 1996: 303–304). Most importantly, the World Bank received the PHC agenda as legitimating its entrance into the health field, and at the end of the 1970s began to fund health-specific projects (WHO 2011a: 7–8; Ruger 2005: 64–65). It became the largest international health donor by the 1990s and claimed intellectual leadership with its 1993 World Development Report entitled “Investing in Health.” Through its propagation of neoliberal privatization strategies, the report posed a significant challenge to WHO and its PHC approach (Lee et al. 1996: 303–304; Lee 2009: 111–112). But also UNICEF began to challenge WHO’s leadership and started to hire its own health professionals in the 1970s. By formulating its own concept of “‘Selective’ Primary Health Care” – an approach that favors targeted interventions, such as vaccination and oral rehydration, over broader efforts to strengthen health systems – right after the Alma Ata conference, UNICEF also parted ways with WHO in policy terms (Cueto 2004; Lee 2009: 66–68).

This loss of focality was cemented, finally, with the multilateral response to HIV/AIDS that moved from a health-sectoral approach in the 1980s to an interagency response in the 1990s. At first, when the virus emerged and became an international concern in the 1980s, it was addressed as a health emergency requiring a rapid and chiefly medical response. In the midst of the uncertainty, politicization and stigmatization surrounding early AIDS research, states turned to WHO as an impartial “clearing house” that should guarantee an evidence-based approach to HIV (Garrett 1995: 359; Soni 1998: 25–26). WHO reacted by installing a “special” program on AIDS in 1987 that was renamed Global Program on AIDS (GPA) in 1988. GPA became the central coordinator of the multilateral response to AIDS, through which half of all aid flows were channeled by the end of the 1980s (Jönsson 1996: 65). Its coordinating and directing role in the multilateral response to AIDS was acknowledged by the UN General Assembly in 1987 (Soni 1998: 29). It assumed this orchestrator role by coordinating AIDS research, convening consultations among UN agencies (Jönsson 1996: 66), and by providing material and administrative support to the myriad local NGOs working against HIV/AIDS.¹¹ The program also channeled technical

¹¹ According to one estimate, the number of AIDS-related NGOs amounted to 60,000 by 2006. See Garrett 2007. In terms of NGO orchestration, GPA provided grants to local NGOs, facilitated networking among them and supported the formation of, for example, the International Council of AIDS Service Organizations (ICASO) and the Global Network of People Living with HIV (GNP+). See Soni 1998: 35.

assistance to more than a hundred national AIDS programs with the help of UNDP, which acted as GPA's main IGO intermediary (Soni 1998: 35).

The program could not maintain this position into the 1990s, however, as the virus continued to spread and internal fights led to a significant contraction of GPA and thus a loss of its initial competitive advantage (Hanrieder 2014). The mobilization of development agencies around the topic of HIV therefore increasingly marginalized WHO. Many UN agencies including UNICEF, UNDP, UNFPA, the World Bank and UNESCO developed their own AIDS-related programs. Their activities often duplicated the work of GPA, and they increasingly resisted WHO orchestration. This led to intricate interagency struggles in the early 1990s, the outcome of which was a new UN-wide orchestrator: from 1996 onward, the Joint United Nations Program on HIV/AIDS (UNAIDS) became the official umbrella organization for all UN agencies working against AIDS. Within UNAIDS, WHO was one among (initially) six co-sponsoring agencies, but was denied a leading position.¹²

The creation of UNAIDS cemented the transition from a period of initial WHO focality in health assistance toward its degradation into one among several orchestrators, if not an orchestratee (Lee 2009: 62). This loss of focality resulted from a historical linkage between health and development, which enabled myriad organizations to challenge WHO's position. The linkage was presumably facilitated by the functional properties of health aid. This domain of activity is based on long-term projects and allows for variable approaches, the direct effects of which are not swiftly visible. This loose coupling between activities and outputs also lowers the barriers to entry for new actors who can enter health aid stepwise and capitalize on their diverse resources. For WHO, however, the loss of focality would not only impair its ability to orchestrate, but also allow for greater state oversight over its work in health aid.

After focality: less orchestration, less autonomy

Health aid has continued to grow since the 1990s, not least thanks to the agenda set by the three health-related Millennium Development Goals (see above). It is now, according to the World Bank, the sector of

¹² Its founding co-sponsoring agencies were WHO, UNICEF, the World Bank, UNDP, UNFPA and UNESCO, cf. Knight 2008; Soni 1998. WHO initially hosted UNAIDS and served as its administering agency, yet eventually UNAIDS became administratively independent. See Lee 2009: 62.

international aid where the proliferation of actors is starkest (IDA 2007: 19). It comprises bilateral agencies, IGOs, NGOs, business actors and also resourceful philanthropists such as the Rockefeller foundation and the Bill and Melinda Gates Foundation, which was established in 2000 and is now one of the main donors in international health.

These actors do not work in isolation but collaborate in myriad ways, mostly through the close to a hundred global health partnerships that exist today.¹³ These partnerships bring together public (state and IGO) and private (NGO, business and philanthropy) actors in multi-stakeholder governance schemes to attain specific goals, for example mass vaccinations, drug donations or the training of health-care workers in developing countries. Orchestration plays a critical part in the emergence and operation of health partnerships. Their creation requires one or more initiators that convene the actors to be included, set the agenda for the partnership's program and provide administrative and/or financial assistance for institution-building. Once a partnership is established, it is often materially assisted by a host agency. Such modes of orchestration can critically shape the composition and program of global health partnerships.

In this context, however, WHO is only one among many, and certainly not the dominant orchestrator. WHO has initiated and hosts important partnerships, such as the Stop TB partnership that brings together around seven hundred partners in an effort to eliminate tuberculosis as a public health problem (People's Health Movement et al. 2008: 216). WHO also acted as secretariat for the International Medical Products Anti-Counterfeiting Taskforce (IMPACT) for several years after launching that initiative in 2006, and provided critical administrative support to the Interim Secretariat of the Global Fund to Fight AIDS, Tuberculosis and Malaria during its creation in 2002 (WHO 2002). Still, intermediaries can more easily shop around for orchestrators, or demand more influence if they are to participate in a partnership.¹⁴ Indeed, in most partnerships that exist today, WHO is only one among many partners, without formal representation at the governing board. A much more influential orchestrator is the Gates foundation that often serves as the main funder, if not informal principal, of health partnerships (for example, it jump-started the GAVI Alliance with an initial grant of

¹³ According to the Initiative for Public-Private Partnerships for health, ninety-two partnerships existed in 2004. See Bull and McNeill 2007: 65. More restrictive counts come up with the number of seventy partnerships for 2007. See Lorenz 2007: 567.

¹⁴ For example, it is argued that many partners withdrew from the WHO-hosted Roll Back Malaria partnership, resenting WHO's lack of inclusiveness and responsiveness vis-à-vis external participants. See Schäferhoff 2009.

US\$ 750 million) and is on the board of all major health partnerships (People's Health Movement et al. 2008: 219–220).

From WHO's perspective, the proliferation of health aid initiatives not only means a significant marginalization. In addition, the coexistence of myriad "vertical," i.e. disease- or campaign-specific, health projects is widely criticized for jeopardizing efforts at strengthening national health systems. Global health programs often lack "horizontal" integration with national health priorities, are volatile in their commitment and poorly coordinated amongst each other and therefore often fail to produce a sustainable impact on the health conditions in developing countries (IDA 2007: 19–23; Lorenz 2007). In reaction to such dysfunctions, WHO has positioned itself as an advocate of the strengthening of health systems and the integration of global health efforts – thereby responding to demands that WHO reinstall itself as the global platform for coordinating health aid (Kickbusch et al. 2010). However, WHO has proven unable to assume this coordinating role at a global level. Most recently, an attempt by the WHO Secretariat to initiate a "World Health Forum," a platform for all major stakeholders in international health to be hosted by WHO, has found little resonance and was given up (WHO 2011c, 2011e: 18).

Similarly, at the national level WHO seeks to coordinate health projects through its consulting position with national ministries of health. WHO advises health ministries on how to apply for assistance, for example from the Global Fund, and how to integrate these projects with national health policies (WHO 2010b). However, given that many health projects are not even channeled through ministries of health, such attempts can hardly achieve sector-wide coordination.¹⁵ Thus, both WHO's ability to orchestrate other actors in health aid, and its ability to directly influence health-aid policies via its governmental ties are rather limited in the context of institutional fragmentation and competition.

Finally and in addition to WHO's declining authority with regard to potential intermediaries, its loss of focality has also negatively affected its organizational autonomy. For as Walter Mattli and Jack Seddon argue in their contribution to this volume, low IGO focality also translates into a weak position vis-à-vis states, offering them the opportunity to forum-shop (Mattli and Seddon, in this volume). Due to the growing inter-organizational competition in health aid, states and other donors now

¹⁵ For example, the World Bank reported in 2007 that in Rwanda, only 14 percent of total donor support for health was channeled through the national ministry of health, and another 12 percent through local governmental districts. See IDA 2007: 20.

have a wider variety of options when looking for agents or programs they are willing to support. As a result, WHO is faced with a growing tendency among donors to make their contributions short-term and conditional. This is made possible by the fact that WHO today heavily relies on voluntary contributions to its budget (Lee 2009: 39): Compared to about 25 percent in 1971 (Walt 1993: 128), in 2010 extrabudgetary funds made up 80 percent of WHO's budget (WHO 2010c: 2). The huge majority of these voluntary contributions – about 90 percent – are “ear-marked” for usages specified by donors (WHO 2009: 14). As most donors prefer to fund tangible outputs “on the ground” over paying for administrative “overhead,” the Secretariat's hands are increasingly tied by this funding practice, which makes organizational planning and the pursuance of corporate priorities quasi impossible (Lee 2009: 106).

This loss of organizational autonomy thus points to a second, more indirect, hurdle to orchestration resulting from the erosion of IGO focality. Inter-orchestrator competition here undermines an organizational property that according to the introductory chapter allows IGOs to undertake orchestration initiatives, namely their relative freedom from state oversight (see Abbott et al., in this volume). Thus, in addition to a declining capacity to absorb potential intermediaries, a decline in focality makes an IGO more vulnerable to state oversight when attempting to ally with intermediaries, which can further undermine its orchestrator role. Nevertheless, the following section will demonstrate that an opposite, virtuous feedback loop is also possible. An IGO that is focal can use the emergence of potential intermediaries to escape state oversight via orchestration. This has been the case in a sub-domain where WHO continues to be the focal agency – that of global disease surveillance and response.

The combating of infectious disease: closing the surveillance gap with new intermediaries

The developmental agenda outlined above has broadened the outlook of health work far beyond the focus on disease control. Yet at the same time, acute outbreaks of contagious diseases have always remained a core problem of international health, and of WHO's work. In fact, the developments of the twentieth century have made clear that advances in the medical sciences did not mean that contagious disease would sooner or later become obsolescent. Quite the contrary: the emergence of new and highly lethal diseases like Ebola (discovered in 1976) and the re-emergence of seemingly obsolescent diseases – most importantly tuberculosis, which re-emerged in new, multi-drug-resistant variants in

the 1990s – made contagious outbreaks a major concern of the post-Cold War health agenda.¹⁶ Moreover, contagious outbreaks are not only a threat in regions with underdeveloped health systems and poor health conditions. The growing worldwide interconnectedness through increased travel and trade allows diseases to spread around the globe at high speed. In addition, bioterrorist attacks such as the Aum Shinrikyo cult's assault on the Tokyo subway in 1995 can occur anywhere. For these reasons, "health security" now occupies a prominent place on the international agenda.¹⁷

Unlike the boom in health aid however, which has eroded WHO's focality through the linkage between health and development, WHO's focal role in the containment of infectious disease has not been contested. In this biomedical domain, WHO's professional authority is unrivalled by other IGOs. This is also due to the – compared to health aid – higher barriers to entry into a domain of activity where speedy decision-making is asked for and the consequences of measures are immediately felt. During outbreaks authoritative information and technical advice are eagerly sought, and WHO usually serves as the main point of call in emergency situations (Zacher and Keefe 2008). Still, as I will discuss in this section, WHO's focal position had for a long time been countervailed by a restrictive mandate that made disease surveillance and response entirely dependent on state consent. This only changed with the emergence of new non-state informants in the 1990s who enabled WHO to become a rather autonomous orchestrator of global containment efforts.

Focality in the shadow of the sovereign veto

WHO has always been active in disease surveillance and response. In cases of acute outbreaks, WHO traditionally acts as the central "facilitator and coordinator" of response measures in which local and regional WHO staff provide technical advice, other IGOs such as UNICEF and NGOs such as Doctors Without Borders provide material assistance, and WHO Collaborating Centers contribute information about an outbreak,

¹⁶ See Zacher and Keefe 2008: 43–44; Garrett 1995. Other prominent examples of re-emerging diseases in the 1990s were new cases of cholera in Latin America, ten years after it appeared to be eradicated, and a severe outbreak of plague in India in 1994, cf. Kamradt-Scott 2010: 77.

¹⁷ Health began to be addressed as an international security issue in 2000, when the UN Security Council declared HIV/AIDS to be a threat to international security. On the health security paradigm see for example Elbe 2009; Kelle 2007; McInnes and Rushton 2011. On the global governance of infectious disease see Zacher and Keefe 2008.

its causative agent, and effective counter-measures (Zacher and Keefe 2008: 51–54). Research collaboration is most developed in the domain of pandemic influenza preparedness, where the WHO-led Global Influenza Surveillance Network (since 2011 the Global Influenza Surveillance and Response System) has been active since 1952.¹⁸ The network comprises more than a hundred national influenza centers and six WHO Collaborating Centers specializing in influenza. Its monitoring of circulating influenza strains serves as the basis for WHO recommendations on the composition of seasonal vaccines, and its system for sharing virus samples facilitates vaccine development and production (WHO 2011d: 3; Zacher and Keefe 2008: 47–48).

The influenza network demonstrates how WHO can use orchestration in disease surveillance and response. WHO coordination not only brings together the complementary resources of research institutions, but also grants legitimacy to the institutes through which governments share virus samples for research purposes, and whose interventions are tolerated much more easily when *endorsed* by WHO (Zacher and Keefe 2008: 52). Beyond influenza surveillance, however, WHO's orchestration activities have long been tightly circumscribed by the requirement of member-state consent. Not only do WHO's emergency interventions require the invitation of the affected state(s), but state oversight has also constrained WHO's informational activities.

Until the 1990s WHO's outbreak alerts were entirely dependent on state reporting or verification – not only because WHO lacked the material capacities to engage in monitoring on the ground, but also because states were able to censor information about suspected outbreaks. State reporting was mandatory only for a limited number of “quarantinable” diseases that were included in the International Health Regulations (IHR), namely plague, cholera and yellow fever.¹⁹ Yet even regarding these few diseases, routine violations of states' reporting duties made the IHR a rather ineffective vehicle of disease surveillance (Fidler 2005: 335–336). This notorious noncompliance was the result of an underlying conflict between affected states and the Secretariat. States that suffer from outbreaks often prefer to conceal them, even at the risk of allowing further contagion, because they fear embargoes and losses in trade and tourism. The WHO Secretariat, by contrast, is above all interested in containing outbreaks, and therefore in making them public (Cortell and Peterson 2006: 267–270).

¹⁸ See www.who.int/influenza/gisrs_laboratory/en/ accessed August 29, 2012.

¹⁹ Temporarily, the list also included typhus, relapsing fever and smallpox, cf. WHO 2008b: 1–2.

That these conflicting goals regarding the implementation of the IHR did not stir WHO orchestration initiatives – as the goal divergence hypothesis would have us expect – can be explained with reference to the state oversight hypothesis: states effectively held a sovereign veto over WHO's surveillance activities (see also Elsig, in this volume). This constellation was stirred up, though, with the emergence of new intermediaries in the 1990s, a development that would allow WHO to play out its focality and renegotiate state oversight.

A “post-Westphalian” health monitor

The 1990s brought major changes to the actor constellation shaping global disease surveillance. As Mark Zacher and Tanja Keefe have outlined in their study of the global health governance system, these changes were mainly due to the advances made in communication technologies and the spread of email and the Internet.²⁰ The information revolution made it quasi impossible to contain outbreak news, confirmed or not, within national boundaries. The Internet also allowed non-state informants to organize themselves in Internet-based surveillance networks. The first such group was the Program for Monitoring Emerging Diseases (ProMED), a network of health professionals created in 1993 that collects outbreak news and disseminates it to electronic subscribers. A similar network was created by the Canadian government in 1997: the Global Public Health Intelligence Network (GPHIN) – notably with WHO assistance, an indication of the interest that WHO had in the emergence of these new informants who could easily bypass the sovereign veto (WHO 2000: 5).

For the WHO Secretariat, these new sources of information were a welcome opportunity to enhance its authority. It thus began to actively gather the epidemiological intelligence available through Internet-based networks and electronic media. The organization claimed to be in a “unique position to coordinate infectious disease surveillance and response,” thanks to its quasi-universal membership and broad professional network (WHO 2000: 21). Drawing on its expert authority, WHO positioned itself as a clearing-house for outbreak rumors, which it verified with the help of WHO staff and NGOs on the ground before disseminating the information electronically, through the WHO Outbreak Verification List and the Disease Outbreak News (Grein et al. 2000: 99; WHO 2000: 6).

²⁰ For more details on new surveillance technologies and networks cf. Zacher and Keefe 2008: 46, 48–50.

Furthermore, WHO not only processed the newly available information, but also began to orchestrate new informants by assuming a coordinating role with the establishment of the telecommunications-based Global Outbreak Alert and Response Network (GOARN). GOARN interconnects more than a hundred existing institutions and networks to engage in timely information-sharing and coordinate response measures. Though it became operational as early as 1997, the network was only formalized in 2000 and its work officially acknowledged in a 2001 resolution by the World Health Assembly (WHA) in 2001 (Fidler 2005: 347). Nevertheless, GOARN operated even without a formal legal basis, in that it was applied to a wide range of diseases beyond those specified in the IHR and also covered threats resulting from intentionally caused outbreaks (Fidler 2005: 348). GOARN investigated outbreaks of various diseases including meningitis, haemorrhagic fevers, or anthrax (Fidler 2005: 348), and it coordinated the response to acute outbreaks – most importantly to the 2003 Severe Acute Respiratory Syndrome (SARS) crisis.

Between 2002 and 2003, the previously unknown SARS spread from China to thirty other countries, infecting altogether 8,000 people (of whom approximately 700 died). Its rapid spread and the huge losses in trade and income caused by it made SARS a highly publicized international health event through which WHO's alert and response system gained much visibility and prestige. During the crisis, GOARN coordinated the investigations of thirteen laboratories on whose output WHO could base its technical recommendations and guidelines. GOARN also facilitated the sharing of virus samples for research purposes, and coordinated measures to contain the further transmission of the virus. The rapid identification and containment of SARS has come to be considered a major success in the combat of emerging diseases in times of globalization (Zacher and Keefe 2008: 60–62).

In addition, the SARS intervention was not only an example of successful WHO orchestration in disease surveillance and response. It also constituted the most marked departure from the established sovereign veto in this domain. In the SARS case, WHO alerts not only exceeded formal state reports, but were even published in opposition to member states' official statements. This was famously the case for WHO's public criticism of "inadequate reporting" on the part of the Chinese government, and for the travel advisories that WHO issued against Canada, in spite of the protest by the Canadian governments (Zacher and Keefe 2008: 61–63). It thereby overtly transgressed its formal competencies with the help of new intermediaries.

Still, in the aftermath of the SARS crisis, WHO member states did not strive to reclaim their sovereign veto. Quite the contrary: through a major

revision of the IHR by 2005, they provided the legal basis for autonomous WHO orchestration in disease surveillance and response. Under the new IHR, the WHO Secretariat is authorized to draw on non-state informants in monitoring all potentially threatening contagious diseases (and all other events that may constitute an international health emergency). In addition, not only the dissemination of epidemiological information, but also the decision of whether a threat constitutes a “public health emergency of international concern” is now upon the WHO DG, and not subject to sovereign veto.²¹ The new IHR thus constitute a major and unprecedented empowerment of the WHO Secretariat (Fidler 2005). The extent of these new authorities was felt for the first time during the H1N1 (“swine influenza”) outbreak of 2009, where WHO invoked a health emergency and issued highly consequential recommendations regarding vaccination and treatment provisions.²² Although such recommendations are not formally binding, the uncertainty and public pressure surrounding health crises endow them with considerable compliance pull (Deshman 2011: 1095–1096). WHO’s authority has thus been greatly enhanced with the removal of the sovereign veto from the IHR.

WHO’s empowerment in the domain of disease surveillance and response yields interesting insights for the orchestration model. It demonstrates how the influx of intermediaries can boost the authority of a focal IGO at two levels. First, the direct effect of new intermediaries is that they allow focal IGOs to expand their orchestration activities. Over the 1990s and 2000s, WHO became a powerful orchestrator of disease surveillance and response. Moreover, successes such as the rapid identification and containment of SARS made WHO orchestration a welcomed pillar of international health security. For David P. Fidler, this orchestrated response marked the shift to a “post-Westphalian” mode of health governance, i.e. an order where the sovereign veto of national states is no longer in force (Fidler 2007b).

Second, intermediary proliferation can reinforce a focal IGO’s positional advantage vis-à-vis states, even where the IGO does not directly ally with the new actors but only draws on their outputs. This has been evident with WHO’s positioning as an authoritative clearing house for outbreak news in the IT era. The rise of non-state informants in the 1990s had caused concerns among states that they would be unable to contain outbreak alerts, even where alerts would later be proven to be

²¹ The Director General is merely obliged to consult with affected member states, cf. WHO 2008b.

²² For a critical assessment of how WHO used its new authorities in the swine flu case, see for example Cohen and Carter 2010.

Table 8.1 *Interaction of focality and intermediary availability in WHO orchestration*

	Intermediary availability high	Intermediary availability low
Focality high	Contemporary disease surveillance/ response → dynamic orchestration	WHO in early decades → little orchestration
Focality low	Contemporary health aid → little orchestration	Radionuclear safety, e.g. ²³ → no orchestration

wrong or exaggerated. Fearing the spread of economically disruptive rumors, states preferred strengthening the focal IGO over tolerating a further diffusion of authority in global disease surveillance. Not only its orchestration successes, but also its accountability to member states through institutionalized consultations made WHO a preferable orchestrator of epidemiological intelligence in the age of the Internet. States thus relaxed their oversight over WHO with the revised IHR, which have installed the organization as the global authority in international disease surveillance and response (Fidler 2005: 354; Kamradt-Scott 2010: 81).

In sum, WHO's enhanced autonomy under the new IHR stands in stark contrast to its eroding authority in technical assistance. While WHO's health-aid work is constrained by the priorities defined in conditional budgetary grants, the application of the new IHR does not follow budgetary cycles. Decisions are taken within days and hours, in consultation with an emergency committee and the affected state, but ultimately at the discretion of the DG. Likewise, while WHO's focality in disease surveillance enabled the organization to orchestrate incoming intermediaries, its loss of focality in health aid coincided with a role transformation in many contexts – from orchestrator to orchestratee.

These findings support the supposition of the introductory chapter that intermediary availability and focality enhance IGO orchestration, also by showing that their combined effect is greater than the effect of one factor in isolation. This combination of both factors in the WHO case is summarized in Table 8.1.²⁴

²³ Although nuclear safety and radiation control are evidently health topics, since a 1959 interagency agreement, WHO's authority in this domain is subordinate to the IAEA, which is widely seen to hold a veto over WHO's informational and research activities. See Tickell 2009. Moreover, in this secretive “high politics” domain, there are few intermediaries to draw upon, making orchestration an unlikely governance technique (see also Dai, in this volume).

²⁴ I owe the idea for this table to the editors of this volume.

In addition to lending support to the framework hypotheses, the WHO case demonstrates the decisive role that focality plays not only for orchestration, but also for its organizational prerequisite: an IGO's relative autonomy from state oversight. A growing organizational field can induce principals to strengthen the focal IGO in order to avoid diffused authorities. As the surveillance case has demonstrated, such a move not only helps to check intermediaries, but also enhances the IGO's authority vis-à-vis states. By contrast, where focality is low, rival orchestrators can detract intermediaries, and also weaken an IGO vis-à-vis its principals. Focality thus appears to be a critical variable in the two-level game of IGO orchestration and a decisive determinant of IGO authority. It may not guarantee that IGOs can orchestrate, just as a lack in focality need not prevent orchestration (Baccaro, in this volume; van der Lugt and Dingwerth, in this volume). Still, by shaping an IGO's standing in the principal-agent and inter-organizational constellations, focality conditions the chances of an IGO to govern through intermediaries.

Conclusion and implications for future research

This chapter has investigated how changes in its organizational field affect an IGO's ability to engage in orchestration. By comparing orchestration attempts by the WHO in different inter-organizational settings, the chapter has particularly highlighted the difference that focality makes. Focality is a positional advantage at both levels of an IGO's relationships. It helps the IGO exert influence on intermediary organizations, and empowers it vis-à-vis its principals. We have observed these advantages in disease surveillance and response, where WHO, with the help of new intermediaries, considerably gained in organizational autonomy and authority. By contrast, WHO's eroding focality in health aid not only undermined its orchestration attempts vis-à-vis potential intermediaries, but also made it more dependent on states and the conditions attached to their institutional choice.

Beyond identifying such effects of IGO focality, the analysis of the WHO case has yielded insights into contextual conditions of IGO focality. For one, an IGO's focal position hinges on the resources and behaviors of its organizational peers. Thus, other organizations can become more assertive and challenge an IGO's focal status. This was the case, for example, when UNICEF began in the 1970s to challenge WHO's leadership and promote different health policies. Alternatively, the emergence of the Gates Foundation in 2000 is an example of a rival orchestrator being created in the first place. These behaviors were facilitated by the nature of health aid, too, given that this domain of activity allows for

longer time frames and varied approaches than disease surveillance and response. In addition, however, focality also has a discursive component, in that it depends on how issue areas are defined and redefined. In the domain of health aid, the emerging health-development nexus has redefined international public health and thereby raised the status of developmental IGOs and NGOs (see also Inoue and Drori 2006). This example demonstrates how issue-linkages can blur the boundaries between organizational fields, thus creating competency overlaps and diffusing previous focal points.²⁵ In the context of an increasingly dense international polity, the renegotiation of focality – also, but not only with recourse to orchestration – will most likely be a constant feature of inter-organizational politics.

The observations made in this chapter also emphasize that there is no linear historical trend toward more orchestration. First, the WHO case puts into question the assumption that orchestration is indeed a new mode of governance in international organizations. While the introductory chapter treats orchestration as a recently discovered mode of governance that demands innovation and risk-taking from IGOs (Abbott et al., in this volume), for WHO, working through intermediaries is an established organizational practice (see also Baccaro, in this volume). Second and more importantly, the historical expansion of the international health field has boosted as well as undermined WHO orchestration. This observation points to the ambiguous impact that growing organizational density beyond the state has on IGO orchestration. Orchestration can be a critical strategy to manage organizational density where a focal IGO is faced with cooperative intermediaries. To the extent, however, that other organizations prefer to act as orchestrators, the overall effect may be less, rather than more, orchestration within an organizational field. In the health-aid field, at least, this diffusion of focality is often criticized for undermining sector-wide coordination and policy coherence.

Finally, the ambiguous role that organizational density plays for orchestration also points to the analytical limitations that come with this volume's focus on individual IGOs as orchestrators. An IGO focus is fruitful for studying organizational governance strategies, but makes it difficult to assess to what extent orchestration shapes different policy fields in international politics. Hence, to grasp broader trends, the main unit of analysis would have to be organizational fields rather than individual IGOs. Although certainly not a trivial task, such a systemic

²⁵ See Betts 2009. On orchestration as a means to transcend issue boundaries, see van der Lugt and Dingwerth, in this volume.

perspective would be an important next step to put this chapter's insights on IGO focality into historical perspective and thereby also contextualize the role that orchestration can play in ever-denser organizational fields beyond the state.

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