Exploring the utility of institutional theory in analysing international health agency stasis and change

Eduardo J. Gómez*

Department of Public Policy & Administration, Rutgers University, Camden, NJ 08102, USA

*Corresponding author. Assistant Professor, Department of Public Policy & Administration, 401 Cooper Street, Camden, NJ 08102, USA. E-mail: edgomez@gmail.com

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Of recent interest is the capacity of international health agencies to adapt to changes in the global health environment and country needs. Yet, little is known about the potential benefits of using social science institutional theory, such as path dependency and institutional change theory, to explain why some international agencies, such as the WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria, fail to adapt, whereas others, such as the World Bank and UNAIDS, have. This article suggests that these institutional theories can help to better understand these differences in international agency adaptive capacity, while highlighting new areas of policy research and analysis.

Keywords Institutional theory, international health agencies, agency and health policy reform

KEY MESSAGES
- Health policy makers have overlooked the potential utility of path dependency and institutional change theory in explaining the transformative capacity of international health agencies and policy reform.
- Path dependency can help to explain why international health agencies, such as the World Health Organization and the Global Fund to Fight AIDS, Tuberculosis and Malaria, continue to experience difficulty in reforming their agencies and health policies for greater effectiveness.
- Path dependency provides a more robust causal explanation of international agency and policy reform as it provides a discussion of originating bureaucratic policy beliefs and decision making, over time.
- Institutional change theory helps to better explain the complex exogenous and endogenous sources of international health agency and policy reform.

Introduction

Understanding the ability of international health agencies to transform for greater efficiency has been of ongoing interest. Studies have emerged suggesting that agencies such as the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and UNAIDS have failed to achieve these objectives (Peabody 1995; Horton 2002; Nay 2012; Sridhar and Gostin 2011). Nevertheless, in striving to understand why this has occurred, researchers have not explored how institutional theory can be used to better understand and explain if, how, and to what extent these transformations can occur.

This article seeks to fill in this lacuna by applying two areas of institutional theory, path dependency and institutional change theory, to select case studies of international health agencies. This is done to examine if these theories can help to understand why the WHO and the Global Fund have...
consistently failed to reform their bureaucracy and policies in response to global health challenges and country needs, whereas others have been more successful in doing so, such as the World Bank and UNAIDS.

Findings suggest that several advantages emerge from the application of these institutional theories. In contrast to theories focusing on threats to individual career stability, financial resource constraints and agency leadership, path dependency focuses on the historical policy factors and experiences shaping individuals’ policy beliefs and interests and how this explains ongoing resistance to change. This approach seems to provide a more robust, long-term explanation than these three alternative approaches, which are often static in their explanation, i.e. failing to address historical decisions and their enduring consequences. Case studies of the WHO and the Global Fund are provided to illustrate the potential utility of path dependency.

Alternatively, institutional change theory encourages researchers to go beyond looking within international agencies for understanding the sources of reform. In contrast to those theories focusing on the endogenous capacity of agency adaption, institutional change theory suggests that it is a combination of exogenous and endogenous conditions that are necessary for transformations to occur. A study of the World Bank and UNAIDS is introduced to illustrate the potential effectiveness of this approach.

### Methodology

The methodological goal of this article is to apply path dependency and institutional change theory to case studies to illustrate their applicability and potential effectiveness. In line with an ‘analytical narratives’ methodological approach (Bates et al. 1998), instead of selecting cases to test a theory’s effectiveness, the goal is to select cases based on their known value on the dependent variable. This is done to illustrate the analytical sophistication and efficacy of a theory and its potential to explain complex causal processes (Bates et al. 1998).

Regarding data, this article relied on qualitative data in the form of journal articles, newspaper articles, policy reports and books. The author used theories obtained from this literature and applied them to select case studies. The cases of the WHO, the Global Fund, World Bank and UNAIDS were selected because of the author’s knowledge of their transformative capacity and policy outcomes. Similar to Collier and Mahoney (1996), this selection on the dependent variable was done to provide new questions and analyses through the application of institutional theory, as well as using theory to provide a more detailed discussion and knowledge of these cases. In addition, the goal was not to randomly select cases to test these theories but rather to carefully choose cases that would provide a good illustration of their potential utility.

### Re-assessing international agency stasis and change

Studies focusing on the ability of international health agencies to reform their bureaucracy and policies often examine why it is that agencies cannot achieve these objectives. One area of research examines how threats to individual career stability lead to fear and resistance to policies threatening their employment (Johnson 2011; Oomman 2011). As seen with the WHO during the 1990s, this approach predicts that innovations seeking to reform agencies for greater efficiency, such as staff downsizing and accountability, are resisted by those fearing the loss of employment (Yamey 2002; Johnson 2011; Oomman 2011; Global Health Watch 2012). Moreover, these fears instigate incessant debate between potentially affected staff and management, in turn obstructing policy implementation (Yamey 2002). Such fears also incentivize staff to leave for more secure positions elsewhere, thus reducing the agency’s pool of expertise (Oomman 2011).

Another area of research emphasizes how financial resource constraints limit an international health agency’s ability to implement policy. Here, several consequences emerge when agencies are incapable of garnering sufficient funding. First, agencies will not be able to adequately finance their existing policies and/or create new ones (Radelet 2004; Klarner et al. 2008). Second, agencies are often forced to adopt unpopular neo-liberal measures, such as reducing staff to balance budgets (Chorev 2012), while experiencing an exodus of staff due to financial uncertainties (Bloom 2011; Johnson 2011). Consequently, agencies may eventually lack the talent needed to devise policies and pursue their traditional line of work (Saenz 2011; Kamal-Yanni 2012).

Finally, others emphasize the importance of agency leadership. Effective leadership, such as through the WHO’s Director Generals (DG), has been viewed as vital for ensuring an agency’s ability to achieve its goals (Andresen 2002; Prah Ruger 2007). An aspect of agency leadership deemed as important is a leader’s ability to set the policy agenda, while working with others to implement it (Andresen 2002). Leaders must, therefore, work closely with staff to ensure that they are incorporated into decision-making processes, representing their interests and securing their support (Andresen 2002; Global Health Watch 2012).

While these approaches help to highlight the obstacles to reforming international health agencies, scholars have overlooked the potential benefits of applying institutional theories. For example, a path dependency perspective takes a historical approach to explain why decision makers within institutions fail to reform them (Rose 1990; Mahoney 2000; Pierson 2000a,b). This perspective claims that policy choices made at an earlier point in time establish institutions/policies that are incessantly reinforced through different types of processes, ranging from individuals’ cognitive beliefs and legitimacy, to the ongoing investment of resources and policy coalitions (Mahoney 2000; Pierson 2000a,b).

In contrast to the aforementioned literature, path dependency theorists believe that the cognitive beliefs of decision makers matter when explaining an agency’s inability to reform (Pierson 2000a,b). Beliefs are the primary variables leading to institution/policy choices; the inability to transform them is the product of individuals’ cognitive constraints, whereby beliefs in the legitimacy of an institution or policy, as well as the inheritance of knowledge and policy learning, create incentives to maintain inefficient institutions/policies (Rose 1990; Clemens and Cook 1999; Mahoney 2000).
But the sequencing of policy decisions also matters (Pierson 2000b; Thelen 2003). As Pierson (2000b) explains, institutions have advantages over others when they are the first to confront a crisis and to implement policies in response. Consequently, when other institutions confront similar situations, earlier responders have not only already established supportive policy coalitions, thus leaving few behind for their competitors, but they also possess more experience and expertise (Pierson 2000b). Moreover, for early arrivals, initial policy choices create self-reinforcing coalitions of support, thus helping solidify early policy choices (Pierson 2000b). Even when seemingly more effective policy alternatives emerge, these coalitional beneficiaries resist them in favour of earlier policies that continuously provide them with benefits (Pierson 2000b). Early policy decisions, therefore, ‘lock in’ a policy onto a particular path, as the benefits these policies provide for their supporters are too lucrative to forgo (Pierson 2000a,b).

A path dependency approach is therefore potentially more effective than the aforementioned literature for several reasons. First, path dependency explains the origins and evolution of individual policy beliefs and interests, shaped by historic policy experiences and knowledge. In contrast, the aforementioned approaches seem to assume that policy beliefs and strategies are shaped by crisis situations and future benefits, failing to account for the psychological impact of policy history and supportive coalitions. Second, path dependency provides a fuller explanation for the reasons why individuals continue to resist reform. The aforementioned perspectives only provide a static explanation of this issue, i.e. immediate policy decisions and their consequences. Third, path dependency requires that researchers consider the beliefs, interests and reactions of all individuals involved in the reform process. In contrast, the aforementioned perspectives focus mainly on the beliefs and interests of agency leaders, placing less emphasis on those staff responsible for policy implementation.

**Institutional change**

International health agencies eventually do pursue reforms. In this literature, the focus is often on explaining the conditions most conducive for organizational change to introduce health policies. Some emphasize the importance of managerial leaders incessantly preparing workers for reform (Chorev 2012) and managers’ handling of the ‘social dynamics’ associated with policy change (Yeats 2002). Alternatively, others argue that a leader’s vision and managerial commitment to change is necessary (Garside 1998).

Nevertheless, scholars have not considered how the literature discussing institutional change processes may help to better understand these reforms. As the cases of the World Bank and UNAIDS will illustrate, several analytical and empirical advantages emerge through the application of institutional change theory.

First, and as I explain shortly, an application of institutional change theory reveals that bureaucratic and policy change is not an entirely endogenous process. Instead, exogenous conditions and interests are as important for endogenous change to occur, and that this process often unfolds through an international health agency’s interaction with other international actors. Second, an application of institutional change theory underscores the specific actors involved in the change process and how they interact with shifting international conditions and interests.

But this is not to say that other scholars have not addressed these issues. Work by Burci (2005) highlights the importance of international pressures and how increased demands for WHO services and leadership motivated the Secretariat to pursue reforms without having to formally change the WHO’s constitution. This included hosting public–private partnerships for the provision of vaccines and policies for disease surveillance (Burci 2005). Chorev (2012) also explains how the World Bank applied pressure on the WHO to introduce neo-liberal proscriptions increasing organizational efficiency, and how DG Gro Brundtland attempted to incorporate some of these measures.

However, these studies do not explain how individuals within agencies use external pressures to aid them in their cause. Furthermore, this literature does not examine all the actors involved in institutional change processes, such as lower-level staff, who are often the main proponents for reform (Mahoney and Thelen 2010).

Yet, one may gain insight by using institutional change theory to analyse and explain these processes. For example, as the theories of institutional ‘conversion’ and ‘displacement’ emphasize (explained shortly), individuals within agencies, such as mid-level staff and directors, gradually cultivate their own coalition outside of the agency, in turn bolstering their legitimacy and influence when seeking reform (Mahoney and Thelen 2010). This may especially be the case at the international level, where the sudden rise, pressures and influence of state and non-state actors provides a network of international and domestic actors involved in health policy reform (Füller 2005). In this context, agency reformers may have an array of individuals and agencies that they can use to increase their influence.

**Path dependency in international health agencies**

Several path dependent concepts are used to explain why institutions and policies fail to adapt for greater efficiency. They range from individual cognitive constraints, such as ‘legitimacy’ and ‘learning’ to resource constraints, such as ‘increasing returns’, ‘power’ and ‘co-ordination’.

**Legitimacy and learning**

Cognitive constraints deal with an individual’s beliefs and interests in a particular institution/policy design. These constraints often deal with issues of ‘legitimacy’ and ‘learning’. ‘Legitimacy’ takes the form of individuals favouring the inheritance of prior approaches to policy implementation because they are perceived as the most legitimate (Clemens and Cook 1999; Mahoney 2000). Over time individuals resist alternative institutional/policy designs and pursue the same ones because they believe they are still popular, notwithstanding their inefficiencies.

Alternatively, ‘learning’ occurs when individuals invest a lot of time in applying and understanding a particular approach to bureaucratic procedure and policy making; this is emblematic of ‘social learning’, where individuals accumulate experience and knowledge about a particular approach (Rose 1990). Individuals expect to inherit and bequeath this knowledge
(Rose 1990). Subsequent efforts to introduce new policies are avoided as it costs too much to retrain individuals, while some resist policies based on their belief that what they know is the most effective approach. Inefficient institutions/policies persist because individuals are unwilling to learn new ones (Pierson 2000a).

An assessment of the WHO provides a good example of how ‘legitimacy’ and ‘learning’ hampers reforms. In his study of the WHO, Peabody (1995) claims that its organizational structure and culture in a more technical approach to epidemiological analyses and intervention, such as YAWS, present since the 1970s, ultimately hampered the WHO’s ability to effectively respond to AIDS (p. 736). Responding to AIDS required technical rigour as well as social and political analyses for prevention policy (Peabody 1995). Despite DG Hiroshi Nakajima’s insistence in 1991 that a new policy strategy be adopted, Peabody (1995) maintains that the organizational culture and beliefs in the legitimacy of YAWS precluded policy reforms (p. 736).

Peabody’s (1995) analysis suggests that there was individual ‘learning’ going on, where WHO leaders and staff were trained in a YAWS approach to policy analysis and response to disease. Over time, these officials learned and passed on this approach to others, making it subsequently difficult to reform their policy approach (Peabody 1995, p. 736).

Notwithstanding a change in WHO leadership in the late-1990s, policy ‘legitimacy’ and ‘learning’ appears to have continued to hamper the WHO’s ability to reform policy. Some claim that 1998 marked a turning point in the WHO’s strategies with the arrival of DG Gro Harlem Brundtland (Horton 2002; McCarthy 2002). Brundtland was focused on creating a more efficient WHO, while strengthening its partnership with the private sector and WHO country office capacity (Horton 2002). Horton (2002) and McCarthy (2002) nevertheless claim that WHO staff resisted her reforms, that they viewed their own approach as the most legitimate.

Similarly, the next DG, Lee Jong-Wook, assembled a change team to implement his policies, such as job rotation, transparency and the decentralization of resources to WHO country offices. This was done for greater organizational efficiency and responsiveness to country needs. However, Klarner et al. (2008) found that ultimately the WHO did not have the organizational commitment needed to adopt these policies: mid- and lower-level staff were ensconced in their own legitimate policy legacies, comfortable, unwilling to support Dr Lee’s reforms (Klarner et al. 2008, p. 65).

Perhaps an alternative approach to institutional ‘legitimacy’ and ‘learning’ would emphasize threats to individual career stability that new policies instigate? Findings suggest that this may have been the case. Lerner and Matzopoulos (2001) found that Brundtland’s efforts to increase organizational efficiency through staff downsizing, transparency and accountability confronted staunch resistance from staff because of their fear that they would lose their jobs (Oomman 2011; WHO 2012b). This led them to incessantly question and debate her efforts (Global Health Watch 2012).

While threats to individual career stability may help to explain resistance to policy implementation, this approach provides a static analytical approach because of its failure to explain the ‘ongoing’ incentives and beliefs that individuals have to resist policy reform. While this approach explains staff resistance, this resistance may decrease once individuals remain employed. Indeed while many staff members survived Brundtland’s downsizing, they continue to resist policy change and behave inefficiently when tasked to regulate policy under DG Margaret Chan (WHO 2011), thus requiring additional reforms, such as staff evaluation and increased accountability.

Alternatively, one could argue that financial resource constraints were an issue and that the WHO did not have the money needed to implement policies. Findings suggest that this may have been the case. Since the 1990s, the WHO has been in a financial crisis, where revenues through member state contributions have decreased (Bloom 2011; Global Health Watch 2012). This has led to a lack of sufficient funding for staffing and research (Bollyky 2012). And because human resources cost ~50% of the WHO’s budget (WHO 2011), to help defray expenses DGs since Brundtland have imposed mandatory redundancies and replaced long-term with short-term staff appointments (Johnson 2011; Kamal-Yanni 2012).

In response, there has been an exodus of WHO staff seeking secure, lucrative positions (Bloom 2011; Kamal-Yanni 2012). This has reduced the number of individuals available to conduct research, devise policies and provide technical assistance (Andresen 2002; Kamal-Yanni 2012), while complicating recruitment (WHO 2012a,b). Moreover, the WHO has recently lacked the funding needed to engage in its traditional line of work, such as research and evaluation (Global Health Watch 2012; Kamal-Yanni 2012).

But there are limitations to this approach. First, it is static in its explanatory power, such that it concerns itself with an agency’s immediate financial problems, policy decisions and consequences. It does not consider the enduring beliefs and motivation of staff continuously making decisions in reaction to policies. Second, this approach’s unit of analysis restricts itself to the decisions made by DGs, not staff. Yet, it is staff that is responsible for implementing policy.

But what about theories emphasizing the importance of agency leadership? Evidence seems to support this approach as well. While DGs Brundtland, Lee, Nordström and Chan were effective in setting their policy agenda (Lerer and Matzopoulos 2001; Saez 2011), they have consistently failed to work with staff to implement it (Global Health Watch 2012; WHO 2012b). DG decision making is still ‘top down’, hierarchical, not taking the staff’s views seriously (Global Health Watch 2012; WHO 2012b). DGs since Brundtland have not been committed to addressing this issue (Yamey 2002; Global Health Watch 2012). Staff consequently continue to lack trust and support for many of the DG’s policies (Global Health Watch 2012). Thus, while agenda setting has been achieved, effective leadership in policy ‘implementation’ has not (Global Health Watch 2012). Some believe that until DG Chan addresses this problem, she will not be able to achieve her policy objectives (Bollyky 2012; Global Health Watch 2012).

However, while an agency leadership approach informs us of the reasons why leaders may not be able to garner the support needed for reform, it ignores a focus on those individuals considered to be more important in implementing policy: agency
Increasing returns

Alternatively, resource-based constraints are different from cognitive constraints. This is because resource-based constraints often involve physical and material resources, such as funding and infrastructure. ‘Increasing returns’ represents a concept that is emblematic of this process. This approach claims that actors remain committed to inefficient institutional/policy designs because of the high amount of initial investments they put into it, essentially ‘locking in’ institutional paths (David 1985; Pierson 2000a,b). Individuals consequently have invested too much into an institution/policy and find it either financially or politically too costly to change it (David 1985; Pierson 2000a,b).

‘Increasing returns’ may help to explain why the Global Fund has not been able to fully adopt a diagonal approach to health financing, which combines funding for horizontal health systems strengthening (HSS) with a vertical approach to disease funding. Since its inception in 2001, the Global Fund has been committed to providing a vertical-based approach to funding AIDS, Tuberculosis and Malaria programmes (Ooms et al. 2008; Marchal et al. 2009). Initially, all expenses and staff training were invested in providing this kind of support (Marchal et al. 2009; Steinlage 2010; McCoy et al. 2012). While interest in funding health systems began during Round 4 (2004), and while the governing board agreed to accept proposals for health systems in Round 7 (2007) (Sherry et al. 2009; Steinlage 2010), by this point no formal shift to a diagonal approach had occurred (Ooms et al. 2008). Indeed by Round 6 (2006) HSS as a separate fundable category was no longer pursued.

Because of the Global Fund’s high initial investment in a vertical approach, the board and staff were ‘divided’ over whether or not to pursue a diagonal approach (Marchal et al. 2009, p. 2; Steinlage 2010; Hill et al. 2011). An early consensus emerged that investing in health systems should instead be pursued by the Global Fund’s partners, such as the WHO and UNAIDS (Steinlage 2010). Others explain that a diagonal approach was possible ‘but only if donors [i.e. the Global Fund] and recipient governments are willing to abandon the conventional approach to sustainability [i.e. vertical approach]. . . .’ (Ooms et al. 2008, p. 5). Moreover, within the board there was ‘a struggle to accommodate health systems strengthening with the objectives of the Global Fund and its administrative guidelines. The change made in Round 6 guidelines to abandon the possibility for separate health systems proposals can be interpreted as a consequence of this dilemma’ (Drager et al. 2006, p. 11).

Nevertheless, the Global Fund eventually did pursue a diagonal approach (WHO 2007; McCoy et al. 2012). For Round 8 (2008), the board allowed for HSS activities; however, this was to be built into disease-specific proposals or as a ‘discrete’ HSS section within a disease application (McCoy et al. 2012). For Round 9 (2009), the board approved a funding initiative called National Strategy Applications (NSAs), designed to align the Fund’s grants with national country strategies in HSS (McCoy et al. 2012). In total, 17 of the 34 proposals for HSS were also approved (McCoy et al. 2012). And for Round 10 (2010), 8 of 11 proposals were approved for cross-cutting HSS activities, while the board announced that Round 11 (2011) would consider applications for stand-alone HSS activities (McCoy et al. 2012).

Furthermore, in 2009 the Global Fund joined the GAVI Alliance, WHO and the World Bank in creating a new ‘Health Systems Funding Platform’ (Global Fund 2012). Through this ‘Platform’, these donors provide harmonized, direct streamlined funding to support HSS in a long-term, predictable, results-focused manner while involving multiple stakeholders (Global Fund 2012). The ‘Platform’ is country-focused, such that through jointly assessed national plans, it is tailored to meet the needs of governments (Global Fund 2012).

While these endeavours revealed the board’s increased commitment to diagonal funding, analysts found problems. First, Round 9’s NSAs- were too disease-specific, focusing on limited HSS aspects supporting particular diseases (McCoy et al. 2012). Second, researchers still found governing board ambivalence over the need to further increase commitments to a diagonal approach (McCoy et al. 2012). This has led others to conclude that the board’s actions still do not demonstrate a ‘consistent’ commitment to it, that it is not a priority (Hill et al. 2011; McCoy et al. 2012).

Corroborating ‘increasing returns’ theory, some believe that the Global Fund’s lack of commitment is the result of heavily investing in a vertical approach since the beginning, leading to a sudden, recent ‘bolt on’ of HSS activities (McCoy et al. 2012). This seems to imply that the Global Fund was not originally designed to pursue a diagonal approach, and that this is why there is ongoing division within the board.

Finally, with regard to the ‘Platform’, several problems have emerged questioning the Global Fund’s commitment. First, the board was not able to secure HSS funding for Round 11 (Glassman and Savedoff 2011), which was supposed to be used for HSS ‘Platform’ requests. Second, the ‘Platform’s provision of joint funding between GAVI and the Global Fund will make this option difficult unless the Global Fund can switch to a rolling request evaluation process, like GAVI’s, rather than one-time yearly Round evaluations. But because the board is still disputing the significance of HSS, this will be ‘unlikely’ (Schäferhoff et al. 2012, p. 4). These disputes highlight the ongoing problem of conflicting policy interests over a diagonal approach, which has weakened the board’s ‘Platform’ commitment (Hill et al. 2011, p. 7).

Thus, while there is evidence of increased Global Fund commitment to a diagonal approach, there is little evidence of a ‘complete’ commitment to it. In fact, recent budgetary estimates reveal that while the board considers diagonal funding a priority ‘only a meager sum of $86 million (0.006% of all funding) was spent in that area over nine years, and in only eight countries’ (Center for Global Development 2012, p. 17).
commitment could be that Global Fund staff feared that transitioning to a diagonal approach would threaten their career prospects given their extensive training in vertical programmes. This could have been the case when staff also considered the high degree of board contestation over this issue. Evidence seems to point in this direction. There has been ~600 staff working under the Secretariat (Global Fund 2011). Nearly, 50% of these employees are on fixed short-term contracts (Ryan et al. 2007). Short-term staff must, therefore, compete with each other to obtain a long-term position (Ryan et al. 2007). This has contributed to a sense of fear and low morale (Ryan et al. 2007, p. 56; Global Fund 2011). Through annual surveys conducted by the Secretariat’s office, fear of job insecurity has negatively affected the staff’s motivation and job performance, while many have left the organization because of this (Ryan et al. 2007). In this context, it may be that staff were simply afraid to upset board and senior officials, especially those not fully committed to a diagonal approach, and that as a result, staff did not fully support this approach.

Alternatively, the Global Fund’s inability to completely shift to a diagonal approach could have been attributed to financial constraints, as the aforementioned literature predicts. Evidence seems to support this notion. Radelet (2004) claims that by 2003, yearly contributions received from member states and the private sector fell short of adequately funding projects. And while the board agreed to start supporting a diagonal approach in 2007, Steinlage (2010) finds that support for this approach decreased as the board’s budgetary revenue waned. Since 2009, the board has not had the money needed to adequately fund this approach (Center for Global Development 2012). And because of the worsening financial situation, staff have left in search of other positions (Global Fund 2011). This loss has not helped to retain and hire staff, while gradually depleting the pool of talented personnel (Global Fund 2011).

Finally, another approach explaining why international health agencies fail to reform emphasizes poor agency leadership. Does this explain why the Global Fund could not fully commit to a diagonal approach? Evidence seems to support this argument.

Indeed, while the board was able to set the agenda for diagonal funding, they have not displayed adequate leadership in working with staff to implement policy. Surveys conducted by the Secretariat’s office reveal that staff believe that they have been repeatedly ignored when it comes to making important policy decisions (Global Fund 2011). Furthermore, surveys reveal that the staff felt ‘undervalued’ and unappreciated (Ryan et al. 2007). Staff also believed that the Secretariat had become too hierarchical, imposing decisions without obtaining staff feedback (Global Fund 2011). This has created to a lack of trust within the Secretariat, which seems to have contributed to low staff morale and enthusiasm for implementing policy (Sherry et al. 2009; Global Fund 2011).

Yet several limitations emerge with these alternative theoretical approaches. Once again, both the individual career stability and financial resource constraints approach offer a static analytical perspective. Despite many short-term staff retaining their positions, they still exhibit an unwillingness to fully support a diagonal approach (McCoy et al. 2012; Schäferhoff et al. 2012). Thus, an individual career stability perspective seems to provide no insight into the staff’s ‘ongoing’ policy beliefs and reactions, and how prior policies continuously shape staff reluctance to embrace a diagonal approach. Similarly, a financial constraints perspective is too static in its analytical approach, failing to address ongoing staff resistance to change. While a financial resources approach does explain the board’s inability to pursue further reforms and its staffing consequences, it provides no insight into the ongoing perceptions and beliefs of the staff and their reluctance to implement policy.

Finally, while an agency leadership perspective does a good job of explaining the consequences of poor Global Fund leadership, there is no discussion of the perceptions and beliefs of staff responsible for implementing policy. Merely focusing on agency leadership is insufficient for explaining policy reform (Andresen 2002); a fuller explanation requires an analysis of agency staff, their beliefs and incentives to support reforms (Andresen 2002).

Change within international health agencies

Another theoretical approach providing insight into the reform capacity of international agencies is the literature on institutional change. The analytical concepts guiding this process have typically been the following: ‘conversion’, ‘placement’, ‘layering’ and ‘de-legitimization’. Because of space limitations, this section will only provide case study illustrations of institutional ‘conversion’ and ‘placement’. Briefly, a process of institutional ‘layering’ occurs when reformers confront resistance to institutional change and, realizing that they cannot reform institutions on their own, create similar, alternative institutions to achieve their objectives (Mahoney and Thelen 2010). ‘De-legitimization’ occurs when reformers highlight the ongoing inefficiencies associated with an institution/policy and strategically use these criticisms to de-legitimize them while proposing and implementing effective alternatives (Mahoney and Thelen 2010).

Institutional ‘conversion’ occurs when reformers seek to re-use existing bureaucratic rules for new policy ends. In response to exogenous pressures, previously marginalized individuals within institutions emerge to seek reforms in response to these pressures. This is done to discredit elites pursuing inefficient policies. But this also reflects reformers’ opposing views and strategy in waiting for the appropriate time to seek reform (Thelen 2003). In doing so, reformers work with supportive external actors to add legitimacy to their cause (Thelen 2003). The goal is to not only gain control over the institution, but also to use its bureaucratic procedures for new policy objectives (Thelen 2003).

An instance of institutional ‘conversion’ can emerge when international pressures or changes in the environment prompt officials within multilateral donors to re-evaluate their interests and policies for aid assistance. Gradual transformations within the World Bank provide a good example.

By the 1950s, a UN consensus emerged emphasizing the need to address increased poverty, welfare and inequality (Webb 1997). The WHO and UNESCO also pressured the Bank to respond to these problems (Webb 1997; Prah Ruger 2005).

Despite the Bank board’s resistance, arguing that funding welfare was not part of its original mandate (Webb 1997), there were others in the Bank that thought differently. Although
often ignored by the board, staff working within the International Development Association (IDA), a funding agency administered by the Bank to provide assistance to low-income countries (Mason and Asher 1973), viewed funding health and education as a means to eradicate poverty and foster development (Webb 1997).

Seeking to pressure the board into funding these initiatives, IDA staff knew that the time had come to seek allies and collaborate with the WHO and UNESCO (Webb 1997). By working with these agencies, it seems that IDA reformers used the WHO and UNESCO’s pressures to legitimize the IDA’s policy ideas and increase their influence (Mason and Asher 1973). Furthermore, by proposing policies that the UN viewed as critical, it seems that IDA staff sought to de-legitimize the Bank board’s historic focus on economic sectors, viewing them as unresponsive to the poor (Mason and Asher 1973). By the early 1960s, scholars note that the IDA succeeded in achieving its objectives, gradually transforming the Bank from an institution focused on economic reconstruction, to one that combined this with a commitment to poverty alleviation and social welfare (Mason and Asher 1973).

However, it is important to note that the Bank’s transformation occurred prior to the emergence of Bank Presidents harbouring the need to fund poverty and social welfare policies (Mason and Asher 1973; Webb 1997). Scholars, therefore, attribute the success of the Bank’s transformation to the IDA and its reform strategies (Mason and Asher 1973; Webb 1997). Alternatively, institutional ‘displacement’ seeks to supplant bureaucratic and policy procedures with new ones. Reformers seek to do this quickly, though settle for gradual approaches (Clemens and Cook 1999; Mahoney and Thelen 2010). New bureaucratic rules/policies reflect new policy visions (Clemens and Cook 1999; Mahoney and Thelen 2010). Typically this kind of process emerges when individuals seeking reform are emboldened both by changes in the political environment (e.g. government transitions) or when international and domestic groups have discredited existing institutions (Clemens and Cook 1999; Mahoney and Thelen 2010).

Nay’s (2012) discussion of the UNAIDS’ transformation since 2005 provides a good example of ‘displacement’ processes, where a change in the international environment gradually empowered UNAIDS officials to supplant bureaucratic procedures and policies with new ones. Nay (2012) claims that UNAIDS’ transformation was the product of shifts in the international environment, never the result of financial resources and leadership: ‘international institutions tend to be path dependent, and only external inducements may have encouraged them to opt for change’ (p. 30).

Since its creation in 1994, international donors, NGOs and governments highlighted the UNAIDS’ inability to respond to worsening AIDS conditions because of its lack of capacity to build sustainable inter-agency partnerships, low human resource capacity, discrepancies between priorities and objectives, mistrust between managerial teams, lack of funding and transparency (Nay 2012, p. 13). In response to international pressures, as well as UN Secretary General Kofi Anan’s mandate for administrative reform and international conferences advocating for increased harmonization and co-ordination between UN agencies, Nay (2012) maintains that the UNAIDS Secretariat was empowered by these conditions and took advantage of them to pursue reforms.

Since 2005 several new bureaucratic rules and policies were introduced, essentially transforming the entire way UNAIDS was governed. These reforms were focused on introducing performance-based managerial and financial instruments (Nay 2012, p. 19); increasing inter-agency co-ordination through the creation of new steering committees (p. 20); a clear division of labour and responsibilities for policy implementation (pp. 22–3); and new efforts to make funding and policy decisions transparent. While these changes helped increased UNAIDS efficiency, Nay (2012) cautions that inter-agency competition still existed and that the complete institutionalization of these new procedures would take time.

**Conclusion**

This article has provided case study illustrations of the potential efficacy of path dependency and institutional change theory in explaining the capacity of international health agencies to adapt to health challenges and country needs. In contrast to other theoretical approaches emphasizing the importance of individual career stability, financial resource constraints and agency leadership, path dependency appears to be helpful in providing a more thorough explanation for the reasons why agencies do not pursue reforms.

While there was empirical evidence supporting these three alternative approaches, it was static in nature and limited in explanatory scope, highlighting immediate policy choices and their consequences, while failing to discuss the actions of all individuals involved. Moreover, none of the evidence revealed the historic policy origins of individual beliefs, policy preferences, and how this ‘continuously’ shaped resistance to reform; conversely, evidence supporting path dependency’s discussion of ‘increasing returns’ (e.g. Global Fund), ‘learning’ and ‘legitimacy’ (e.g. WHO) achieved this, in turn providing a more comprehensive, long-term analysis of why leaders and staff members resisted change.

When seeking to explain why and how international health agencies transform for greater effectiveness, the cases of the World Bank and UNAIDS suggest that institutional change theory can help to underscore the exogenous and endogenous sources of reform. The aforementioned literature’s emphasis on technical capacity, resources and agency leadership may not be sufficient for explaining agency transformation. Instead, theories of institutional ‘conversion’ and ‘displacement’ suggest that successful strategies often rely on staff’s ability to find supportive international allies, e.g. the Bank’s IDA working with the WHO and UNESCO, while using these allies and international pressures to discredit and pressure agencies into using existing financial procedures for new policy ends, e.g. the Bank’s emphasis on social welfare, or to pursue entirely new bureaucratic and policy procedures, e.g. UNAIDS.

Nevertheless, this article has not addressed how path dependency and institutional change theory can be ‘combined’ to explain institutional transformation. Just as cognitive mechanisms of ‘legitimacy’ hamper reforms, ‘de-legitimization’ may lead to institutional change (Mahoney and Thelen 2010). Scholars will need to examine the conditions under which
reformers within agencies use changes in the international environment to ‘de-legitimize’ inefficient agency policies and implement reforms. Similarly, other path dependency theories, such as ‘power’ (Mahoney 2004), where individuals with excessive resources, provided by institutions, historically defending inefficient policies suddenly decide to redirect their ‘power’ and pursue reforms for greater efficiency. Future research will need to examine which international agencies exhibit this type of ‘power’ and the conditions motivating leaders to suddenly pursue reforms.

Exploring the utility of institutional theories to explain the behaviour of international health agencies is an uncharted area of research. As these agencies confront ongoing global recession, organizational challenges and heightened demands for assistance in combating disease, the time has come for political scientists to work with the health policy community in exploring alternative ways of analysing, comparing and proposing solutions to strengthening these agencies. As this article has shown, there is certainly plenty of opportunity and need for this marriage of the minds to occur.

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Endnotes
1 These concepts represent a small sample of concepts introduced by political scientists.
2 The term ‘YAWS’ comes from a disease of the 1960s. Peabody (1995) claims that the WHO’s response led to practices that the WHO adopted for other diseases, i.e. (1) holding international symposia; (2) offering fellowships to staff; and (3) prescribing penicillin, and more recently, technical meetings, consultative visits and the provision of supplies (Peabody 1995).

References