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LOOKING FOR ALTERNATIVES IN GLOBAL GOVERNANCE:

WHY MULTI-LEVEL HEALTH GOVERNANCE IS NOT THE ANSWER FOR POVERTY REDUCTION

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Introduction

Concern about reaching the targets set by the UN Millennium Development Goals (MDGs) has galvanised questions surrounding the need for alternative models of global governance that respond more effectively to the challenge of poverty reduction. One response to such questions has been the suggestion of more inclusive, multi-level governance. Multi-level governance refers to a disaggregation of power at the global, national, and community level, that involves new structures of co-ordination and planning drawn up between the private and public sector. Its emphasis is on inclusion of multiple actors and ideas that provide the space for 'innovative' solutions to the complex issue of poverty reduction. This paper explores the limitations of multi-level governance as a mechanism of governing poverty reduction. It does so by considering the experiences and lessons from global health governance and what multi-level governance is in practice. The paper argues that despite presenting the opportunity for more inclusive, innovative and participatory forms of governance, multi-level governance embeds wider problems of governing poverty. As global health interventions show, multi-level health governance is highly centralised and organised around a distorted separation of power that reduces the conceptual and practical space for different actors to operate. In this sense, it presents a form of bad governance that rests on confusion and hidden decision-making.

The paper develops this argument in the following way. First it outlines the problem of governing poverty reduction and why multi-level governance presents a possible solution. Second, the paper outlines what multi-level governance is and how it is understood in the context of the European Union (EU) and debates on deliberative democracy. Third, the paper traces the emergence of multi-level governance within global health strategies. Fourth, the practical ramifications of multi-level governance are explored to suggest that in practice, this form of governance does not offer a change towards inclusive models of poverty reduction. The paper then considers the implications of multi-level governance for sustained poverty reduction, before offering several conclusions as to the nature and role of multi-level governance in providing an alternative to current understandings and practice of global governance.

Crisis, poverty reduction and the need for governance 'innovation'

The governance of poverty reduction has consistently received criticism for the practices, structures and presence of particular actors committed to alleviating extreme poverty, particularly in sub-Saharan Africa. This criticism usually falls into one of the following categories: i) a general critique of foreign aid, predominantly by ex-employees of the World Bank; ii) blame the state; iii) blame the institutions; and iv) the failings of the good governance agenda as the main mechanism in which to achieve sustained poverty reduction. The first criticism is less about governance, but the presence of foreign aid as a strategy for alleviating poverty. This critique suggests that foreign aid – either bilateral or multilateral assistance to a country – does more harm that good, creating a dependency culture and less incentive for developing countries to engage in reforms.[1] A modification of this argument, is that there is too much aid, or that aid needs to be more selective and contribute to initiatives that are sustainable.[2] This line of argument suggests a need for less 'charitable' giving and more infrastructure-based and long-term credit initiatives for 'the poor' to work themselves out of poverty.[3] Thus the problem with poverty governance is that it relies heavily on foreign aid, most of which is mis-spent and lacks clear objectives or goals. Much of this critique has now been adopted by international aid agencies; whilst aid has not been suspended, the last twenty years have seen a shift towards more infrastructure and long-term seed investment strategies.

The second critique refers to the familiar problem of the state and how to construct political will to make the necessary changes to allow growth to flourish and create the space for poverty strategies to work. This approach rests on the notion that it is not the strategies that are the problem, but the states that implement them. States some how ignore, subvert, bureaucratise, embezzle money or engage in corrupt practice so that aid does not get to those that it was intended for.[4] States lack the capacity to manage the demands and interests placed upon them and foreign aid creates rent-seeking behaviour. This leads to

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[1] D. Moyo, *Dead aid: why aid is not working and how there is another way for Africa* (London: Penguin, 2009)

[2] J. Sachs, *The end of poverty: how we can make it happen in our lifetime* (London: Penguin, 2005); S.C. Smith, *Ending global poverty: a guide to what works* (Basingstoke: Palgrave, 2005)

[3] W. Easterly, *The White Man's Burden: why the West's efforts to aid the rest have done so much ill and so little good* (London: Penguin, 2006)

[4] P.T. Bauer, *Dissent on Development (Revised edition)* (London: Harvard University Press, 1976); R. Klitgaard, *Controlling corruption* (London: University of California Press, 1991); R. Klitgaard, 'International co-operation against corruption' *Finance and Development* March 1998; J. Svensson, 'When is foreign aid policy credible? Aid dependence and conditionality' *Journal of International Development* 61, 2000: 61-84

questions as to the credibility of aid[5] as the primary tool of governance initiatives in combating poverty, and its relationship to economic growth. The problem with poverty governance here is that it relies too much on state support and funding streams that operate in partnership with national governments, which at worse engage in large-scale corruption and human rights abuses, and at best have complex bureaucracies or their own poverty strategies that restrict the effectiveness of external support. This critique has led to a widespread blame-the-state mentality that foreign aid agencies and institutions use as justification for conditional-based lending, without considering the mechanisms, policies and culture of their own institutions in failing to deliver successful outcomes for the world's poor.

This lack of recognition or gap in accountability is covered by the third critique of poverty governance, that of international institutions, predominantly the international financial institutions (IFIs). From criticism over the long-term negative impact of structural adjustment and conditional-based lending,[6] to the Comprehensive Development Framework and Poverty Reduction Strategy Papers,[7] the World Bank has received the majority of criticism aimed at the financial institutions when it comes to governing poverty. This is in part the Bank's fault, for positioning itself as the largest multilateral lender to development projects and country assistance to developing countries, and declaring its dream to be a 'world free from poverty.' On the other hand, the Bank has suffered from failing projects; poor management and overly bureaucratic procedure; bad advice; a narrow policy paradigm that relies too heavily on growth and the primacy of the market and the private sector; lack of proper engagement with the governments it seeks to partner; and criticism from ex staff members.[8] Criticisms of the

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[5] Svensson, 2000

[6] R. Hopkins, A. Powell, A. Roy, and C. Gilbert, C. 'The World Bank and Conditionality' *Journal of International Development* 9(4), 1997: 507-516; P. Mosley, J. Harrigan, and J. Toye *Aid and power: the World Bank and policy-based lending (2nd edition)* (London: Routledge, 1991)

[7] P. Cammack, 'The mother of all governments: the World Bank's matrix for global governance,' in R. Wilkinson and S. Hughes (eds) *Global Governance: Critical Perspectives* (London: Routledge, 2002) 36-53; P. Cammack, 'What the World Bank means by poverty reduction and why it matters,' *New Political Economy* 9(2), 2004: 189-211; M. Goldman, *Imperial Nature: the World Bank and struggles for social justice in the age of globalizaton* (London: Yale University Press, 2005); G. Harrison, 'HIPC and the Architecture of Governance' *Review of African Political Economy* 31(99), 2004:125-164; G. Standing,'Brave new words? A critique of Stiglitz's World Bank rethink,' *Development and Change* 31, 2000: 737-763; C. Weaver, and R.J. Leiteritz, 'Our poverty is a world full of dreams:' reforming the World Bank' *Global Governance* 11, 2005: 369 – 388

[8] R. Wade, 'Showdown at the World Bank,' *New Left Review* 15(2), 2001: 124-137; J. Stiglitz, 'The World Bank at the millennium' *The Economic Journal* 109(459), 1999: 577-597; J. Stiglitz, 'Democratizing the IMF and the World Bank: Governance and Accountability,' *Governance* 16(1), 2003: 111-139

International Monetary Fund (IMF) tend to focus on poor advice of the 1980s and 1990s,[9] but have failed to be as sustained and complex as they are towards the Bank. The World Trade Organisation (WTO) and the free trade policies it promotes receive similar criticism for the structural limitations and bias against developing countries. UN agencies such as UNDP receive less of a critique, but mainly because they are seen as being somewhat secondary in terms of decision-making to the IFIs. What this critique suggests about the governance of poverty is that it is highly centralised, and the global area of governance refers to predominantly IFIs, and the pursuit of co-operation or dominance by key states through these institutions.

It is this highly centralised nature and bias towards key member states that suggests a lack of good governance on the part of these institutions, and the need for more inclusive, participatory forms of governance that involve developing countries and 'the poor.' The 'new' era of engagement with states, civil society and the private sector through initiatives such as the poverty reduction strategy papers have failed to deliver, hence the need for more innovative approaches to successfully reach the MDGs. This new era of engagement relates to a common theme shared between these three critiques of poverty governance: good governance, or moreover a lack of it within the state and international aid agencies and institutions. Despite efforts and claims to the contrary, good governance based on accountability, representation, transparency, and clearer monitoring and evaluation systems is lacking in every arena of poverty governance, especially within the IFIs such as the World Bank,[10] and the IMF.[11] It is this gap in good governance that multi-level governance seeks to fulfil.

The critiques of poverty governance suggest that it is somehow in crisis. The MDG deadline of 2015 is fast approaching at a time when funding to international aid and development assistance is threatened to be squeezed on account of the subprime crisis. Mechanisms to address poverty alleviation have become stagnant, with little time or space to re-evaluate the path governance has gone down.

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[9] M. Fratianni, M, 'The IMF and its critics' in M. Ratianni and P.Savona (eds) *Sustaining growth and development: G7 and IMF Governance* (Aldershot: Ashgate, 2003); M. Hodd, 'Africa, the IMF and the World Bank' *African Affairs* 86(344), 1987: 331-342; R. Peet, *Unholy Trinity: The IMF, World Bank and WTO* (London: Zed Books, 2003)

[10] N. Woods, 'The challenge of Good Governance for the IMF and the World Bank themselves,' *World Development* 28(5), 1999: 823-841; N. Woods, 'Making the IMF and World Bank more accountable' *International Affairs* 77(1), 2001: 83-100; N. Woods, *The Globalizers: The IMF, the World Bank and their borrowers* (New York: Cornell University Press, 2006)

[11] S. Soederberg, 'Grafting stability onto globalization? Deconstructing the IMF's recent bid for transparency' *Third World Quarterly* 22(5), 2001

Critiques of existing interventions and the need for a new approach lead to widespread calls for 'innovation' in terms of technology, service delivery, and ideas as to how best address the problem of global poverty. In theory, multi-level governance provides the space for such innovations to occur. The purpose of multi-level governance is to allow for inclusionary forms of decision-making in such a way that it overcomes problems of state hijacking or co-operation, and dominance of highly centralised global institutions, as well as promoting decentralisation of decision-making and the responsiveness of global governance to new and emerging problems associated with global poverty alleviation. Moreover, it allows for the private sector to flourish, channel funds to encourage civil society inclusion and thus disperse decision-making away from state-centred forms of global governance and look for funding streams that do not directly draw from the public purse. To measure the success and ability of multi-level governance to overcome shortcomings in poverty alleviation strategies it is important to consider different interpretations of the concept.

What is multi-level governance?

The term multi-level governance has principally been applied to the EU and models of integration. Multi-level governance in this regard refers to the sharing of authority and policy-making across subnational, national and supranation levels of government,[12] as well as the public, private and voluntary sector.[13] The state is still of paramount concern and multi-level governance has a statist core, but it does not have monopoly over decision-making and must share power:[14] subnational decision-making exists beyond the scope or 'nest' of the state[15] and shared sovereignty exists in that external actors have influence over domestic authority.[16] This form of governance relies less on an 'inside-outsider' power relationship within the EU and thus facilitates greater openness and access to decision-making for interest groups.

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[12] G. Marks, L. Hoooghe, K. Blank, 'European integration from the 1980s: state-centric vs. multi-level governance' *Journal of Common Market Studies* 34(3), 1996: 341 – 378

[13] I. Bache and R. Chapman, 'Democracy through multilevel governance? The implementation of the structural funds in South Yorkshire' *Governance* 21(3), 2008: 397 – 418

[14] R. Eising, 'Multilevel governance and business interests in the European Union' *Governance* 17(2), 2004: 211 – 245

[15] Marks et al 1996

[16] H.M Mamudu and D.T. Studler, D.T. 'Multilevel governance and shared sovereignty: EU, member states and the FCTC' *Governance* 22(1), 2009: 73 – 97

Multi-level governance has also been represented by the terms polycentric governance, fragmentation, rescaling, multi-tiered governance[17] and multi-sectoralism. According to Hooghe and Marks there are two forms of multi-level governance: i) that which resemble a federalist system; and ii) a more fluid, form that 'consists of innumerable jurisdictions' that overlap and is organised around specific policy sector and issues.[18] Both of these definitions are of interest to understanding global governance, the first appeals to those interested in global political systems and the formation of world government, whereas the second has become increasingly salient in understanding complex regimes and governance structures organised around issues such as the environment and climate change. The use of a multi-level analysis has allowed for a conceptualisation of global environmental governance that does not isolate or ignore the state in the same way regime-based or transnational understandings are said to do.[19] In this sense, it gives the 'conceptual space' to understand the complexity of such governance.

This conceptual space is part of what makes multi-level governance appear convincing and useful as a mode of analysis, especially when understood in conjunction with understandings of deliberation and deliberative democracy. Multi-level governance provides space for inclusion of civil society and global civil society both within and outside processes of global governance as an arena or 'a space for critical reflection and affective expression.'[20] Different forms of multi-level governance, such as multi-sectoral governance that points to the inclusion of all aspects of society in decision-making, shift the focus away from state-centred, institutional narrative of power and agenda-setting to allow for greater recognition of both deliberations within civil society and between civil society and international institutions. Multi-level governance in this respect confers a degree of 'communicative power' through the use of 'minipublics.'[21] Hence, in the long term multi-level governance presents the opportunity for democratising global governance. Processes of deliberation can be provided by institutional design[22]

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[17] A. Harmes, A. 'Neoliberalism and multilevel governance' *Review of International Political Economy* 13(5), 2006: 725 - 749

[18] Bache and Chapman 2008; L. Hooghe and G. Marks, *Multi-level governance and European Integration* (Oxford: Rowman and Littlefield, 2001)

[19] M.M Betsill and H. Bulkeley, 'Cities and the multilevel governance of global climate change' *Global Governance* 13, 2006: 141 – 159

[20] J. Brassett and W. Smith, 'Deliberation and global civil society: agency, arena, affect' *Review of International Studies* 36(2), 2010: 413 – 430

[21] J. Bohman, 'Democratising the global order: from communicative freedom to communicative power' *Review of International Studies* 36(2), 2010: 431 - 447

[22] Bohman 2010

that allows for 'a range of approaches' to 'globally just' decision-making.[23] It is this democratising function and potential that has facilitated development policy strategies in areas such as global health that seek to integrate forms of multi-level governance.

The potential of multi-level governance to overcome the shortcomings or democratic deficit of global governance must, however, be understood in the wider context of social and economic forces that condition and/or restrict global decision-making processes. Problems of accountability rise when 'many agents' and with 'many hands' have to agree to a decision that appeals to the 'many eyes' watching the system of governance.[24] Deliberation and inclusion through multi-level governance is in many ways tokenistic and occurs within a neoliberal paradigm for decision-making. According to Harmes, multi-level governance is part of an explicit normative project of neoliberalism that is consistently applied to federal, regional and global levels.[25] The 'underlying logic' of which is the separation of the economic and the political through legal mechanisms and governmental bargaining, or what Gill terms the discipline of 'new constitutionalism.'[26] Hence multi-level governance is not just about opening the space for greater inclusion of multiple actors and decisions, but this happens within a particular neoliberal space that uses inclusion and the rhetoric of sovereignty as a means of separating the political and economic. This can clearly be seen in the application of multi-level governance to global health and wider frameworks of poverty governance. As the following section will show, despite presenting the image of inclusive and 'apolitical' governance, on application multi-level governance exists within a wider paradigm of neoliberal separation of the economic, political *and* social that in effect provides limited deliberation and apolitical democratisation. On paper multi-level governance provides an effective solution to some of the reach, accountability and inclusion problems underpinning the governance of poverty, but in practice it embeds these problems further.

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[23] P. Newell, 'Democratising biotechnology? Deliberation, participation and social regulation in a neoliberal world' *Review of International Studies* 36(2), 2010: 471 – 491; G.W. Brown, 'Safeguarding deliberative global governance: the case of the Global Fund to Fight AIDS, Tuberculosis and Malaria' *Review of International Studies* 36(2), 2010: 511-530

[24] A. Benz, 'Accountable multilevel governance by the open method of co-ordination?' *European Law Journal* 13(4), 2007: 505-522; M. Bovens 'Analysing and assessing accountability: a conceptual framework' *European Law Journal* 13(4), 2007: 447 – 468

[25] Harmes 2006

[26] Harmes 2006; S. Gill, 'Globalisation, Market Civilisation, and Disciplinary Neoliberalism' *Millennium* 24(3), 1995; S. Gill, 'New Constitutionalism, Democratisation, and Global Political Economy', R Wilkinson (ed.), *The Global Governance Reader* (London: Routledge, 2005) 174 – 186

Multi-level governance and global health

Multi-level governance has been applied to global health through 'multi-sectoral' policy designs and initiatives. Multi-sectoralism has its roots in the World Health Organisation (WHO)'s 1978 Alma Ata Declaration that acknowledged health for all through an emphasis on primary healthcare. Primary healthcare would be achieved through a combination of international and state funds and local, direct responses.[27] This emphasis on inclusion of multiple actors and levels of service delivery has permeated through global health initiatives, particularly within the discourse of the new public health. The new public health has sought to prove the explicit linkages between poverty and development and poor health and the spread of disease. Much of this literature has focused on the relationship between globalisation and exacerbated health inequalities.[28] Globalisation has stimulated inequalities in global health through restriction of access to treatment through the distorting affects of trade policies and global financial markets,[29] cutting of public spending in healthcare and thus poorly staffed and resourced health centres in developing countries,[30] economic migration that has facilitated the spread of infectious disease, changing family relationships, and greater complexity to the causes and treatment of disease. On the other side of the argument, globalisation has allowed for the spread of financial investment in health interventions, the introduction of the private sector in developing countries to elicit greater value for money in health outcomes, and the movement of health workers and the sharing of health expertise and biomedical research. Globalisation has made health or international health a *global* issue that makes individuals and states interdependent in terms of health outcomes and the threat and spread of infectious disease. The

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[27] K. Lee and H. Goodman, H. 'Global policy networks: the propagation of health care financing reform since the 1980s' in K. Lee, K. Buse, and S. Fustukian (eds) *Health in a globalising world* (Cambridge: Cambridge University Press, 2002) 97-119

[28] M. Larkin, 'Globalisation and health' in J. Green and R. Labonte (eds) *Critical Perspectives in Public Health* (Abingdon: Routledge, 2008); K. Lee, S. Fustukian, and K. Buse, 'An introduction to global health policy' in K. Lee, S. Fustukian and K. Buse (eds) *Health Policy in a Globalising World* (Cambridge: Cambridge University Press, 2002)

[29] R. Labonte, C. Blouin, and L. Forman, 'Trade and health' in A. Kay and O.D. Williams (eds) *Global Health Governance: crisis, institutions and political economy* (Basingstoke: Palgrave, 2009); T. Schrecker, 'The power of money: global financial markets, national politics and social determinants of health' in A. Kay and O.D. Williams (eds) *Global Health Governance: crisis, institutions and political economy* (Basingstoke: Palgrave, 2009)

[30] R.P Buckley and J. Baker, 'IMF policies and health in sub-Saharan Africa' in A. Kay and O.D. Williams (eds) *Global Health Governance: crisis, institutions and political economy* (Basingstoke: Palgrave, 2009); R. Loewenson, 'Structural adjustment and health policy in Africa' *Radical Journal of Health* 1, 1995: 49 – 61

application of multi-level governance to global health has been both a part of globalisation and a response to the inequalities it creates.

Globalisation has led to a multiplicity of actors being involved in global health. Provision of health outcomes and the right to the highest attainable standard of health for individuals is no longer based on a loose social contract between the state and the individual. It now involves government agencies, non-governmental organisations, private providers, international donors and community groups. Moreover, recognition that infectious diseases such as HIV/AIDS are a global security threat by United Nations Security Council Resolutions and General Assembly Special Session recommendations[31] has led states to co-operate in addressing such epidemics through measures such as border control, aid and development, and co-ordination through intergovernmental organisations. At the local level, globalisation demands increased involvement of local community groups, as well as national and international non-governmental organisations to plug the gaps in public spending, and deliver cheap and affordable interventions. Beyond the increase in the number and scope of such actors, the inter-relationship between poverty and health makes addressing health less about sickness or treatment of the ill, but more encompassing of eradicating the structural socio-economic factors that drive illness, risk, and well-being. The result of such logic is the need to involve non-health specific actors and initiatives in combating health problems.

Applied to practice, the presence of multiple health actors and the need to stimulate wider involvement in health interventions requires a specific form of multi-level governance to co-ordinate and initiate various activities at the individual, community, state and global level. This specific form of multilevel governance has manifested itself through sector-wide approaches (SWAPs) to health or multi-sectoralism.[32] These approaches were first introduced to global health interventions in the late 1980s and early 1990s when structural adjustment programmes were having the effect of an overall reduction in health spending,[33]

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[31] UNGASS UN General Assembly, *UN General Assembly Special Session on HIV/AIDS (UNGASS): Declaration of Commitment on HIV/AIDS* (New York: UN, 2001); United Nations Security Council Resolution 1308 (SCRes 1308) (17 July 2000) *http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N00/536/02/PDF/N0053602.pdf?OpenElement* (accessed February 2010)

[32] S. Harman 'The World Bank and Health' in A. Kay and O.D. Williams *Global Health Governance: Crisis, Institutions and Political Economy* (Basingstoke: Palgrave, 2009a)

[33] K. Buse, 'Spotlight on international organisations: the World Bank' *Health Policy and Planning* 9(1), 1994: 95 – 99; S. A. Zaidi, 'Planning the health sector: for whom, by whom?' *Social Science and Medicine* 39(9), 1994: 1385 – 1393

and the need for community and private based initiatives to work with the state to facilitate outcomes in the areas of malaria, tuberculosis and neglected disease. During this time the WHO emphasised the need sector-wide or multi-sectoral approaches to circumvent cuts in public spending, to attract attention to health concerns, and to recognise the inter-relationship between poverty and ill-health. This emphasis led to the broadening of health policy and projects to include actors beyond the health sector. It was not, however, until the discovery of HIV/AIDS in the early 1980s and recognition of the impact it was having in developing countries, most notably sub-Saharan Africa, did the application of multi-sectoralism come into full effect.[34]

The exceptionalism of HIV/AIDS as both a driver and outcome of poverty and the stigma and denial surrounding the disease stimulated the need for non-health specific interventions. Interventions within the health sector alone did not and could not address the drivers of the epidemic alone. The result of which was the widespread application of multi-sectoralism through projects by the World Bank and the Multi-Country AIDS Program in the first instance, and then the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. The multi-sectoral approach in which every aspect of society is included in the fight against HIV/AIDS at every level of governance remains the dominant paradigm in which HIV/AIDS interventions are organised.[35] The relative success or presence of such multi-sectoral systems has seen cross-over not only into more mainstreamed multi-sectoral interventions into tuberculosis and malaria, but towards maternal health programmes and neglected diseases. One of the key drivers of putting multisectoral governance into practice has been the World Bank. Multi-sectoralism is the embodiment of World Bank practice and the anti-poverty paradigm established by the good governance, Comprehensive Development Framework (CDF) approach of the late 1990s.[36]

In practice, multisectoral or sector-wide approaches to health governance take the following form. The first component is the identification and removal of the health concern out of the Ministry of Health within the government and into a specialised agency in the cabinet office, the Office of the President or Prime

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[34] S. Harman, 'The Causes, Contours and Consequences of Multi-Sectoralism within the HIV/AIDS response' in S. Harman and F. Lisk (eds) *Governance of HIV/AIDS Responses: Making Participation and Accountability Count* (Abingdon: Routledge, 2009b)

[35] S. Harman, The World Bank and HIV/AIDS: Setting a Global Agenda (Abingdon: Routledge, 2010)

[36] Harman 2010; S. Harman, 'The World Bank: Failing the Multi-Country AIDS Program (MAP): Failing HIV/AIDS' *Global Governance* 13(4), 2007: 485-492

Minister. This is to signify the importance of the issue, and to recognise that the health concern is of relevance to poverty and development, and thus requires interventions that go beyond health. The funding of such an agency is done by the government and an international donor, for example the World Bank or the Global Fund. This agency is the primary site of co-ordination and management of multi-level governance at the state level. It is not to replace the Ministry of Health, but to work alongside it. The agency in central government is to be complemented by regional and district partners through a decentralised structure of authority and decision-making, with clear structures that feedback local concern to the state. The second component is the inclusion of civil society organisations within this agency, or the need to generate civil society participation at the national, district and community levels of interaction. The most straightforward way of doing so is the provision of financial incentive. The third element is the need for individuals within a local community to take 'ownership' of the problem, which means providing care, treatment and support services on a voluntary basis. They are then to be linked-in to the wider structures of this form of health governance through the local decentralised equivalent of the health agency and community groups or non-governmental organisation. Where necessary these individuals or groups must participate in government feedback processes and consultation. The fourth factor is the need for one co-ordinating agency among international aid donors that works with the government lead agency to effectively interact and deliver between multiple actors and directives. This is to promote donor harmony and to avoid any overlaps or 'double-dipping' of aid. Fifth, the private sector, and public-private partnerships must be established through funding and financial incentive to provide 'innovative' solutions to health concerns and break with the stringent and bureaucratic nature of state-based directives. The sixth tool of co-ordination is the presence of one strategic plan or over-arching strategy that all actors must adhere to. The multi-sectoral approach is at the heart of such plans. The final constituent part of this form of multi-level governance is the need for high-level declarations within international institutions that bind member states to financial and political commitments surrounding specific health issues. The purpose of which is to secure sustained support and global recognition of health interventions as problems of global poverty and development. In some instances the application of multi-sectoralism requires regional co-ordination, but this is less the case in health interventions that operate along the axis of global-state-community-individual.

Regional actors have little involvement in these areas, although, in the case of actors such as the African Union this is part of their remit and likely to grow in the future.

The model of multi-level governance through multi-sectoral health interventions provides some solutions to the problems of governing poverty. It decentralises decision-making by putting the state at the centre of co-ordination practices and agenda-setting and introducing more decentralised systems of governance towards local government and civil society. This should have the net effect of making governance structures more responsive to the needs of local 'on the ground' issues. The presence of multiple actors increase accountability and transparency mechanisms as they in theory represent a clear separation of power and would thus act as a check on each other. Developing countries appear very much in the driving seat of development through these government agencies and large-scale civil society presence, with the international community co-ordinated to provide technical financial assistance. At the very least, these factors open up wider space for deliberation and participation within global governance. However, as the next section will show, in practice the application of multi-level governance to health as a poverty concern has several limitations.

Multi-level governance in practice: the problems of apolitical development

The application of multi-sectoralism in global health interventions provides a clear example of multi-level governance in practice. In involves the dual process of decentralisation and globalisation of policy-making and service delivery and in many ways provides a workable solution to the problem of unbalanced, state-centric global governance. However, the practical outcomes of each of the constituent elements of multi-sectoralism suggest limited deliberation and participation by state-based actors, and re-orientation towards global arenas of decision-making and agenda-setting.

The centre of multi-sectoral activity is within the state. The state co-ordinates and manages every aspect of multi-level governance but is susceptible to demands from international donors and institutions. This is because these co-ordinating state agencies were introduced by international institutions,[37] and the scope to set the national agenda and shape policy decisions can only exist within the wider remit of multi-sectoral interventions established in Washington and

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[37] Harman 2010, p56-57

Geneva. Without international intervention key health issues would have remained in the remit of the Ministry of Health.[38] This leads to a discrepancy over who owns health interventions, between these specialist agencies and the Ministry of Health, and between the government and those donors who are able to set the agenda.[39] The decentralised structure of these government agencies introduces an additional layer of bureaucracy, confusion and loss of transparency at the local level.[40] Multi-sectoral interventions in practice construct a specific form of multi-level governance that separates health from health planning, and the state from the wider features of national or local politics by emphasising the functional nature of their role and the importance of promoting better health and eradicating disease through more structural, non-health specific interventions.

This separation of health from the health sector or the political realm is further reflected in the second key element of multi-sectoral intervention: inclusion of civil society groups. The onus here is on local community groups as the most efficient and cost-effective means of service delivery. Beyond provision, the purpose of civil society inclusion is to act as a check and balance on the state, and broaden the scope of health to address the cultural and socio-economic drivers of poor health and disease. However, the broadening and inclusion of civil society is driven by the state, with the state highlighting familiar actors it wants to support both politically and financially, and processes of deliberation being highly formal and structured by government agencies.[41] Civil society thus comes to represent less of a 'third sphere' of political activity, but more a low cost extension of state services. Dependency on funding and the origins of that funding makes it hard for civil society to become independent observers of the process or to fully control or direct the agenda in response to local demands, as in practice local demands are often only met when they fall into pre-established strategic priorities.[42] This has particularly important implications for local community groups, the individual and society in developing countries. Individuals are unable to direct or advise as to what interventions or policies would best help support them, yet are to provide their services free. This restricts the political agency of individuals and local communities as they become trapped in the need to elicit funds to support

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[38] S. Harman, 'Fighting HIV and AIDS: Reconfiguring the state?' *Review of African Political Economy* 36(121), 2009c
[39] Harman 2009c
[40] Harman 2010, p84
[41] Harman 2009c
[42] Harman 2010, p84-90

themselves, whilst narrowing the political space for alternative, or any meaningful deliberation as to what their needs or wants are.

The emphasis on one strategic plan or project to organise multi-level health governance around narrows the space of decision-making and inclusion further. There is little point in having multiple actors, with multiple points of view and projects if they are excluded from the process of governance because they do not adhere to one strategic plan. Adherence to one strategic plan by its very nature restricts notions of polyarchy as it outlines the limits and language of participation in which all actors must pursue, as well as the rules for participation. Any exception to the rule is seen as a form of bad governance, or the wrong type of health intervention, and thus restricted from funding streams and engagement in decision-making or agenda-setting.[43] Criticism and alternative ideas and views on health interventions can exist outside of this plan, but the limited scope for full deliberation with these dissenting voices restricts full multilevel governance as a form of polyarchy. Analysis of specific health issues occurs within the confines of policy-making and has the net effect of pigeon-holing issues and prescribing interventions that are broad in scope but narrow in conceptual clarity.

This narrowing of political space is less of a problem for actors from the for-profit private sector. These actors also undergo a process of becoming embedded within the structures of the state, but are able to sustain their independence as state resources are not their primary form of income. Private actors are often involved in multi-level forms of governance for specified tasks or through the introduction of new 'innovations' or developments. The reification and need for new solutions to sustained problems, e.g. new vaccines and new, more accessible and improved medicines, gives the private sector a degree of self-legitimacy. States and civil society actors often lack the funds or expertise to fully hold such actors to account; and where they can, private actors have the ability to leave such a state, or opt out of a policy initiative that does not suit their organisation's objectives. The private sector relies on systems of self-regulatory practice, with limited mechanisms of transparency to the state, civil society or the individual. Hence, inclusion of the private sector often makes multi-level governance less accountable and transparency, as consumer choice is narrow, with little knowledge or scope to hold these actors to account, specifically in health interventions where policy-

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[43] Harman 2010, p87

makers are dependent on innovation and generous licensing arrangements for new drugs, treatment, and prevention strategies.

The central constraint on multi-level governance as a solution to the shortcomings and lack of good poverty governance is the role of international institutions. The role of international institutions within multi-level governance is to provide a co-ordination function, expertise and financial support to states, the private sector and civil society in delivering sustainable outcomes for global health interventions. However, in practice the scope of these institutions is much broader, with organisations such as the World Bank able to set the agenda through multi-sectoral state institutions.[44] This can be seen in the case of donor co-ordinating committees. Co-ordinating committees are not only to avoid overlap, but present the opportunity to bring actors in line with clear objectives. Similar to the national strategic plan, these committees have a specific working culture that prioritises certain practices or institutions over others. With older, multilateral institutions having more sway than newer or bilateral institutions. This is because of longevity, closer links to the government, and the ideas that these organisations are in some way 'non-political' honest brokers. However, in presenting themselves as non-political agencies with no state-led objectives, these organisations have far higher reach. They are able to recommend multi-sectoral interventions and a shift away from the Ministry of Health, use their 'expertise' to outline the central components of the strategic plan, and most importantly establish a government agency within the highest level of political office. Decision-making remains highly centralised in international institutions, consensual and operative at the state level, and then delivered at low cost at the community level: those international institutions that are presented as non-political, with large amounts, and more importantly, sustained levels of funding have the greatest influence. The core of what health governance is about has become blurred through multi-level governance to the stage where it is now about anything but health.

The net effect of these structures of multi-level health governance is limited transparency, accountability and representation, and thus an embedding of the bad form of governance seen in wider processes of global poverty governance. The multiple actors involved in multi-level governance make it difficult to identify who is responsible for what and how and to whom they are accountable. There is a clear delineation of roles and responsibilities, but on clearer inspection they do not

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[44] Harman 2009b; Harman 2010

appear as they seem. States do not co-ordinate, agenda-set or organise strategic plans independent of international donors, and those international donors prefer to have a hidden role so as to promote state legitimacy. This leads to a confusion over to who is being held to account for national health policies and how.[45] Civil society organisations are unable to hold those state agencies and international donors to account as they suffer from a conflict of interest as these are the very agencies they receive funds from. Civil society activity is primarily located within localised communities who often have limited access to decision-making or knowledge as to the structures and processes of health governance to hold actors to account. Even at the local authority level, information is often closed, and where available there is little local communities can do to create space for alternative discourses or much to gain in doing so as the outcome would be a loss of resources and/or seat at the decision-making table. The formation of networks or coalitions at the local level is limited by competition over resources and claims to 'local knowledge.'[46] Multi-level governance thus leads to a disaggregation of civil society based on competition rather than a cohesive voice or check on the government. Whilst this is emblematic of most civil society activity, and is an important component to its effectiveness, this division is constructed through economic incentive and only opens up the space for alternative ideas within a limited language and culture of doing health governance. Participation and inclusion remains relative and has the over-arching purpose of bringing civil society and the private sector into the state as a means of embedding multi-level governance and governance reform further.[47] Hence the state is only held accountable to the international organisations that partner it. Those international organisations are only accountable to their directors and dominant member states, as for them good governance is more about state representation and transparency than their transparency. The result of this form of multi-level governance is the inclusion of multiple actors with limited good governance, in what is in effect a highly centralised system designed and orchestrated in global centres of decision-making in Washington and Geneva.

The highly centralised nature of decision-making suggests that multi-level governance remains a state-centric, hierarchical mode of organisation that rests on a separation of unequal power. Power in multi-level health governance is

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[45] Harman 2010, p64
[46] Harman 2010, p90
[47] Harman 2010, p97

organised in such a way as to limit influence of communities and local government, hide the relevance of international institutions and aid donors, and prioritise the state as the main site of good governance. Power in terms of agenda-setting and decision-making is located within international institutions and donors, mainly the World Bank, the Bill and Melinda Gates Foundation, and states within the G8. The governments and civil society actors within developing countries are only able to express power through project implementation and the delivery of services. This separation of power reflects a wider separation of the political from the economic and social within multilevel governance. Health governance is characterised and organised in such a way that policies and projects are presented as 'apolitical' in their nature as the central purpose of these policies is to deliver innovative health interventions to address the poverty and socio-economic determinants of poor health and disease. Politics and the political in this respect are substituted for governance as an organisational concept resting on good governance. Politics is seen as how power is organised within the state, and about competition, conflict and political parties, i.e. something that gets in the way of the implementation of global health objectives. Within multi-level health governance, this 'politics' should not be involved in addressing the socio-economic determinants of global health, and is abstracted from the nature and purpose of civil society. Applied to global health, Harmes' understanding of multi-level governance as the separation from the economic and political is extended to the social through the inclusion, construction and limitations put on civil society actors.[48] The result of this is a paradox between the apolitical nature of health and poverty governance as seen by actors and institutions within this multi-level system, and the highly political nature of how power is organised within multi-level governance as a centralised and hierarchical form. This separation is both the main basis and central problem of multi-level analysis.

Why multi-level governance is not the answer for poverty reduction
Revisiting the central problems with poverty governance outlined at the beginning of this paper in conjunction with the outcome of multi-sectoralism suggests instead of providing a solution, multi-level health governance further embeds these problems. Multi-level health governance is driven by foreign aid initiatives, mainly from bilateral and multilateral donors. This makes all non-global levels of

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[48] Harmes 2006

governance i.e. the state, civil society and local communities dependent on aid for the system to work effectively. Multi-level health governance extends this dependency in the following ways. First, it draws in the private sector to expand the source of foreign aid and the financial incentives in place within a system of multi-level governance. Second, multi-level governance re-enforces the prominence of aid without a clear outcome, through its emphasis on rapid disbursal of funds to local community groups and national civil society organisations. The 'sustainable' aspect of these programmes leads to the establishment of governance systems in response to the health needs of the poor, which remain dependent on international aid and charitable giving to sustain them. Sustainability in this regard refers to the building of infrastructure, staff training and the development of good governance within state institutions. However, the effect of these initiatives is limited by a lack of political will or funds within the state to fully support them. Hence the problem of governing poverty and health is heightened from a dependency on general, project-specific vertical aid strategies, to dependency on horizontal, infrastructure-based aid money.

Situating the state at the centre of multi-level health governance allows for a re-enforcement of the 'blame the state' mentality, as any limitation to successful outcomes can be targeted at the central institution responsible for co-ordination: the state, or moreover the government. This mentality is embedded by the dual process of internationalisation of decision-making, and decentralisation of power within the state to local authorities and civil society organisations. In situating accountability, transparency and ownership wholly within the government, local authorities and community groups, any blame or responsibility is firmly entrenched within a broad definition of the state. Where global health initiatives fail, the blame can now be dispersed between local and national government authorities and community groups. Hence, instead of overcoming this problem, multi-level governance extends it further.

The emphasis on the state within multi-level governance embeds the problems of international institutions associated with the governance of global poverty. Multi-level health governance disaggregates responsibility and accountability in such a way that international institutions remain unseen in global health policy-making despite their presence and impact being very much felt. They operate through states in such a way as to diminish their responsibility. The new era of inclusion of governments and civil society organisations in decision-making

takes place in a pre-established framework, to limited outcome for these state-based actors. Good governance becomes more of a challenge as these institutions work through not only governments, but local community groups and individuals, in implementing their strategies and agendas under the notion of multi-level governance.

Conclusion

Multi-level health governance provides a problem for the governance of poverty as opposed to a solution, because of its centralised and hierarchical nature and rescinding of space for alternative political voices and participation. Space for innovation exists within a narrow framework defined by global institutions. The possibility of opening such a framework is limited by the construction of civil society within a specific language and practice of doing global health governance. Alternative 'mini publics' or voice as to how global health could be practiced is limited by a lack of access to knowledge, and the need to frame such knowledge within this language and practice. This in turn facilitates a specific form of democratisation that promotes apolitical development centred around one programme or policy, not evidence of polyarchy in the form of competing interest and pressure groups and public opinion.

Multi-level governance does not present an opportunity for wider participation or good governance, but embeds practices of bad governance – hidden decision-making, distorted separation of power, limited participation and lack of accountability – within global health structures. Bad governance is promoted by the separation of the political and economic from the social, and attempts to embed an economically-constructed form of community-based civil society within the state. This form of bad governance will affect multiple programmes and frameworks in which poverty governance become implemented, as initiatives follow the precedent set by global health interventions in global governance.

In conclusion, the multi-level health governance does not provide an alternative to existing ways of governing global poverty. Any innovation it suggests refers to the bringing in of local communities and the private sector to existing hierarchical, state-centric mechanisms of promoting liberal democracy and reform of state institutions. Innovation that is based on alternative ideas or strategies either does not exist, or occupies the 'outsider' category that multi-level governance is supposed to overcome. This form of governance extends the 'blame

the state nature' of poverty governance to community groups and individuals, whilst limiting any form of accountability or visibility of the global institutions that set the parameters of this global health framework. For innovation or change to exist in the governance of poverty, multi-level governance as seen in global health strategies should be resisted, as it does not present an alternative but just a deepening of the same state-centric, hierarchical global governance developed over the last 100 years.

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Working Paper CUTP/007
August 2010