The Governance of Infectious Diseases. An International Relations Perspective

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Abstract

The article explores Global Health Governance (GHG) under conditions of limited statehood – i.e. beyond the nation state. Drawing on empirical examples of governance involving businesses, it analyzes the conditions under which GHG can emerge and be effective despite prevailing conditions of limited statehood. The analysis shows that selective incentives deriving from a skills-driven business model, in combination with a hegemonic role of the firm in its locality, give rise to the emergence of business-driven GHG structures. Meta-governance and norm-congruence with the designated beneficiaries of the GHG structure, and government authorities, make such GHG effective. Ultimately, the article calls for a conceptual change in international law to account for the fact that private actors may fulfill public functions in situations in which the state is limited in its ability to govern.

I Introduction

This article relates recent research in International Relations (IR) on collective goods and services provision in areas of limited statehood to current

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debates about Global Health Governance[1] (GHG) of infectious diseases. The main function of GHG in relation to infectious diseases is to prevent, contain and manage pandemics.[2] The current structure of GHG is conceived to fulfill this function mainly through the coordination of states' public health policies – for example in the context of the World Health Organization (WHO).[3] The respective plans address health departments and other government entities in the attempt to contain the disease at its root, mitigate its worst impacts, coordinate vaccination campaigns, and control extensive proliferation. However, in many parts of the world, states have only very limited capacities to govern,[4] and are often not capable of effective policy planning or implementation.[5] This article asks whether and how "new",[6] but "functional equivalent"[7] modes of GHG involving non-state

1 By *governance* this article understands the making and implementation of rules, norms, standards and decision-making procedures for the production or provision of collective goods and services, see Reinicke, W H, *Global Public Policy. Governing without Government?*, 1998, 147-148; Héritier, A, "Introduction" in Héritier, A (ed.), *Common Goods. Reinventing European and International Governance*, 2002, 1.

2 The article refers to epidemics as infectious disease outbreaks on a local population-level; pandemics are disease outbreaks that go beyond a local population and cross national borders, see Morens, D M, Folkers, G K & Fauci, A S, "What Is a Pandemic?" (2009), 200 *Journal of Infectious Diseases*, 1018; Moon, S, Sridhar, D & Pate, M A et al., "Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola" (2015), 386 *The Lancet*, 2204.

3 Goldin, I & Mariathasan, M, *The Butterfly Defect: How Globalization Creates Systemic Risks, and What to Do about It*, 2014. For a different approach towards GHG, see also the contribution of *Mateja Steinbrück Platise*, "The Changing Structure of Global Health Governance" in this volume.

4 For the case of countries in West Africa, see the contribution of *Edefe Ojomo*, "Fostering Regional Health Governance in West Africa: The Role of the WAHO" in this volume.

5 Milliken, J & Krause, K, "State failure, state collapse, and state reconstruction: Concepts, lessons and strategies" (2002), 33 *Development & Change*, 753; Risse, T (ed.), *Governance without a State? Policies and Politics in Areas of Limited Statehood*, 2011.

6 Héritier, "Introduction", above Fn. 1, 1.

7 Börzel, T A & Risse, T, "Governance without a State - Can it Work?" (2010), 4 *Regulation and Governance*, 113.

actors could contribute to controlling and managing infectious diseases under such conditions.[8] The article draws on the author's own and collaborators' empirical research on HIV/AIDS governance in South Africa. It thereby goes in important ways beyond previous calls to move conceptually from International Health Governance (IHG) to Global Health Governance,[9] in that it a.) makes the case for limited statehood as an important context condition of pandemic control, which has so far been mostly ignored; b.) identifies specific challenges that GHG under conditions of limited statehood has to overcome, and the conditions under which GHG is more and less likely to be effective; c.) thereby suggesting a new way of thinking about the role of non-state actors in GHG, which assigns public function roles to them.

Limited statehood is not a new phenomenon. Its relevance for GHG is, however. More specifically, two developments associated with globalization processes unleashed after the End of the Cold War elevated the degree to which GHG is affected by the phenomenon. First, connectivity between formerly only remotely related areas in the world has dramatically increased. This also particularly involves the so-called developing world, where conditions of limited statehood prevail.[10] Intensified trade and investment relations and elevated levels of mobility through, for example, air travel, have helped to increase this connectivity. With this, the risk of local infectious disease outbreaks turning into global pandemics has augmented. Second, the growth of slums, townships and shantytowns in the developing world – often driven by the uprooting dynamics of global economic development and industrialization – have created new potential hot spots of epidemic disease outbreaks. Today, about one billion people live under slum and other sub-standard living conditions according to United Nations Human Settlements Programme (UN-HABITAT).[11] The state's public policies usually do not reach these places. It is in these areas of limited statehood that poverty, lack of sanitation and lack of access to other basic infrastructure and public services combine with high population density and

8 For the case of NGOs health-related activities in Liberia, see the contribution of *Hunter Keys, Bonnie Kaiser & André den Exter*, "The Real Versus the Ideal in NGO Governance: Enacting the Right to Mental Healthcare in Liberia During the 2014-2016 Ebola Epidemic" in this volume.

9 Dodgson, R, Lee, K & Drager, N, "Global health governance. A Conceptual Review" (2002), *Discussion Paper No. 1, WHO, Centre on Global Change & Health, London School of Hygiene & Tropical Medicine*, 7.

10 Goldin & Mariathasan, *The Butterfly Defect*, above Fn. 3.

11 See UN Habitat, *Background Paper*, 2014, available at http://bit.ly/1Q60HQD.

physical closeness of human-animal relations to create the conditions that increase the likeliness of outbreaks of infectious diseases.

II Globalization and Disease Outbreaks: The Need for "New" Modes of Global Health Governance

With the end of the Cold War, globalization has changed the way global governance can and should be pursued. Before 1990, both the discipline of IR and its practice were thoroughly grounded in "methodological nationalism",[12] the belief that states are the only (relevant and legitimate) actors in international relations: internationally, they coordinate policies under conditions of anarchy; internally, they are "domestic sovereigns",[13] effective and legitimate governors in their territory.

Since 1990, two developments related to the emergence of "the global" as a political and social space[14] render these assumptions in relation to many governance issues, including GHG, increasingly anachronistic. The first development concerns a change of roles of transnational networks and private actors in world politics – a development that is reflected academically in the context of a revival of transnationalist thinking in IR.[15] Globalization has improved their strategic position vis-à-vis states. Many businesses and Non-Governmental Organizations (NGOs) are today operating on a global scale – or at least have the option to do so. Once territorially confined and on the receiving end of state-based governance, multinational corporations and global value chains, for example, now play off states competing over investments and trade flows against each other. Depending on businesses' will, states may find themselves entrapped in a "regulatory race to the bottom"[16] – or pushed in the opposite direction of regulatory upgrading and a

12 Cerny, P G, "The Dynamics of Political Globalization" (1997), 32 *Government and Opposition*, 251 (251-252).

13 Krasner, S D, *Sovereignty: Organized Hypocrisy*, 1999; Krasner, S D & Risse, T, "External Actors, State-Building, and Service Provision in Areas of Limited Statehood: Introduction" (2014), 27 *Governance*, 545.

14 Scholte, J A, "Defining Globalization" (2008), 31 *World Economy*, 1471.

15 Kahler, M, *Networked Politics: Agency, Power, and Governance*, 2009; Risse, T, "Transnational Actors and World Politics" in Carlsnaes, W, Risse, T & Simmons, B A (eds.), *Handbook of International Relations*, 2012, 426.

16 Chan, A & Ross, R J S, "Racing to the Bottom: International Trade without a Social Clause" (2003), 24 *Third World Quarterly*, 1011.

"race to the top".[17] Transnational networks of NGOs enjoy addressing different transnational audiences simultaneously, as this allows them to exert pressure on states and other actors, such as businesses, in varied and new ways, thereby often imposing their will on them.[18] Transnational terrorist groups, often only connected via social media, challenge the established state system through the creation of new, asymmetrical security threats. Non-state actors matter for outcomes in global politics today and have emerged as the new "global governors".[19]

The second development concerns an increase in the scope of problems dealt with in the context of global governance. This increase especially concerns so-called "behind-the-border"[20] issues – problems for which the solution requires the regulation of private actors behind national borders. Given methodological nationalism, global governance-institutions usually seek to achieve this via the nation state. But the target is (the behavior of) a private actor or group of private actors, which the state, by adopting public policies inline with global governance stipulations, is supposed to regulate. In global environmental governance, for example, cross-border pollution or CO_2 emissions are mainly caused by private actors, namely industry and consumers. Their behavior is the real target of global environmental governance. But most international agreements and norms in global environmental governance address states' public policies and regulations. The same is true for numerous other issue areas that have become part of the global governance agenda after the Cold War, from occupational health, labor rights, corporate governance, banking standards, and industry processes to public health. This increase of behind-the-border issues in global governance can be traced back to the increase of interconnectedness and interdependence, brought about by globalization processes, which define "the global" as a policy space. *Goldin* and *Mariathasan* attest to a "butterfly defect":[21] rela-

17 Vogel, D, *Trading Up: Consumer and Environmental Regulation in a Global Economy*, 1995; Börzel, T A, Thauer, C R & Hönke, J, "Conclusion: A Race to the Top?" in Börzel, T A & Thauer, C R (eds.), *Business and Governance in South Africa. Racing to the Top?*, 2013, 215.

18 Keck, M E & Sikkink, K, *Activists Beyond Borders. Advocacy Networks in International Politics*, 1998; Risse, T, Ropp, S C & Sikkink, K, *The Power of Human Rights. International Norms and Domestic Change*, 1999.

19 Avant, D, Finnemore, M & Sell, S K (eds.), *Who Governs the Globe?*, 2010.

20 Zürn, M, "Global governance as multi-level governance" in Enderlein, H, Wälti, S & Zürn, M (eds.), *Handbook on multi-level governance*, 2010, 83.

21 Goldin & Mariathasan, *The Butterfly Defect,* above Fn. 3.

tively small, insignificant, "private" acts – individually or collectively conducted – can have global consequences. Traveling by airplane with an unrecognized infectious disease could result in the outbreak of a pandemic. In the attempt to manage such butterfly defect-risks, global governance has become more "intrusive",[22] targeting more and more the everyday activities of ordinary persons and private organizations. This intrusiveness, in turn, has created a potential for conditions of limited statehood impacting global governance. If the state is not capable of public policy planning and implementation, the traditional, state-centrist approach to global governance is bound to fail in relation to behind-the-border issues. Limited statehood is no longer a mere marginal or peripheral problem. Many states, in many areas, are often somewhat limited in their ability to govern.[23] The assumption of "domestic sovereignty" is as much an "organized hypocrisy"[24] as sovereignty is as an external dimension (understood as the principle of non-intervention). Statehood is in reality rather a matter of degree, and thus usually limited. This limitation comes in different forms. It may describe the functional lack of the state's regulatory capacities in a certain policy field. A state, for example, may be "strong" vis-à-vis its society and in the international system, but may lack the ability to provide basic social or health services, or to enforce environmental laws. Limited statehood may alternatively be territorially or socially defined, such as when a state lacks the ability to control parts of its territory as "domestic sovereign" or is limited in its ability to enforce its laws vis-à-vis a certain social, ethnic or religious group. Limited statehood is, of course, not a new phenomenon. But during the Cold War, it affected mainly the periphery – the formerly so-called Third World –, whereas now, with the mentioned interconnectedness, it is a central problem of global governance. The periphery no longer exists.

As concerns the nature of limited statehood, it is important to note that it is not synonymous with anarchy. Recently, *Krasner* and *Risse*,[25] and *Lee*, *Walter-Drop* and *Wiesel*[26] showed that, under conditions of fully consolidated as well as entirely failed statehood, the state's regulatory and public

22 Zürn, "Global governance as multi-level governance", above Fn. 20.
23 Krasner & Risse, "External Actors, State-Building, and Service Provision", above Fn. 13.
24 Krasner, *Sovereignty: Organized Hypocrisy*, above Fn. 13.
25 Krasner & Risse, "External Actors, State-Building, and Service Provision", above Fn. 13.
26 Lee, M M, Walter-Drop, G & Wiesel, J, "Taking the State (Back) Out? Statehood and the Delivery of Collective Goods" (2014), 27 *Governance*, 635.

policy capacities are a valid predictor for levels of collective good and service provision in a polity. That is to say, fully consolidated statehood is associated with high levels of collective goods and services provision, whereas failed statehood – such as in an endemic civil war situation – is associated with extremely low levels. However, where statehood is limited, as in most countries, the degree of statehood is vastly decoupled from levels of governance. In other words, collective goods and services provision varies here, and it does so unrelated to the state's capacity to govern. This begs the question – if it is not the state, then who is it that governs in areas of limited statehood? International organizations, development agencies, NGOs, tribal actors, and local communities have been identified as actors that fill the governance gap.[27] Even businesses – that is, for-profit, private interest-based actors – have been found at times, under certain conditions, to be the one to take over vital governance functions in areas of limited statehood.[28] Thus, in situations in which the state is absent as a policy-maker, significant governance capacities may still exist. However, they are not performed by the states' government, but by non-state actors and actor networks. Since the global governance of infectious diseases is a case *par excellence* of behind-the-border governance, and thus heavily affected by conditions of limited statehood, it is on these governance capacities that GHG will have to draw to prevent, contain and manage infectious disease outbreaks. How this may be organized in concrete situations, and what will be the obstacles and challenges of such alternative, *trans*-national rather than *inter*-national GHG, will be discussed in the next section.

III "New" Modes of GHG – Conditions for their Emergence, and Effectiveness

An important implication of research on governance in areas of limited statehood is, as mentioned, that limited statehood is synonymous with neither anarchy nor a Hobbesian state of war of all against all, except for in

27 Risse, *Governance without a State?*, above Fn. 5; Krasner & Risse, "External Actors, State-Building, and Service Provision", above Fn. 13.

28 Flohr, A, Rieth, L & Schwindenhammer, S et al., *The Role of Business in Global Governance. Corporations as Norm-Entrepreneurs*, 2010; Börzel, T A & Thauer, C R (eds.), *Business and Governance in South Africa. Racing to the Top?*, 2013; Hönke, J & Thauer, C R, "Multinational Corporations and Service Provision in Sub-Saharan Africa: Legitimacy and Institutionalization Matter" (2014), 27 *Governance*, 697.

extreme cases where the state has lost its capacity to control the exercise of violence, such as in civil war situations. Instead, limited statehood, as a system of governance itself, consists of at times more and at times less stable networks of reciprocal relationships between societal actors – sometimes more, sometimes less, capable of collective goods provision. The absence of the state implies that this overall system of governance is highly de-centralized. Social systems characterized by limited statehood are thus in essence decentralized, and not (necessarily) anarchic.

In systematic comparative perspective, centralized systems (of fully consolidated statehood) are more successful as concerns collective goods and services provision. No alternative can beat full-fledged statehood in this respect: fully consolidated statehood is, across the board, strongly associated with high levels of collective goods and services provision, whereas in areas of limited statehood, levels of governance vary. However, it must be emphasized that decentralization is not an obstacle to collective service provision *per se*. It only turns into one in conjunction with what *Perrow* has coined "task complexity".[29] Task complexity refers to the frequency and intensity of interactions and the number of actors that need to be coordinated for a governance task to be accomplished. The more frequent and intense the interactions and the higher the number of actors that need to be coordinated, the more complex the governance task, and *vice versa*. *Krasner* and *Risse* argue that task complexity is indicative of the effectiveness of governance in areas of limited statehood.[30] *Schäferhoff* has applied the concept to the analysis of global health governance.[31] His work shows that when task complexity is low, such as in the context of a one-shot vaccination campaign aimed at eradicating an infectious disease, global health governance is likely to emerge and succeed in its task even under conditions of de-centralization. However, when task complexity is high, this dramatically increases the likelihood of governance failure. Infectious diseases that cannot be contained in a simple way but require complex coordination in order to be contained and managed, are thus the litmus test for GHG in areas of limited statehood. The contributions in *Börzel* and *Thauer*, and *Hönke* and *Thauer*, show in this respect that the governance of complex behind-the-

29 Perrow, C, *Complex Organizations: A Critical Essay*, 1972.

30 Krasner & Risse, "External Actors, State-Building, and Service Provision", above Fn. 13.

31 Schäferhoff, M, "External Actors and the Provision of Public Health Services in Somalia" (2014), 27 *Governance*, 675.

border issues is possible even under such conditions.[32] Their work will be presented below in order to define the challenges of and conditions for complex coordination in decentralized systems of governance. It draws on cases of HIV/AIDS governance in the context of South Africa prior to 2009. In South Africa, about 20 % of the population in the sexually active age group has contracted HIV/AIDS.[33] In the country's townships, where most of the people affected by the disease live, there was, before 2009, hardly any access to health care services. Township inhabitants additionally often lack access to other basic services such as sanitation, and are suffering from poverty and exposure to crime and violence. Before *Jacob Zuma* became President and rolled out the largest antiretroviral medication program in the world in 2009, the government, in particular under President *Thabo Mbeki* who ruled the country until 2008, remained irresponsibly inactive in relation to the disease.[34] Drug coverage for persons sick with AIDS was then an estimated 20 % nationwide, and much lower in the townships.[35] Thus, with respect to HIV/AIDS, the country was, before 2009, an area characterized by the absence of state governance.

Unlike a vaccination campaign, fighting HIV/AIDS requires continuous efforts and goes beyond simple medical intervention: doctors and nurses in clinics have to be trained so that they are able to diagnose the disease; they also have to acquire the skills to effectively treat it. Patients have to be persuaded to test for HIV/AIDS. Fighting the disease effectively also involves prevention measures, such as sexual education programs run in schools, at the workplace and in public. Drugs ranging from immune boosters to antiretroviral medication have to be continuously provided. The lifestyle of patients needs to be changed. In other words, the governance of HIV/AIDS is an extremely difficult task, characterized by high complexity. As will be explained further below, in many instances, attempts at HIV/AIDS governance therefore failed in South Africa. In some instances however they did

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32 Börzel & Thauer, *Business and Governance in South Africa*; Hönke & Thauer, "Multinational Corporations and Service Provision", both above Fn. 28.

33 See UNICEF, *South Africa - Statistics,* available at http://uni.cf/2mEzVKn.

34 Nattrass, N, *The AIDS Conspiracy: Science Fights Back*, 2013.

35 Nattrass, N, *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, 2007; Soest, C von & Weinel, M, "The Treatment Controversy – Global Health Governance and South Africa's HIV/AIDS Policy" in Hein, W, Bartsch, S & Kohlmorgen, L (eds.), *Global Health Governance and the Fight Against HIV/AIDS*, 2007, 202.

succeed, as in the case of Mercedes Benz – a large German multinational car company.[36]

The firm manufactures parts of its C-class models in East London in the province of the Eastern Cape of South Africa. Like most carmakers, Mercedes' production heavily depends on employees acquiring the specific skills necessary for the C-class' production. The firm's business model is thus "asset specific",[37] which heightens the firm's interest in the wellbeing of its employees.[38] In view of the threat HIV/AIDS represented to the specific skills-dependent business model of Mercedes, the firm successfully rolled out a comprehensive HIV/AIDS workplace program in the early 2000s. In the context of the program, the firm's employees were provided with comprehensive health services, including antiretroviral medication on the level of best available science, thereby effectively turning HIV/AIDS into a chronic disease. The firm also distributed condoms and offered sex education and anti-stigmatization programs. In view of the success of its programs in terms of a generally sustained healthiness of its employees (resulting in a reduction of absenteeism, higher productivity, and lower staff turnover and losses), the multi-national corporations (MNC) decided in 2006 to organize a response to the disease with a broader focus. The firm initiated a multi-stakeholder partnership, including the National Ministry of Health of South Africa, local institutions (ranging from hospitals and schools to the municipality), the DEG (Deutsche Entwicklungs- und Investitionsgesellschaft) – a German development agency –, a local association, as well as the Border Kai Chamber of Commerce (BKCC). The aim of the project was to support small and medium-sized businesses in their efforts to draw up and implement HIV/AIDS workplace policies on the basis of the WHO guideline "Healthy workplaces: a model for action".[39] More than 26,000 persons have gained access to health care services through this supplier initiative alone, in addition to another 30,000 persons who have gained

36 See for the following Thauer, C R, "Coping with uncertainty: The automotive industry and HIV/AIDS governance in South Africa" in Börzel, T A & Thauer, C R (eds.), *Business and Governance in South Africa. Racing to the Top?*, 2013, 45; Hönke & Thauer, "Multinational Corporations and Service Provision", above Fn. 28.

37 Williamson, O E, *Markets and Hierarchies: Analysis and Antitrust Implications. A Study in the Economics of Internal Organization*, 1975.

38 Thauer, C R, *The Managerial Sources of Corporate Social Responsibility. The Spread of Global Standards*, 2014.

39 See WHO, *Healthy workplaces: a model for action. For employers, workers, policy-makers and practitioners*, 2010, available at http://bit.ly/2ndkTrH.

access in the context of the firms' program for workers and their extended families.[40] The project also offers training for nurses and doctors in local clinics in order to improve the public health services in relation to HIV/AIDS, coordinates with schools' sex education programs, and assists local communities affected by the disease with sponsorships.

Needless to say, a comprehensive public health response organized by the government could have been more inclusive. But given that this option was not available at the time, the alternative to this multi-stakeholder initiative would have been no governance at all. The multi-stakeholder initiative thus filled a void, with important consequences for those who benefitted from it. The case shows that complex coordination for the provision of health services is possible, even under conditions of limited statehood. But what is it that sets the case of this multi-stakeholder initiative apart from other situations in which governance structures either failed to emerge, or failed to successfully deliver health services? More generally, what are the specific challenges that GHG under conditions of limited statehood have to overcome for the creation of effective governance structures? Based on the mentioned work of firms in South Africa, which includes the systematic analysis of HIV/AIDS governance - both failed and successful, involving businesses in different industry sectors - four coordination problems for the creation of complex governance structures in de-centralized systems can be identified. The first two problems concern the emergence of institutionalized forms of GHG involving firms. The third and fourth concern the effectiveness (in terms of health service delivery) of these institutionalized forms of GHG.

1 Why and Under Which Conditions Does GHG Emerge?

Public health is a public good[41] in that the society as a whole as well as each member will benefit from the absence of diseases physically, socially and economically. The health care services necessary for the creation of this public good are costly however, in particular in the presence of a sexually

40 Lorentzen, J, "Multinationals on the periphery. DaimlerChrysler South Africa, human capital upgrading and regional economic development" (2006), 2 *Occasional Papers of the Human Research Council South Africa*, 1.

41 Cornes, R & Sandler, T, *The Theory of Externalities, Public Goods, and Club Goods*, 1996.

transmitted infectious disease, as in South Africa. In decentralized systems – that is, in the absence of a central coordinator who could, if necessary, apply monitoring and sanctioning mechanisms[42] – the free rider problem will consequently obstruct the provision of this public good. Unsurprisingly, therefore, the mentioned empirical studies found that many firms in South Africa did not engage in the fight against HIV/AIDS in any significant way. Firms are for-profit actors committed to the maximization of the wealth of their owners in a highly competitive environment. Why would they spend scarce organizational resources to contribute to the fight against a disease, given that doing so could result in competitive disadvantage vis-à-vis other firms that decide to abstain from doing so? The analysis of firm cases in South Africa, such as Mercedes in East London, shows that firms do so when they have "selective incentives"[43] – that is, incentives that selectively work for the individual firm, resulting in the calculation that the benefits it will reap from contributing to public health will exceed the costs of that contribution. *Thauer* found that this is the case when firms have made asset specific investments, that is, when they have invested significantly in training programs that teach employees specialized skills.[44] The consequence of such investments is that the firm cannot substitute employees any more easily in the labor market, but becomes dependent on them, and vulnerable to their behavior. Health and general wellbeing programs offered to these employees by the firm in the context of HIV/AIDS workplace programs are in this situation highly beneficial for the firm, as they effectively mitigate the problem of staff turnover. The mentioned HIV/AIDS program of Mercedes, for example, allowed the firm to retain its investments in employee skills.

Selective incentives, however, explain cases such as Mercedes in East London only partially. The firm decided first and with priority to offer comprehensive health services to its employees. Given the complexity of the issue of HIV/AIDS, after it accomplished this task, it began to additionally coordinate with relevant actors in the strategic environment of the firm – schools, kindergartens, hospitals, suppliers, and the business community

42 This central coordinating function has also been called the "shadow of hierarchy", see Héritier, A & Lehmkuhl, D, "The Shadow of Hierarchy and New Modes of Governance" (2008), 28 *Journal of Public Policy*, 1.

43 Olson, M, *The Logic of Collective Action. Public Goods and the Theory of Groups*, 2009, 51.

44 Thauer, *The Managerial Sources of Corporate Social Responsibility*, above Fn. 38; Thauer, C R, "Goodness Comes From Within: Intra-organizational Dynamics of Corporate Social Responsibility" (2014), 53 *Business & Society*, 483.

writ large – a collective response to the disease. In systematic comparative perspective, this outreach seems unusual. The empirical findings indicate in this respect that firms, which have invested in specific skills of employees, will offer them health care services in the context of HIV/AIDS workplace programs. But not every firm that has made such investments also goes beyond its purview to coordinate a collective response in society with external actors. The firm Crossley Carpets is an example of such a firm that relies on specific skills, but yet does not coordinate with actors in society on the issue of HIV/AIDS.[45] As an industrial textile firm specialized in the making of hotel carpets – a sophisticated product requiring complex modes of production – the firm offers extensive training programs to its employees. Even floor operators on the lowest entry level of employment in the firm have to first receive months of training before they can become operational on the factory floor. Accordingly, in order to retain these built-up skills, the firm runs a highly sophisticated and generous HIV/AIDS workplace program. However, the firm does not reach out to other actors in the community to organize collective action against HIV/AIDS. How can this finding be interpreted? From the perspective of the theory of collective goods and externalities,[46] workplace programs create a different type of good than external coordination. Workplace programs, while contributing to the non-exclusive good public health, simultaneously create an exclusive, private good for the firm, namely skills-retaining, to which firms that do not have workplace programs have no access. In a competitive environment, as in markets, excludability is a key motivation.

Different to that, external coordination contributes in the first place to public health as such – a public good from which no one can be excluded – and thus confronts the mentioned free rider obstacles. But why, then, did Mercedes still decide to initiate a multi-stakeholder initiative in East London, and what sets this case apart from Crossley Carpets that did not do so? The difference boils down to aspects related to the differences in size of the two firms.[47] Mercedes is an extremely large firm in the context of East London, employing several thousand employees. It is also part of a huge multinational corporation. Crossley Carpets, by contrast, is a smaller firm with only a few hundred employees and no ties to other larger firms,

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45 See for the following above, Fn 38, ch. 4.

46 Cornes & Sandler, *The Theory of Externalities*, above Fn. 41; Olson, *The Logic of Collective Action*, above Fn. 43.

47 Börzel & Thauer, *Business and Governance in South Africa*; Hönke & Thauer, "Multinational Corporations and Service Provision", both above Fn. 28.

neither in South Africa nor abroad. Size matters in two ways. Firstly, there is the rather trivial fact that for a large firm such as Mercedes with extensive administrative structures and financial resources, the relative burden of organizing a multi-stakeholder initiative such as the one in East London is much lower than for a small organization such as Crossley Carpets with only a thin administrative layer and very limited financial resources. From a theory of the firm perspective, going big is a specific market strategy.[48] Integrating various value-adding processes under one roof comes with the advantage that the organization has significant resources at its disposal to build up the respective administrative capacities for the management of external risks. Large firms engage in lobbying, extensive public communication, buy up competitors, and engage in corporate social responsibility activities in order to influence and shape their strategic environment. Small firms, by contrast, have the advantage that they can react to external changes flexibly and through innovation. From this perspective, the prospect that general public health-levels in South Africa may further deteriorate means for a small firm such as Crossley Carpets that it may have to change its business model and become less skills driven – or leave the country. By contrast, a large firm such as Mercedes will try to influence its strategic environment such that the actual deterioration is prevented. Large firms thrive on being governors in their environment; small firms survive because they avoid this burden.

Second, large firms such as Mercedes are in their local context economic hegemons. The whole economy and in particular their suppliers depend on their purchasing power, know-how and planning. The local public administration – the municipality and government districts – also depend on their economic power in terms of tax revenues and job creation. In the case of Mercedes, this hegemonic position is particularly strong as the firm has very close relationships with its direct suppliers, involving mutual asset specific investments.[49] The suppliers thus have made investments specifically in order to be able to trade with Mercedes. Mercedes, in turn, depends on these investments and extensively controls operations and procedures in the suppliers' factories. The multinational is thus able to take on the role of a central coordinator in the setting of East London, including the possibility to

48 Williamson, O E, "The logic of Economic Organization" in Williamson, O E & Winter, S G (eds.), *The Nature of the Firm: Origins, Evolution, and Development*, 1993, 90.

49 Héritier, A, Müller-Debus, A & Thauer, C, "The Firm as an Inspector: Private Ordering and Political Rules" (2009), 11 *Business and Politics*, 1.

monitor and, if necessary, sanction unwilling suppliers and public agencies. Small firms, by contrast, do not enjoy such a central position and lack power vis-à-vis other firms and public agencies. Large firms such as Mercedes are thus able to effectively mitigate the free rider problem, and thus to overcome the obstacles to external cooperation for collective action.

GHG structures within firms thus emerge in the event of asset specificity; asset specificity in combination with a large size of a firm create the conditions in which firms seek to initiate health governance structures beyond their purview. But under which conditions are these governance structures also effective?

2 Effective Implementation: A Matter of Legitimacy

The effectiveness of health governance networks such as the one of Mercedes Benz in East London described above is, as concerns its ability to actually deliver health services, not at all self-evident. The higher the level of complexity of the governance task, the more actors have to be continuously coordinated, and so conflicts of interest are likely to emerge, subsequently undermining the effectiveness of service delivery.[50] Indeed, on at least two levels, GHG by firms confronts norm and power clashes that can render the provision of health services ineffective. One concerns the interaction with local communities, the other government agencies of the host country of the governance network.

Firm-based GHG, such as HIV/AIDS workplace programs, is usually oriented towards international norms and standards. HIV/AIDS workplace programs, for example, cite WHO guidelines. However, these may clash with norms, culture, tradition, routines and power structures in local communities, which are, however, the designated beneficiaries of GHG.[51] In the case of HIV/AIDS workplace programs in South Africa, many firms offering sophisticated workplace programs to their employees are, for example,

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50 The assumption of this argument is that the more actors are involved in close and re-iterated cooperation, the higher the likelihood of value, norm, and power conflicts.

51 Hamann, R, Kapelus, P & Sonnenberg, D et al., "Local Governance as a Complex System. Lessons from Mining in South Africa, Mali and Zambia" (2005), 18 *Journal of Corporate Citizenship*, 61; Idemudia, U & Ite, U E, "Corporate–community relations in Nigeria's oil industry: challenges and imperatives" (2006), 13 *Corporate Social Responsibility and Environmental Management*, 194.

frustrated by low participation rates in these programs.[52] Often, employees resist the programs on account of the stigmatization associated with the disease in their community. HIV/AIDS, prevention and treatment programs put established gender relations, sexual identities and traditional power structures (such as the status of traditional healers) into question. They also clash with local power structures. In townships, traditional healers have important positions. They see their social status and income threatened by the company programs, and therefore sometimes actively advocate against health services offered by firms. In consequence, persons who have contracted HIV/AIDS remain at times untreated, which renders the HIV/AIDS workplace programs of companies ineffective. However, there are also examples of firms that managed to mitigate these norm and power conflicts. A case in point concerns BMW in South Africa. The firm produces parts of its 3-series in Rosslyn and Midrand, in the Gauteng province.[53] As in the case of Mercedes, BMW's business model is specific skills-based, thus influenced by concerns with asset specificity. As a consequence, in South Africa the firm runs an extensive HIV/AIDS workplace program that offers comprehensive health services to its employees. This program is more successful than most other HIV/AIDS workplace programs in the country. The firm managed to drastically reduce absenteeism and losses. According to the project manager and local NGOs, one reason for the program's success is that the firm has realized that the acceptance of the program in the local communities where its employees live is key for its efficacy. When the firm started the program, very few employees were willing to enroll in it, which limited the program's effectiveness. It was then that the HIV/AIDS program manager recognized the extent to which the firm's health activities clashed with local community norms and power structures. In particular, local healers in the townships conceived of the company program as a potential threat to their own authority, power and economic wellbeing in the township economy and society. Most employees, however, routinely consulted these local healers. The advice they received from the healers at the beginning of the roll-out of the program seemed to have discouraged them from enrollment. To change this, the manager of the firm's HIV/AIDS program invited the local healers to the headquarters of the company to coordinate the firm's

52 For the following, see Bray, Z & Thauer, C, "Utopian Spaces, Dystopian Places?: A Local Community-Based Perspective on Corporate Social Responsibility" (2016), 11 *Nature and Culture*, 278.

53 See for the following Thauer, C R, "In Need of Meta-Governance: Business Networks of Transnational Governance" (2015), 48 *Israel Law Review*, 189.

program, which is based on Western medicine, with the advice traditional healers give to employees and their families. She offered the healers a deal: She would in the future routinely refer employees to them for nutrition and general healthy lifestyle advice. This offer signaled acknowledgment of and respect for the social status and work of healers, and guaranteed that they would not lose business. In return, she asked the healers to encourage employees to enroll in the company program for medical advice, and to refrain from a lifestyle that could undermine or clash with the medical treatment the firm provides. Through this strategy she managed to secure the buy-in of most traditional healers in the company program, so that they today recommend that employees enroll in the program, which makes the firm's fight against the disease so successful. The example shows that GHG confronts norm conflicts, potentially even with the designated beneficiaries of governance. These conflicts can be managed, although they may not always result in conflict resolution. The traditional healers still have a different approach to medicine than the occupational health manager and factory doctor of BMW. Rather, what was achieved was coordination on the basis of acceptance of these differences. There is no guarantee that this can always be achieved. However, the case shows that GHG is in practice, on account of the numerous conflicts it runs into, bound to engage in a management of these conflicts – thus in the governance of governance ("meta-governance"[54]).

When firms take over governance functions, however, norm and power conflicts may not only emerge in relation to local communities, but also with the local, provincial or national government.[55] Two cases illustrate such conflicts. One is the mentioned case of Mercedes Benz in East London; the other is a multinational car firm in Durban. The cases illustrate different intensities of conflict of the firms' governance activities. As concerns the Durban-based case, a large Japanese multinational car manufacturer attempted to organize a collective response to the HIV/AIDS pandemic between 2001 and early 2003 – similar to the one of Mercedes later on.[56] The firm's business model is, as in the case of Mercedes and BMW, based on skills that are not easily available in the labor market. The firm thus offers

54 Ibid.

55 On the interaction between firms and governments see a recent special issue on "Corporate Social Responsibility, Multinational Corporations, and Nation States" (2012), 14 *Business and Politics*, edited by Prakash, A & Griffin, J.

56 See for details Hönke & Thauer, "Multinational Corporations and Service Provision", above Fn. 28.

training programs to employees. At the time of the governance network, however, HIV/AIDS prevention and treatment was faced not only with capacity problems on the side of the state; the attempt by the Japanese multinational was also resisted by leading figures of the early Mbeki government, who was in power during that time and opposed the so-called "international scientific consensus" on HIV/AIDS.[57] This consensus refers to the fact that HIV causes AIDS and that medical treatment prolongs the time span between the infection with HIV and the outbreak of AIDS. The South African government publicly denied the relation between HIV and AIDS, and was openly hostile toward any medical approach to the disease.[58] A key figure in the government's denial of the international scientific consensus was the health minister, Ms. *Manto Tshabalala-Msimang* who proposed garlic, lemon juice, and beetroot as AIDS remedies. President *Mbeki* himself also attacked anyone in South Africa who questioned his "denialist" position. In this context of "denialism" the Japanese multinational initiated a multi-stakeholder partnership for HIV/AIDS prevention and comprehensive treatment. Partners were the local municipality, the University of KwaZulu Natal and the local chamber of commerce. The partners successfully applied for funding with the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria in 2002. The project was to be rolled out throughout the local business world and from there on to the local community in 2004, and would have provided full medical services in relation to HIV/AIDS, including antiretroviral treatment. The project was based on the norms for public health programs in relation to HIV/AIDS of the WHO and the Global Fund itself. It was therefore inevitably in conflict with the position held by the Mbeki government. When the central government realized that Durban would start the project, at the last minute it insisted on taking full control over the budget and the content of the program before the money was released by the Global Fund. As a result, the MNC and its partners withdrew, for fear of becoming involved in a project dominated by the Mbeki government, and of consequently being held accountable for the foreseeable misuse of Global Fund money. Thus this transnational governance network ran into norm and power conflicts with the national government of South Africa, which made the project and the entire network fail. In the end, no governance services

57 Nattrass, *The AIDS Conspiracy*, above Fn. 34.

58 Dugger, C W, "Study cites toll of AIDS policy in South Africa" (November 26, 2008), *New York Times*, available at http://nyti.ms/2mhR368; Robbie, J, "Don't call me Manto" (September 14, 2000), *BBC*, available at http://news.bbc.co.uk/2/hi/africa/924889.stm.

were provided. Hence, in view of this case, it seems that a clash of norms between the car firm's governance initiative and the government rendered service delivery unsuccessful.

The second case – Mercedes in East London – was however successful. How so? By 2004, the South African government had come under international and domestic pressure for its ignorance toward the disease and its failure to fight it effectively.[59] In particular, the civil society pressure group Treatment Action Campaign (TAC) organized broad public resistance against the Mbeki government's policy. The TAC and increasing international isolation forced *Mbeki* into an agreement imposed on him by his own party, according to which he had to abstain from any public debate on HIV/AIDS. The TAC also pressured the cabinet to draft a new government program, which resulted in the "Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa". In addition, the Constitutional Court ruled that the government had to provide antiretroviral drugs to prevent the infection of newborns. The ruling established the international scientific consensus toward the disease as the only acceptable one in South Africa. So, when U.S. President *Clinton* offered a team of experts to help the country put together a national treatment plan, *Thabo Mbeki* agreed, and a team was sent in 2004 to implement the Operational Plan.[60]

From this time on, the South African government accepted, and even supported, international help to fight HIV/AIDS. The second case of Mercedes Benz in East London reflects this new context. Mercedes' multistakeholder initiative made the strategic decision to also include the National Ministry of Health, so as to assure the buy-in of the national government. The initiative was successful in that it did organize health service delivery in East London. When compared to the previous case, the precondition for this effective rollout was that the South African government had moved from "denialism" to a position closer to the international "scientific consensus", on which Mercedes' program was built – and that Mercedes made a conscious decision to actively involve the national government from the very start of the project. The two cases illustrate the importance of aspects of legitimacy for the success of GHG.

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59 Dickinson, D, "Fronts or front-lines? HIV/AIDS and big business in South Africa" (2004), 55 *Transformation: Critical Perspectives on Southern Africa*, 28.

60 Nattrass, *The AIDS Conspiracy*, above Fn. 34.

IV Conclusion: Implications for the Governance of Infectious Diseases

This article argued to move from International (IHG) to Global Health Governance (GHG) – more specifically, to move to a governance concept that includes private actors and actor networks in infectious disease outbreak response planning and management. Conditions of limited statehood and their relevance for the governance of health risks make this a necessity: township and slum conditions, for example, combine poverty, lack of sanitation and access to basic infrastructure and public services with high population density and physical closeness of human-animal relations – which increase the likelihood of infectious disease outbreaks. In these high-risk areas the state is often incapable of policy planning and implementation. Health governance should thus be conceptualized and planned beyond the state so as to be able to contain and manage a disease outbreak under such conditions. While it is yet unclear how this could and should be done precisely, the article showed that there are already empirical precedents of GHG that could helpfully inform future more systematic thinking about the legal and administrative planning of infectious diseases beyond the state – how it can and should be organized.

The article showed in this respect that in contexts of limited statehood it is often private actors that fill the policy-void. The article demonstrated this by looking at firms as governance providers in areas of limited statehood. Firms are unlikely private actors to provide governance, given their profit-seeking nature. Still, in South Africa, they have made significant contributions to the governance of HIV/AIDS. The case of HIV/AIDS governance in South Africa is particularly indicative for the potential of new modes of health governance. The governance of the disease is a highly complex task; South Africa has for a long time had a government that was openly hostile to any attempt to fight it medically. Irrespective of these generally adverse conditions, new, alternative modes of GHG involving firms emerged in order to fight the disease. More specifically, the article reported that firms, which have invested heavily in specific skills of employees, emerge as health governors in the face of the HIV/AIDS epidemic. Such firms offer sophisticated health care services to their workforces and families inside the firm, thereby contributing to public health as a public good. What is more, they also act as primary coordinators in their localities by organizing collective action against the disease beyond their own workforce. Firms such as Mercedes, BMW and others have tried to organize such a collective response in their respective localities.

As in any attempt at GHG, governance by firms is not always or automatically effective. In some cases the designated beneficiaries of firms' health governance – employees who have contracted HIV/AIDS – were unwilling to enroll in their health programs. In other instances, the South African government undermined the efforts of firms to take on central coordination functions in the fight against HIV/AIDS. The article also reported examples in which firms experiment with meta-governance mechanisms to deal with, manage and overcome these norm and power conflicts they confronted in their attempt to provide governance services. At times, these meta-governance mechanisms were capable of improving the effectiveness of GHG.

The call to move from IHG to new modes of GHG is thus not to imply that all problems of effective health governance could easily be resolved. In this respect, it is important to recall that, as the article explained, nothing beats fully consolidated statehood in terms of public goods provision. Service provision by business is also not entirely unproblematic. New modes of GHG involving firms, for example, are unlikely to be as inclusive as GHG via fully functioning statehood. Firm activities' inclusiveness is from the outset limited. In South Africa, firms' governance programs are, for example, not necessarily located where they would be needed the most – such as where infection rates or poverty are highest and public services and the general infrastructure are at their lowest – but simply where the firms are located. But since fully functioning statehood is not available in most parts of the world, including in those parts where new infectious diseases are likely to emerge in the future, such as under township and slum conditions, new modes of governance including private actors is all GHG will be able to draw on in the event of infectious disease outbreaks. The article showed that GHG is principally possible under such conditions even when the governance of an infectious disease requires a highly complex set of governance interventions. More case studies and analyses beyond the HIV/AIDS case in South Africa are needed to arrive at a more generalizable, yet more fine-tuned understanding of GHG in areas of limited statehood. This means, however, from a normative-legal perspective, that GHG may need to rethink international law in order to account for the fact that under conditions of limited statehood, private actors may fulfill public functions and roles.[61]

61 Clarke, L, *Public-Private Partnerships and Responsibility Under International Law: A Global Health Perspective*, 2014.