

Coordinating U.S. Global Health Policy

By

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ABSTRACT

The United States (U.S.) has a longstanding history of providing foreign assistance and public health for varying political, economic, and humanitarian reasons. Each set of imperatives has led to its own individual intervention strategies reflecting the discreet goals of its own agenda. These interventions have resulted in parallel delivery systems whose distinct and independent operations have certainly provided some therapeutic and supportive services while they have also neglected other basic needs important to the overall health of recipient populations. The Obama Administration's Global Health Initiative (GHI) builds upon the previous successes of global health strategies but takes a more comprehensive approach by establishing a representative leadership group tasked with aligning all governmental global health activities with federal policy objectives by consolidating the various departmental, agency, and initiative processes. My research question asks why such a leadership group was not established earlier, and the purpose of this study is to determine whether by avoiding doing so, political leaders enjoyed greater freedom to pursue individual agendas and were able more flexibly to respond to emerging global health needs. My data are from my examination of publicly available documents, interviews of elite stakeholders, and a systematic review of previous interagency committees. I analyzed these data using a theoretical framework drawing from advocacy coalitions and institutional veto points. I conclude that, while executive and legislative decision makers may have greater policymaking latitude in the absence of a coordinating interagency committee, it is unlikely that these freedoms are responsible for delaying the establishment of a body like the GHI leadership.

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INTRODUCTION

The US has a longstanding historical precedent of global health policy with roots in both foreign assistance and public health. As our understanding of health determinants has developed and new health challenges have arose, American global health policy has adapted to address these issues. However, federal programs are not the only interventions at work; as public awareness of global health issues increases, so does the number and variety of participating organizations, and today's complex topography of aid organizations consists of non-profit, non-governmental, private, public, bilateral, multilateral, and international actors. Even within federal programs resides a diverse group of agencies and institutes with discreet agendas, priorities, and duties that may or may not overlap, coordinate with, or operate independently of each other. While each of these activities may accomplish some or all of their aims, the diversity has resulted in a lack of integration across programs and areas, overlapping bureaucracies, conflicts over responsibilities, and confusion among aid recipients. The relatively narrow and focused initiatives that largely represent the recent growth in U.S. global health assistance have also resulted in aid distribution profiles that reflect politically appealing subjects instead of recipient countries' needs (Atwood 2008).

In 1997 the Institute of Medicine (IOM) published a report advocating for a continued and expanded U.S. role in global health, and among its recommendations was to develop a more coherent national strategy for US involvement in global health. The report acknowledged that the American role in global health is too complex to be contained by any one agency, since the determinants of health include economic, political, and environmental variables (Figure 1), but it argued for establishing an inter-agency task force to develop and coordinate a coherent, effective approach. It specifically suggested this task force be developed under the Department of Health

and Human Services (DHHS), but regardless of the particulars, the general expectation was that this task force would be responsible for coordinating a global health strategy, setting priorities across participating agencies, and acting as a liaison to other, non-federal actors (IOM 1997, 62).

During the subsequent Bush Administration the government's overall foreign assistance institutional architecture was changed in 2006 by determining allocations to the U.S. Agency for International Development's (USAID) through a Department of State budget process and creating an administrative role with two responsibilities, director of foreign assistance at the Department of State and head of USAID (Atwood 2008). Although these changes had implications for global health activities, they were performed with the goal of elevating development assistance to the status of the other foreign relations strategies, defense and diplomacy, and other major contributors to global health activities outside of these two departments were not formally incorporated into this process. In addition, not only was the integration of global health activities a peripheral aspect of these changes, but according to an evaluation by the Government Accountability Office (GAO) three years later, these changes still faced significant organizational, leadership, and coordination challenges to achieving foreign assistance reform (GAO 2009).

Eleven years after its initial report the IOM again assessed the status of U.S. global health policy, and during the interim period much progress had been made in developing a more robust commitment to global health. On the international stage, the Member States of the United Nations had adopted the Millennium Development Goals (MDGs) to reduce poverty and improve health outcomes, which helped rekindle international investments in global health. The U.S. increased its investment in most areas of global health, especially for HIV; the President's Emergency Plan for AIDS Relief (PEPFAR) still represents the largest commitment ever by any

nation dedicated to a single disease and tripled the number of HIV-infected people receiving antiretroviral treatment sub-Saharan Africa. In the private sector, the Bill & Melinda Gates Foundation, now the world's largest charitable organization, has donated \$3 billion to global health (IOM 2009).

Despite these advances in global health policy, the IOM still found a lack of oversight and coordination among the blooming global health activities sponsored by the federal government. During the development of its report the IOM was unable effectively to assess the total U.S. commitment to global health and the extent to which its programs had improved global health because a system to coordinate and quantify the efforts of more than twenty US agencies engaged in international aid was not in place. Tracking the funding produced only limited information, and this could not be extended to assess progress or determine whether results justified investments. In addition to recommending building upon existing programs and emphasizing new health priorities, the IOM again advised establishing an interagency committee to formalize the cooperation and coordination between agencies, but this time it proposed locating the group in much closer proximity to the White House (IOM 2009).

While the IOM was finalizing its report, as if on cue President Barack Obama released a statement announcing a new Global Health Initiative for U.S. global health policy, which promised “a more integrated approach to fighting diseases, improving health, and strengthening health systems” (Office of the Press Secretary and White House 2009, paragraph 5). As more specific details emerged, one of the dominating themes became a comprehensive, whole-of-government approach to global health, one that formally established an interagency operations committee, a strategic council composed of representatives of key governmental participants in global health, and an executive director to coordinate goal achievement (U.S. Global Health

Initiative and U.S. State Department). Whether this strategy is effective remains to be seen, but its adoption finally represents an acknowledgement of the need for improved coordination and planning in order to meet the health needs of global populations receiving aid from a myriad of sources.

But why was this strategy not adopted earlier? What stimulated it to be implemented now? Although significant logistical issues may impede the development of a coordinating inter-agency group, the prevailing impetus for maintaining the status quo may have been the flexibility and freedom it allowed political leaders to pursue individual global health agendas and adapt to the most salient issues of their times without having to hew to a single overarching policy framework. My intent is to explore whether this seemed to be the case in global health by analyzing data from three sources using a combination of two different theoretical policy frameworks, that of advocacy coalitions (Sabatier 1988) and veto points (Immergut 1990). Both frameworks have appealing qualities as sources of explanation for the GHI leadership, whose representation involves multiple constituencies and function has a decision-making role, and they are outlined below.

The implementation of the GHI's policy goals is being led by an executive director positioned within the Department of State and an operations committee consisting of the USAID Administrator, the Director of the CDC, and the U.S. Global AIDS Coordinator. The "whole-of-government" approach is being addressed by the formation of a strategic council of representatives from a broader set of agencies with expertise in global health, including the DHHS, the National Institutes of Health (NIH), the Millennium Challenge Corporation (MCC), and others. For simplicity I will refer collectively to these overseeing groups as the GHI leadership, and the framework of GHI leadership is a structural change in the international health

policy making process, one that affects the decision making abilities of the political system in this arena.

Historically decision making associated with global health policy was negotiated in the executive and legislative arenas, whose powers permitted a great deal of influence over the extent and priorities of global health activities. With the creation of a leadership group that formally oversees the collective activities of each contributing participant, the decision making arena may shift to a group of stakeholder representatives functioning within a more structured framework. While the executive and legislative arenas may continue to have some influence in determining which global health domains are addressed, I believe that in achieving its objective to coordinate all global health activities the presence of the GHI leadership will temper these external priorities and redistribute them to maintain a more balanced aid profile. This may introduce the potential for policy developed in the executive and legislative arenas to be modified or overridden by the GHI leadership, not by outright denial but through implementation.

This structural change and the diversity of actors involved lend themselves to interpretation by the advocacy coalition framework (ACF; first propounded by Sabatier in 1988). Governmental departments, agencies, private organizations, non-governmental organizations, and bilateral and multilateral agreements all comprise the policy subsystems in global health. The formation of an interagency task force is an environmental change within which the policy subsystems operate, and although its introduction occurred quite rapidly, its institutional nature categorizes the task force as a stable condition within the ACF.

An interesting extension of the ACF is how this structural change will affect the advocacy coalitions within the policy subsystem and their interactions with each other. Ideally, the inter-agency task force would provide the opportunity for all the dimensions of global health to be explicitly represented for the purpose of developing a more cohesive national strategy. This shift in relative attention among the various advocacy coalitions may have important repercussions in their alliances and formation as previously underrepresented actors gain new attention and more prominent actors cede some of their influence. The status of policy brokers may change as well, as new agents find themselves negotiating between new coalitions and develop different lines of communication.

Advocacy coalition framework

Many models have been formulated to explain the policy process. Dissatisfaction with the constraints of an institutionally driven stages model, which depicts a linear progression through issue emergence, agenda setting, implementation, evaluation, and feedback, led to the development of more comprehensive and, especially, more complex models of policy development. Among these are John Kingdon's streams metaphor and Frank Baumgartner's and Bryan Jones's punctuated equilibrium, and while each model has its merits, no singular model is so universally applicable that it best explains every policy making situation (Birkland 2001). I find Paul Sabatier's advocacy coalition framework (ACF) can be used to map the political actors, public opinion, and environmental conditions that influenced the development of the Global Health Initiative.

The ACF operates under three basic premises: prolonged timeframe, policy subsystems, and the realization of values. Sabatier argues that a wider temporal perspective is needed to

understand the process of policy change, because evaluating timespans in units of decades (rather than years) allows enough time for the full effects of a completed policy process cycle to be seen. He also introduces the notion of policy subsystems, which broadens the scope of potential political actors to include not only administrative agencies, legislative committees, and interest groups, but also journalists, researchers, and analysts. The premise of realization of values stems from Sabatier's likening of the public policy process to belief systems, such that policies incorporate values and worldviews that implicitly influence their development and achievement (Sabatier 1988, 129).

Within the policy subsystem premise, Sabatier organizes political actors into larger coalitions that align overarching individual participants' values to address particular policies. Sabatier refers to groups who share a particular belief system as advocacy coalitions. The advocacy coalition concept is advantageous because it simplifies the process of tracking the changing relationships of individual actors and accounts for political actors previously overlooked by institutional models. Because they are based upon shared value systems, advocacy coalitions tend to be relatively stable over time, and only a few coalitions typically exist for a given policy. Also within the policy subsystem are those who facilitate negotiations between advocacy coalitions, agents Sabatier terms policy brokers (Sabatier 1988, 129). Using informal communication, formal coalitions, and political parties, brokers mediate compromises between advocacy coalitions that ultimately lead to policy decisions (Heaney 2006, 887-944).

In addition, Sabatier acknowledges the importance of the environmental conditions within which the activities of policy subsystems take place. These conditions may be categorized as either relatively static or dynamic parameters. Stable conditions are those that are not easily altered, may set the limits on feasible policy changes, or affect the resources or beliefs of policy

subsystem participants. For example, fundamental cultural values, natural resources, and legal structures may all be considered static environmental parameters. Dynamic conditions may vary within a much shorter time span and swiftly affect policy change, such as socioeconomic conditions and policy decisions exogenous to the given system. Both static and dynamic parameters establish the setting and outline the resources available for the interactions between and among policy subsystems (Sabatier 1988, 129) (Figure 2).

Institutions, veto points, and policy results

As I conceptualize the emergence of the GHI leadership, though, I find the advocacy coalition framework does not adequately address the magnitude of the structural change to global health policy it represents, and the subsequent influence this change in institutional structure is likely to have on the behavior of its participants and the policy they make. These concepts derive from Ellen Immergut's analysis of why the establishment of national health insurance took different forms in various western European nations despite the common presence of strong professional opposition from physician advocacy groups. She uses the national health insurance models of France, Sweden, and Switzerland to demonstrate how their differing political systems dictated the vetoing behavior of opposing physicians, the successes and limitations of this behavior, and the policy results of the conditions surrounding these different "veto points" (Immergut 1990, 391-416).

In her analysis she points out that national political institutions are designed to discourage "extreme factions from introducing radical policy changes" (Immergut 1990, 395). For example, the U.S. government is divided into three branches each of which has the ability to check the others' power in order to maintain a balance. Furthermore the legislative branch, which is

primarily responsible for introducing new policy, is divided into two chambers with an upper house that can “exert a moderating influence by vetoing proposals from the lower house” (Immergut 1990, 395), and, finally, within each house is a bipartisan distribution of representatives. The result is a stable political institution that is resistant to change through various formal and informal institutional mechanisms containing certain “veto points” where political decisions require agreement. The number and location of opportunities for these veto points may vary depending upon the particular political institution, but within any given institution they remain stable (Figure 3).

Using Immergut’s examples, when Sweden’s Social Democratic executive introduced legislation for national health insurance, he enjoyed electoral majorities in both legislative chambers, and since executive decisions were unlikely to be vetoed, decision making authority was retained by the executive with little potential for outside influence by dissenting physician interest groups. Meanwhile in France the executive government did not have a stable electoral majority, which allowed legislative representatives greater opportunity to modify or override executive decisions, and made the legislative arena a critical decision point in which interest groups could participate. The political institution in Switzerland allows referendum campaigns to form in opposition to policy decisions agreed upon by both the executive and legislative branches, providing an opportunity for opposing interest groups to bring the issue into the electoral arena (Immergut 1990, 391-416).

Thus for Immergut, formal constitutional rules create a framework for policy making, and each political institution’s veto points are distinct within that institution. The behavior of the participants in policy making may be predicted by the number and location of these veto points, because the actors have learned when and at which points they have the most influence. Interest

group power is therefore not merely a function of its membership or resources, and political institutions are not randomly under the whimsical influence of interest groups. Because veto opportunities may explain both interest group influence and the effects of institutions on policy results, no singular interest group is successful at imposing its influence because of any inherent qualities; rather all interest groups may be expected to behave similarly. Most attempt to shift the arena of decision making to one with a political distribution in their favor, resulting in predictable behavior (Immergut 1990, 391-416).

METHODS

My analysis is based upon data collected from three different sources: bills that became public law, legislative hearing and committee records, and elite stakeholder interviews. In order to analyze the contributions and perspectives of the participants involved in U.S. global health policy, I traced the development of several pieces of legislation that were successfully enrolled by Congress within the time window spanning the two IOM reports, from 1997 to 2008. I chose to focus solely on legislation that was enacted because it allows a more structured analysis, comparing particular policy pieces' intentions and their outcomes, and I limited the time window in an attempt to characterize the more recent developments in U.S. global health policy with potential relevance to the IOM's recognition of a more coordinated national approach. With these parameters in mind I searched the Library of Congress's records using its THOMAS search engine (<http://thomas.loc.gov/home/thomas.php>) for bills from both the House and Senate containing the term "global health" across the 105th-110th Congresses, which covered the years 1997-2008, and I restricted the search to include only bills enrolled and sent to the President .

I then reviewed all bills containing exact matches using this search strategy to confirm their relevance to global health, after which I examined relevant bills for documentation of their development. Most enrolled bills contain congressional reports from either chamber that document general characteristics of the bill, such as the purpose of the legislation, background and need, a summary of the bill, a Congressional Budget Office estimate of the cost of implementing the policies mandated by the bill, considerations of the congressional committee to which the bill was referred, and any hearings that occurred. Since my goal was to gather evidence of the use of executive authority in lieu of a more coordinated approach, I was most interested in any discussion surrounding the development of each bill and focused on finding their associated hearings. According to the U.S. Government Printing Office (GPO),

A hearing is a meeting or session of a Senate, House, joint, or special committee of Congress, usually open to the public, to obtain information and opinions on proposed legislation, conduct an investigation, or evaluate/oversee the activities of a government department or the implementation of a Federal law. In addition, hearings may also be purely exploratory in nature, providing testimony and data about topics of current interest (GPO, paragraph 1).

The GPO's Federal Digital System (FDsys) is a free, online database that provides access to official federal government publications and contains select House and Senate hearings for the 104th Congress forward, but since the dissemination of a hearing onto this database is up to the discretion of its committee, not all hearings are available. Therefore, for bills for which hearings are unavailable via the GPO FDsys, I used their congressional records as primary sources, which are the official records of the proceedings and debates surrounding a bill and are also available through THOMAS.

These two sources of documentation, hearings and congressional records, likely would provide evidence of the exercise of executive authority and also its repercussions, to a certain extent, but they were unlikely to sufficiently address the specific issue of introducing a new coordinating body into the American policymaking system. To address this larger question, I also performed in-depth interviews of elite stakeholders involved with U.S. global health policy. I identified potential respondents through background reading and preparatory work for this study, and they included members of the 1997 IOM Board of International Health; the 2008 IOM Board of Global Health; GHI Operations Committee on Global Health; GHI Operations Committee members and deputies; 105th Congress's House Committee on Appropriations and Senate Subcommittee on the Department of State, Foreign Operations, and Related Programs; and 111th Congress's House Subcommittee on State, Foreign Operations, and Related Programs and Senate Subcommittee on the Department of State, Foreign Operations, and Related Programs.

I coded the hearings, congressional records, and interview transcripts for the actors who influenced U.S. global health policy priorities, the barriers they faced when enacting their priorities, methods used to navigate those barriers, the coalitions involved in policy making, the balance between pursuing political agendas and responding to emerging global health needs, accountability, and the awareness and effects of path dependence. In addition the elite stakeholder interview transcripts were also coded for how the introduction of a coordinating body like the GHI's operations committee and strategic council might alter each of these constructs. These constructs were conceptualized under the hypothesis that the status quo of operating without a coordinating global health policy making body allowed greater flexibility in the pursuit of individual political agendas and responding to emerging health needs, and I felt

these elements best characterized a framework for how such a body would alter the policy making process. Summaries of the coding schema for each data source are provided in the appendices.

As a causal process tracing, the evidence gathered in this way was not analyzed in the traditional sense of regressions because the data were not considered to be “data-set observations” (Mahoney 2010, 124). As described by the sentinel work of King, Keohane, and Verba, causal process tracing attempts to overcome the limitations associated with small-N qualitative studies, such as those utilizing elite interviews, by expanding the observations of the intervening causal steps in a pathway. However, this viewpoint usually leads to a degenerative process, because an infinite number of steps may be identified, and makes determining which of the mechanisms are truly linked to the exposure and outcome difficult. Instead, my process tracing utilizes “causal process observations” (Mahoney 2010, 124), which provide information about a context, process, or mechanism, and represent in-depth knowledge of particular cases and are distinct from data-set observations. These causal process observations allow an analysis of seemingly non-comparable observations, which, although they would not be suited for a standardized data set, can still be useful for causal inference because they focus on “sequential processes within a particular historical case, not on correlations of data across cases” (Mahoney 2010, 125).

RESULTS

The original search in THOMAS for enrolled bills in the time window yielded eight bills, only three of which were confirmed primarily to involve global health issues, House Resolution (H.R.) 1298, H.R 5501, and H.R. 2764. H.R. 1298 is titled the U.S. Leadership Against

HIV/AIDS, Tuberculosis, and Malaria Act of 2003; H.R. 5501 is the Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008; and H.R. 2764 is the Consolidated Appropriations Act, 2008. Both H.R. 5501 and H.R. 2764 had congressional hearings associated with them, but only the hearing associated with H.R. 2764 is available through the GPO; H.R. 1298 did not have any hearings, but I located and coded congressional records for H.R. 1298 and H.R. 5501.

Of the original eighteen potential interview respondents whom I actively recruited, only three were able to be interviewed within the necessary timeframe of this study, and all three were participants in either the 1997 or 2008 IOM committees. Although each of these respondents had intimate knowledge of U.S. global health policy in general, the lack of insights from participants who hold government positions severely limited the information gleaned on how the GHI and its leadership altered the constructs I was investigating. Those who did allow me to interview them are Thomas Pickering, Harvey Fineberg, and Harold Varmus. Thomas Pickering has an extensive diplomatic career in foreign relations serving as a U.S. ambassador as well as being a former Under-Secretary of State for Political Affairs in the Department of State, and currently he is the vice-chairman of an international consulting group. Both he and Harold Varmus served as co-chairs on the 2009 IOM Committee on the U.S. Commitment to Global Health, which produced two reports on the U.S. involvement in global health. Dr. Varmus is a Nobel-prize winner who has served in several prestigious leadership positions, including the Director of the National Institutes of Health and as the current Director of the National Cancer Institute. After an extended tenure as Dean of the Harvard School of Public Health and also as a consultant to the World Health Organization, Dr. Harvey Fineberg is currently the President of the IOM.

The first construct I investigated was the delegation of power that a coordinating body imposes upon its superiors, and the relevant variables I identified were the most influential actors involved in prioritizing U.S. global health policy decisions, the barriers actors faced when enacting priorities, and the methods available to navigate those barriers. The actors identified by respondents included the President and Presidential Administration, Congress, senior staff of executive departments and agencies like the Department of State, U.S. Agency for International Development (USAID), and major philanthropies like the Gates and Bloomberg Foundations. By far the most commonly referenced actors identified in the hearings and congressional records were the President, the Administration, and certain Members of Congress, as exemplified by this language:

And from my recent conversations with the President, I know that he has worked very hard on this reauthorization, and it is with the support of the White House and the staff, they helped us craft this bipartisan legislation” (Payne 2008, column 1, paragraph 5).

The influence of the President was a sentiment echoed by the respondents as well: “Well, I mean I think certainly the President had to make the final decision” (Pickering interview, 2011, line 97). It is not, of course, surprising that any given president would be a principal actor in any foreign policy arena.

Most of the discussion involving barriers revolved around funding: how much to authorize, when to authorize it, and to whom or which area to appropriate it. Two interview respondents also indicated that competing priorities presented a barrier, such as conflicting morals or health opinions, but discussion within the congressional records referred to

institutional barriers like coordinating bill progression with congressional sessions and the bicameral and bipartisan structure of Congress:

The House of Representatives had ample opportunity to act on this bill before Congress adjourned last November, but it failed to even take it up. Nor was the House interested in conferencing the full bill. The administration provided no impetus, no leadership, and no effort in order to try to get the House to do so (Kerry 2003, column 3, paragraph 5).

Corresponding to the emphasis on funding as a barrier, much of the navigation methods were related to providing money to support programs. Two respondents suggested that positional authority allowed enough freedom to overcome barriers like funding or opposing priorities, either in the form of the President, who “is not a lower-level functionary, he’s the President, and people tend to listen to what the President asks for” (Varmus interview, 2011, line 121), or as an organizing task force “at sufficiently high level to make departmental decisions” (Pickering interview, 2011, line 122). Other avenues identified in the hearing and congressional records were compromising on priorities, “The President [Bush] himself has seen the wisdom of this approach [abstain, be faithful, and use condoms instead of emphasizing abstinence to address HIV] and supports it” (Christensen 2003, column 3, paragraph 6), and devoting multiple appropriations bills to a single cause,

In order to provide adequate financial and human resources to complete the goals of PEPFAR as well as maintain U.S. leadership in the Global Fund, the President has spread the request for HIV/AIDS-related resources across the two appropriations bills (Foreign Operations and Labor-Health and Human Services) (U.S. Senate 2008, page 193, paragraph 6).

The second construct I explored was the reconciliation of attitudes that a coordinating body might engender, and the variables I identified were the inputs influencing policy makers priorities, which I divided into either political agendas or responding to emerging global health needs, and how any coalitions involved affected policy choices. Interview respondents' views on the balance between the contributions of political agendas and emerging health needs on policy choices were equivocal; while they did not favor either category, they did acknowledge the importance of both to policy choices:

I think that most of these issues one way or another are a blend of both realities that come up, some of them new and some of them continuing, and the advocates for the treatment for dealing with those problems, and it's very difficult to say which may be higher or lower (Pickering interview, 2011, line 172).

The testimonies of hearing witnesses and debates in the congressional records strongly favor the pursuit of political agendas. While an emerging health need like the rising incidence and prevalence of HIV/AIDS worldwide prompted the pursuit of a global HIV/AIDS policy, the choices made in shaping the policy and subsequent policies were influenced by political agendas rather than a needs reassessment. Comments ranged in the degree of conviction but generally fell between "Nearly all programs are heavily earmarked, with little or no monies designated for general health threats or health systems management and support" (U.S. Senate 2008, page 64, paragraph 6) and "My own view is that the less Congress injects itself into matters of global health the better, because the result is too often that politics and ideology take precedence over what is in the best interest of public health in a particular country" (Leahy 2008, column 2, paragraph 6).

Important coalitions identified by respondents included advocates for HIV/AIDS, maternal health, and the growing influence of philanthropies, and coalition references in the congressional records were sparse, but referenced unspecified advocacy groups, non-governmental organizations, and faith-based groups. The Congressional Black Caucus was also referenced as a significant influence to President Bush's resumption of a global HIV/AIDS policy after the 107th Congress failed to pass a bill on it before its term ended in 2002. None of the respondents were able to comment on how the GHI or its leadership organization might change the relationship advocacy coalitions have with the policy making process.

The final construct I examined was accountability and how an organizing body might alter the feedback and repercussions U.S. global health policy results have on its decision makers. The variables I identified included whether policy makers feel accountable, who is best at holding them accountable, whether policy makers are cognizant of path dependence in policy making, and how path dependence affects policy makers' choices. For the purposes of this study path dependence refers to the concept that past policy decisions influence the context in which future decisions are made. Respondents had conflicting views on whether policy makers feel accountable. Thomas Pickering noted that "a lot of government policy making lacks a very significant structure for accountability, the use of metrics to determine the effects of results and the way in which inputs are handled" (line 202), but he and Harold Varmus both said that elected officials ultimately feel accountable to the electorate. In the congressional documents, Senator Leahy (D-VT) also questions the sense of responsibility within USAID when he notes:

For example, in Nigeria, you said you want to help them strengthen their institutions and make progress permanent ... But if you take out AIDS you only propose an additional \$20 million for Nigeria, a country of 125 million people. You cut aid to the Ukraine by

\$16 million, I believe. Georgia by \$21 million. How does this show us strengthening their institutions? (U.S. Senate 2008, page 11, paragraph 1)

Each of the respondents said that policy makers were aware of path dependence but with a few caveats; two noted that despite policy makers having an appreciation for what decisions had been made in the past, this does not preclude certain individuals with sufficient authority from striking out in new directions and pursuing new approaches. Policy makers themselves demonstrated an appreciation for path dependence, e.g. Senator Gregg (R-NH): “When it comes to foreign aid reform, what is past is prologue” (U.S. Senate 2008, page 3, paragraph 3). Perhaps more subtly, policy makers and others both frequently alluded to path dependence when referencing the need to amend previously enrolled bills to be expanded and address new issues, but always within the context of the initial bill’s framework. For example, when addressing the need to increase USAID’s maternal and child health, nutrition, and public health programs, USAID Assistant Administrator Hill admits,

But the way it tends to get done is that it is a component within a project that might be HIV or malaria or tuberculosis or contraceptive health or whatever it is, and any good program is going to have a component to it that specifically deals with this issue (U.S. Senate 2008, page 81, paragraph 8).

DISCUSSION: WILL THE GHI CHANGE THE DYNAMICS OF POLICY MAKING?

Although not unexpected, one of the most revealing insights of this analysis is the degree to which the President, the Presidential Administration, and Congress have an influence over the direction U.S. global health policy takes. As actors in the prioritization process those delegated with the responsibility of carrying out government policy, such as the senior staff of

governmental departments and agencies that now comprise the GHI leadership, have historically had little more influence in directing policy than in an advisory role to both the Administration and Congress. Their roles seem to have been more administrative than policy-generating in the past than I had expected, which diminishes my expectations for their future influence acting as a GHI leadership council in its present form. Since much of the initiative for major new policy directions originates above the level of the GHI leadership, it may be best suited for distributing the resources it is allocated, rather than playing a creative role in redesigning the larger policy context within which those resources are meant to effect policy goals. Therefore the introduction of the GHI leadership has not resulted in a significant delegation of power. In Immergut's language the decision making process involving policy prioritization appears to have remained in the executive and legislative arenas, but this process does not occur in a linear fashion. As Harvey Fineberg suggested when it comes to global health:

What we actually have is not the product of a strategic assessment followed by prioritization followed by action as much as an aggregation and accumulation over time of choices made in the face of priorities and understandings at a given moment (line 176).

Whether the distribution of allocated resources occurs in a more comprehensive fashion than it did prior to the inception of the GHI is a matter of path dependence. Even if a GHI leadership board exists, its authority is intricately constrained by the primary barriers facing U.S. global health policy making: funding and differing priorities. The amount of funding devoted to U.S. global health policy, as is true of all policy, is largely determined by a negotiation between the President's annual budget request and what Congress is willing to appropriate, although global health policy is more vulnerable than policies in other domains in that it does not obviously attract the kinds of powerful, broad, and durable advocacy coalitions from which

many domestic policies benefit. Within the advocacy coalition framework the feedback a policy subsystem receives from the policy outputs it produces mirrors the concept of path dependence, and the involved coalitions may revise their beliefs or strategies based on the adequacy of the subsystem's output. If the decision making authority over global health had shifted from the executive and legislative arenas, the GHI leadership would primarily adapt its activities to the outcomes of its own past decisions and not those negotiated between the Administration and Congress. However, this is not the case, and although the GHI leadership's potential ability to speak with one voice, replacing the babble of past global health policy making, may make it more influential, its activities will always be limited by the daunting constraints of budget negotiations. As Thomas Pickering pointed out, this negotiation is a complicated process because budget requests are based upon projections extending two years into the future, and it is difficult for all the participants to anticipate the needs of the world's health in advance.

The GHI leadership's ability to dictate the distribution of its resources is also challenged by the barrier of reconciling different priorities. Because of its diverse membership of leaders representing different, large groups, I envisioned the GHI leadership as a forum where various coalitions would be able to negotiate decisions. The potential outputs from this process would be bounded by the leadership's directive to develop complementary global health programs. This would modify or overrule policy decisions made in other arenas like the Administration and Congress that may reflect political ideologies instead of recipients' needs. Based upon the evidence presented here, though, it is unclear whether GHI leadership will alter the balance of pursuing political agendas and emerging health needs, because its funding authorizations may still be earmarked by those who crafted the bills: the GHI's dialogue with Congress and the President will not be an equal one. And if a unified GHI can articulate a more coherent position

to Congress, the GHI leadership still serves at the pleasure of the President. This is best exemplified by USAID Administrator Tobias's description of his attempt to coordinate USAID and the Department of State's foreign assistance agenda, which targeted all of its programs toward the common goal of transformational diplomacy as defined by the Bush Administration.

Similarly, it is also unclear whether the GHI leadership will alter the representation of coalitions in order to achieve a more balanced global health agenda that better reconciles donor aid profiles with recipient needs. Even in the past, the senior staff of the participants in U.S. global health activities demonstrated an appreciation for comprehensive programs:

I think that most people in the field tend to operate not off of pure predispositions or whim, but out of a fairly deep knowledge of what kinds of issues are out there and how important they are (Pickering interview, 2011, line 175).

The GHI leadership contains a diverse membership with comprehensive perspectives that should, on the face of it, help promote comprehensive policy making, but that in itself may be no match for either Presidential or Congressional agendas. For example, USAID Administrator Tobias testified that his new country-by-country needs assessment process resulted in better coordinated and more appropriate foreign assistance distribution, but that did not prevent Senator Judd Gregg (R-NH) from charging that the process nonetheless merely reflected Presidential preferences:

Well, it doesn't make sense to me that there was a rationale in each case, because it had to be a philosophical decision because it's so apparent that you have moved away from this region of the world [post-Soviet republics] and moved money into another region of the world, specifically Africa, it looks like. It was a regional decision; it wasn't country-

by-country, I don't think, but certainly the dollars have been flying out (U.S. Senate 2008, page 13, paragraph 3).

The literature suggests that interagency committees can, in fact, increase the level of their influence over the policy process. As Lambright found in his analysis of the U.S. Global Change Research Program's Committee on Environment and Natural Resources (CENR), which was an interagency committee whose objective is to develop a coordinated national research agenda investigating environmental issues, one of the potential strengths of an interagency committee may be derived from being legitimized by both the Office of Management and Budget (OMB) and Congress. In the case of the CENR, Congress provided it with a legislative mandate, and the OMB's approval of the committee-produced budgets meant agency leaders could not reprogram allocations to other areas, an action that Thomas Pickering noted frequently occurs in global health. Lambright found that "this changed power in Washington and allowed the committee to assert its priorities on the general interests of agency heads" (Lambright 1997, 39), and once decisions were made, they remain made (Lambright 1997).

This study's lack of GHI leadership as interview respondents resulted in no evidence of how the presence of an institutional structure like the GHI leadership might change how advocacy coalitions are able to affect the policy making process, but for all its novelty, the GHI leadership must still compete in the extant system and must still respond to presidential and congressional preferences. In the advocacy coalition framework, the many participants in policy making may be aggregated into relatively few coalitions according to their shared beliefs, and the arena in which these coalitions negotiate policy decisions about a particular policy domain is called a subsystem. Coalitions employ various strategies to negotiate within these subsystems, and originally I thought the presence of the GHI leadership would alter these strategies. Similarly

the enduring structure of political institutions allows various interest groups to develop predictable patterns of behavior that revolve around the institutions' veto points, and I believed that in meeting its objective of coordinating global health activities, the GHI leadership would serve as a veto point that would modify the policy decisions made in the executive and legislative arenas. However, even with the lack of direct evidence, a trend indicated the GHI leadership may not alter coalitions' strategies as Harvey Fineberg stated, "I don't think any of those agendas [advocated by a coalition] have been altered by the creation of a mechanism of decision making" (line 126).

Although the "need for more coherent global health policy" does not seem to have been particularly visible on the policy agenda, the general, and growing, attraction to notions of "accountability" may have made the GHI seem especially attractive. Many stakeholders both inside and outside government expressed growing displeasure with the lack of measurable, salient returns on our global health investment, without coming to agreement on who should measure performance. Republicans frequently expressed their trust in the President's ability to meet his policy goals, but supported having "additional clarity on how these funds [U.S. contributions to the Global Fund] are being used in the field for those most in need of our assistance" (Fortenberry 2008, column 2, paragraph 17). Thus while the President may be held accountable for narrow, specific policy goals like increasing the number of patients receiving anti-retroviral medication, the position seems insulated from being accountable for broader global health objectives.

However, an interagency body like the GHI leadership, whose goals are comprehensive improvements in health, would be accountable for significantly more domains in global health. In the political institution sense this shift in accountability from the executive arena to that of the

GHI leadership would establish a new point where the potential for repercussions and policy modifications is increased, similar to a veto point. Only a select few in Congress have wanted a larger global health policy framework, and most of them restrict their activities to amending past bills to broaden their scope, rather than envisioning an entirely different framework, speaking both to path dependence and the strength of incrementalism in the American system.

Meanwhile, advocates outside government persisted in identifying the need for more comprehensive legislation, but given the significant challenges presented by the complicated political conditions needed to pass new legislation, this strategy of advocating new policy within the subsystem seems to underappreciate the effect of path dependence. Only those policy goals that were amendments to previously enrolled legislation were successfully enacted, and while these wrap-around health services were limited in scope by their association with HIV/AIDS, tuberculosis and malaria policy, they do represent a successful strategy to address broader, more comprehensive global health activities. This illustration of how path dependence influences political strategies corresponds with the notion that coalitions utilize certain strategies to negotiate policy decisions within the advocacy coalition framework, and how the structure of political institutions results in consistent behavior of its participants.

CONCLUSION

The U.S. government is an active and generous participant in global health. Even though the proportion of the U.S. gross domestic product spent on global health activities is smaller than is true of many other nations (Figure 4), the absolute amount spent has made the U.S. one of the most significant contributors in the world (Figure 5), and its participation continues to grow. However, this growth has occurred unevenly across the various domains of global health, and the

previous state of affairs was an aggregate of activities developed piecemeal, in response to both political agendas and emerging health needs. Piecemeal, disaggregated policy efforts have dismayed those who see the need for comprehensive coordination, generating a call for change on the part of the global health policy elite. The current Global Health Initiative, created by the Obama Administration, addresses this need for a more coherent strategy using language describing a “whole-of-government approach,” which includes the establishment of a representative operations committee and strategic council tasked with integrating the services of the multitude of governmental departments, agencies, and initiatives.

Originally I had anticipated that the GHI leadership would alter the policy making process in a number of ways that may have discouraged it or a similar coordinating body from being established earlier; namely, by delegating authority, providing a forum for reconciling attitudes, and improving accountability, all of which might reduce the ability of executive decision makers to pursue particular agendas or quickly respond to emerging needs. By combining Sabatier and Immergut’s theories I conceptualized the GHI leadership as an institutional decision-making nexus through which several aspects of the policy making process would flow. Tasked with the responsibility of coordinating the U.S. government’s global health activities, the GHI leadership would serve as a resistor to policy decisions made upstream that may result in the unbalanced pursuit of different global health domains. The diffusion of executive authority provided by this checkpoint would be a product of its function as a forum for various advocacy coalitions to reconcile their attitudes through more evenly distributed representation. With improved coordination, however, would come more potential for accountability as the program outcomes resulting from the GHI leadership’s policy outputs would affect the coalitions involved, future decisions, and the leadership’s credibility.

Given what I know after collecting this evidence, it seems I overestimated the potential authority of the GHI leadership within the political institution. These findings suggest that the GHI leadership is still significantly influenced by policy decisions negotiated in the executive and legislative arenas and that its presence is likely not a significant veto point in the decision making process. While it has been tasked to better align global health activities with U.S. policy goals by consolidating global health processes from the various governmental participants, the GHI leadership does not represent an opportunity for various advocacy groups to veto legislation within the political institution. The inability to interview GHI leadership is a significant limitation of this study but, even without in-depth interviews with GHI committee members, the remaining evidence suggests that the executive's need to retain hegemonic control over the policy agenda was not the reason a similar body was not created sooner for U.S. global health policy.

FIGURES

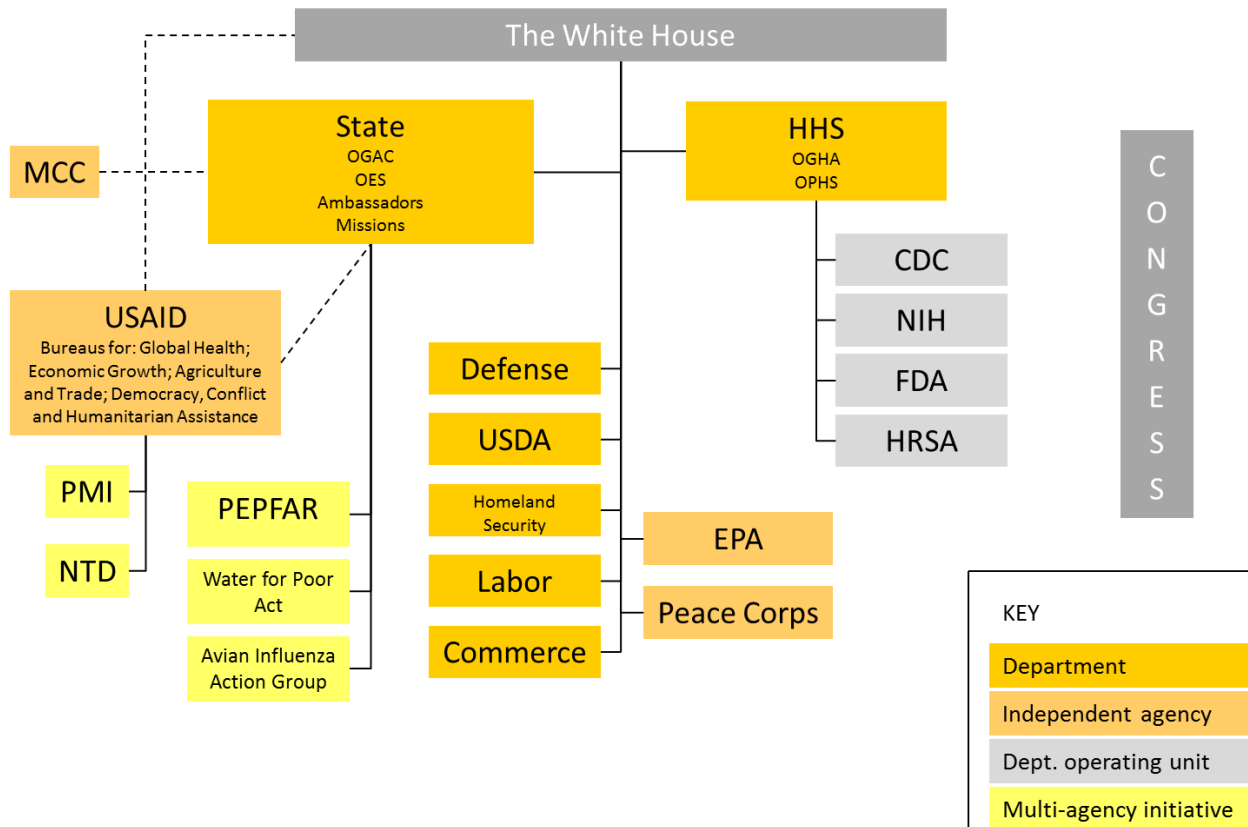


Figure 1. Schematic of the U.S. government's global health architecture. Adapted from Kates, J. "The U.S. Global Health Initiative: Key Issues" Menlo Park, CA: Kaiser Family Foundation; April 2010. Available at <http://kff.org/globalhealth/upload/8063.pdf>. Last accessed 6 June 2011.

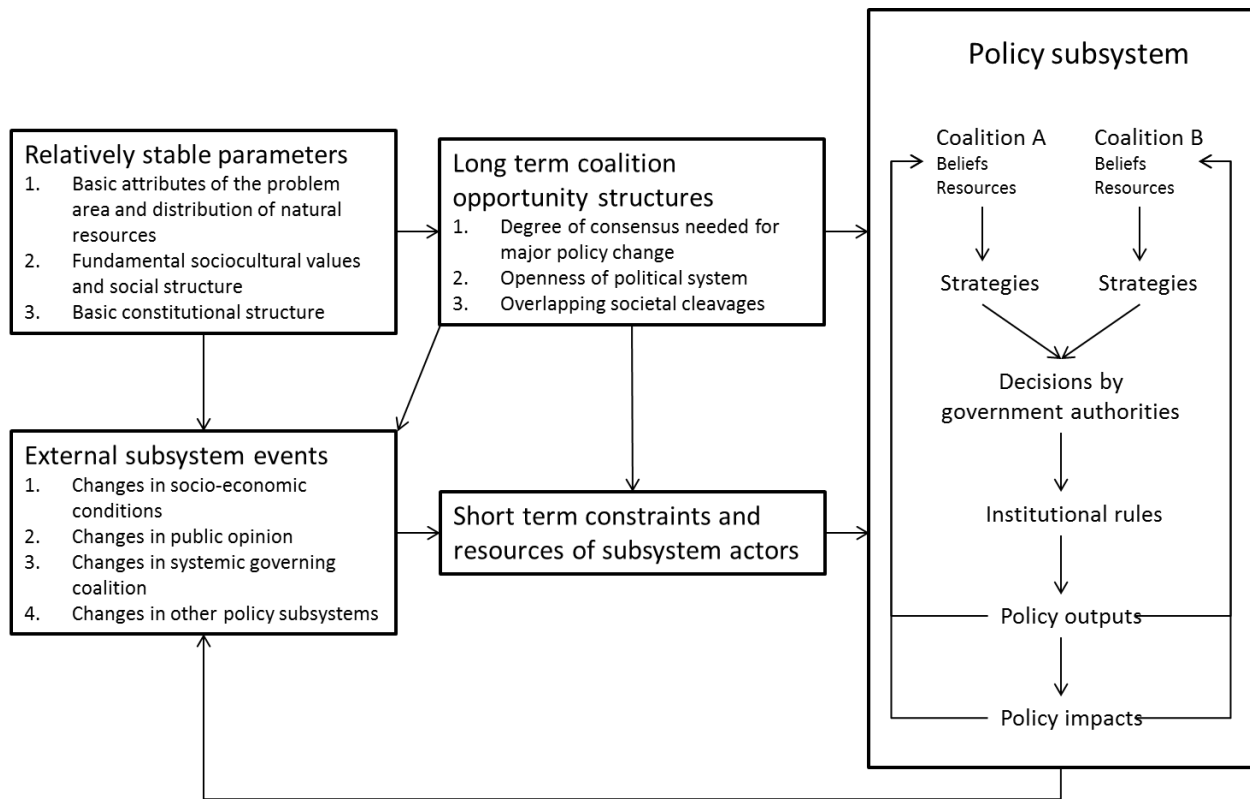


Figure 2. Advocacy coalition framework. From Sabatier, Paul A. 1988. "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein." *Policy Sciences*, 21 (2):129.

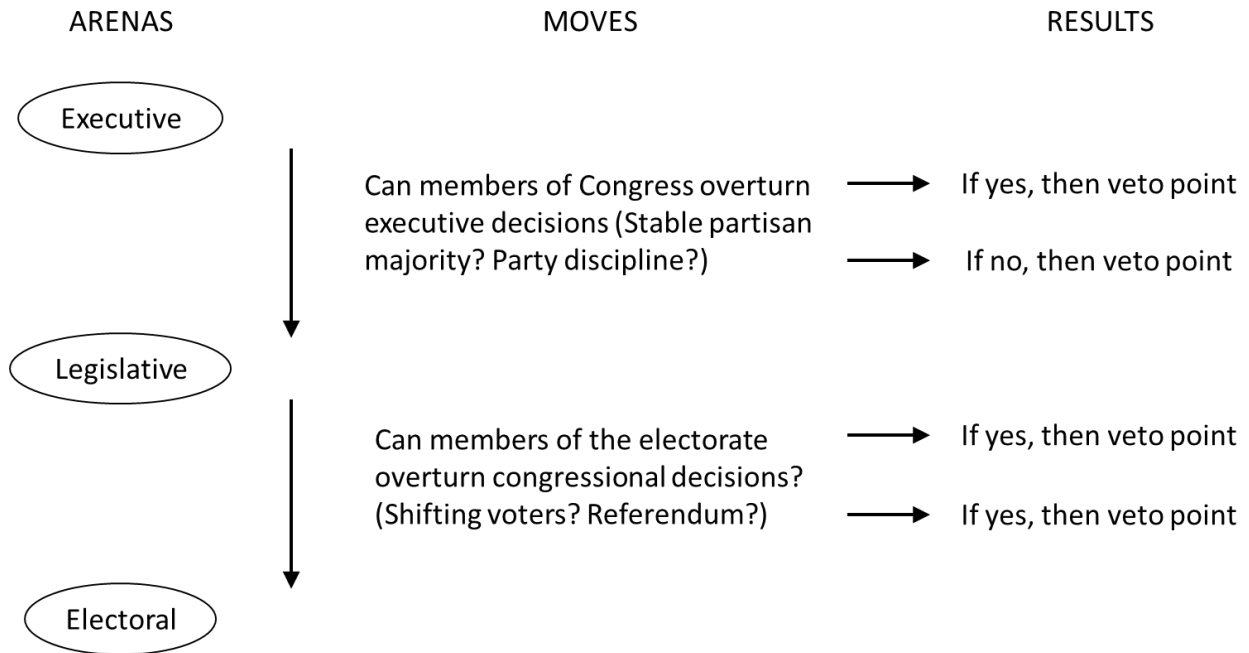


Figure 3. Political arenas and veto points. Adapted from Immergut, E.M. 1990. "Institutions, Veto Points, and Policy Results: A Comparative Analysis of Health Care." *Journal of Public Policy*, 10 (4):391-416.

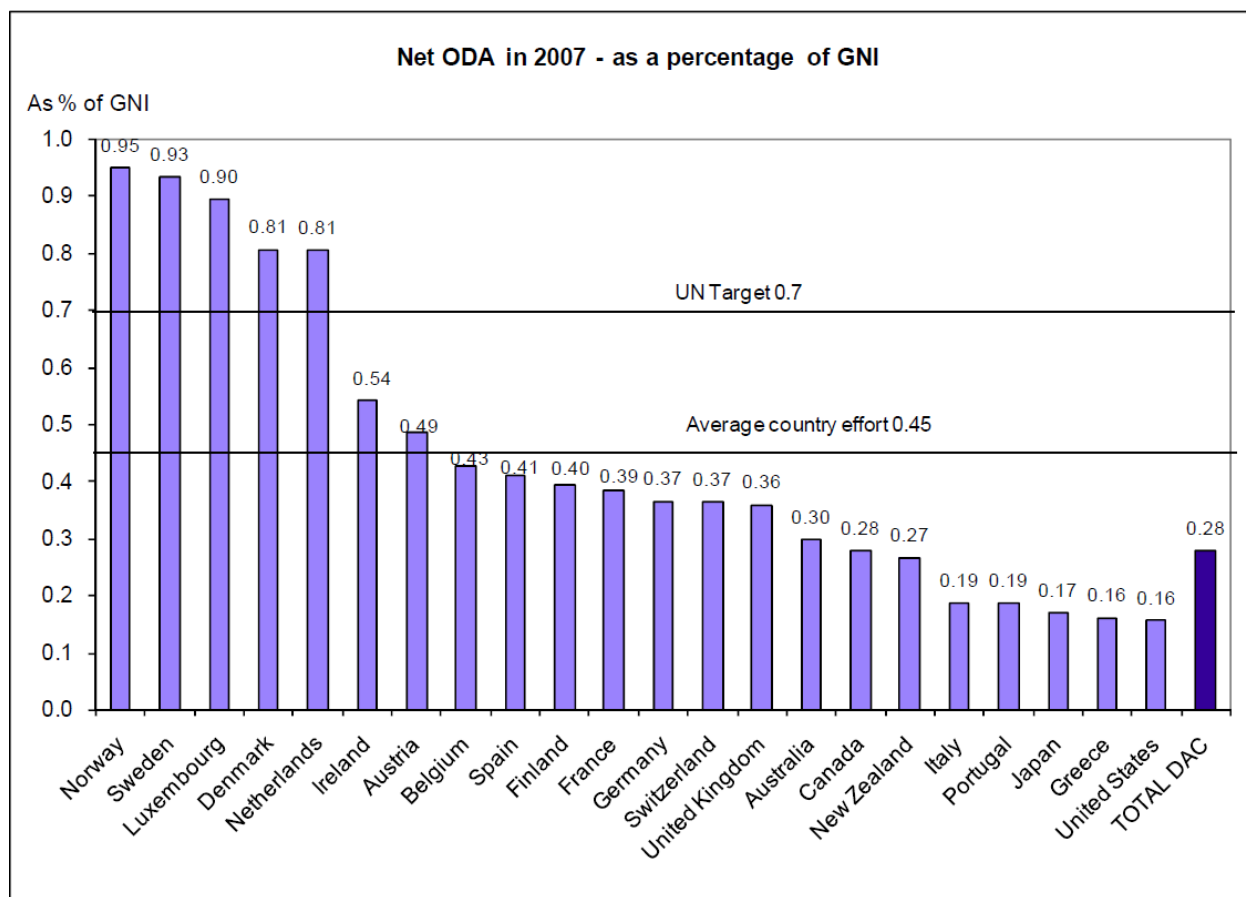


Figure 4. Net official development assistance in 2007. From OECD (Organisation for Economic Co-operation and Development). 2008a. Debt relief is down: Other ODA rises slightly: Tables and charts. Available at http://www.oecd.org/document/8/0,3343,en_2649_34447_40381960_1_1_1_1,00.html (accessed 14 July 2011).

* ODA: official development assistance; GNI: gross national income; UN: United Nations;
DAC: Development Assistance Committee

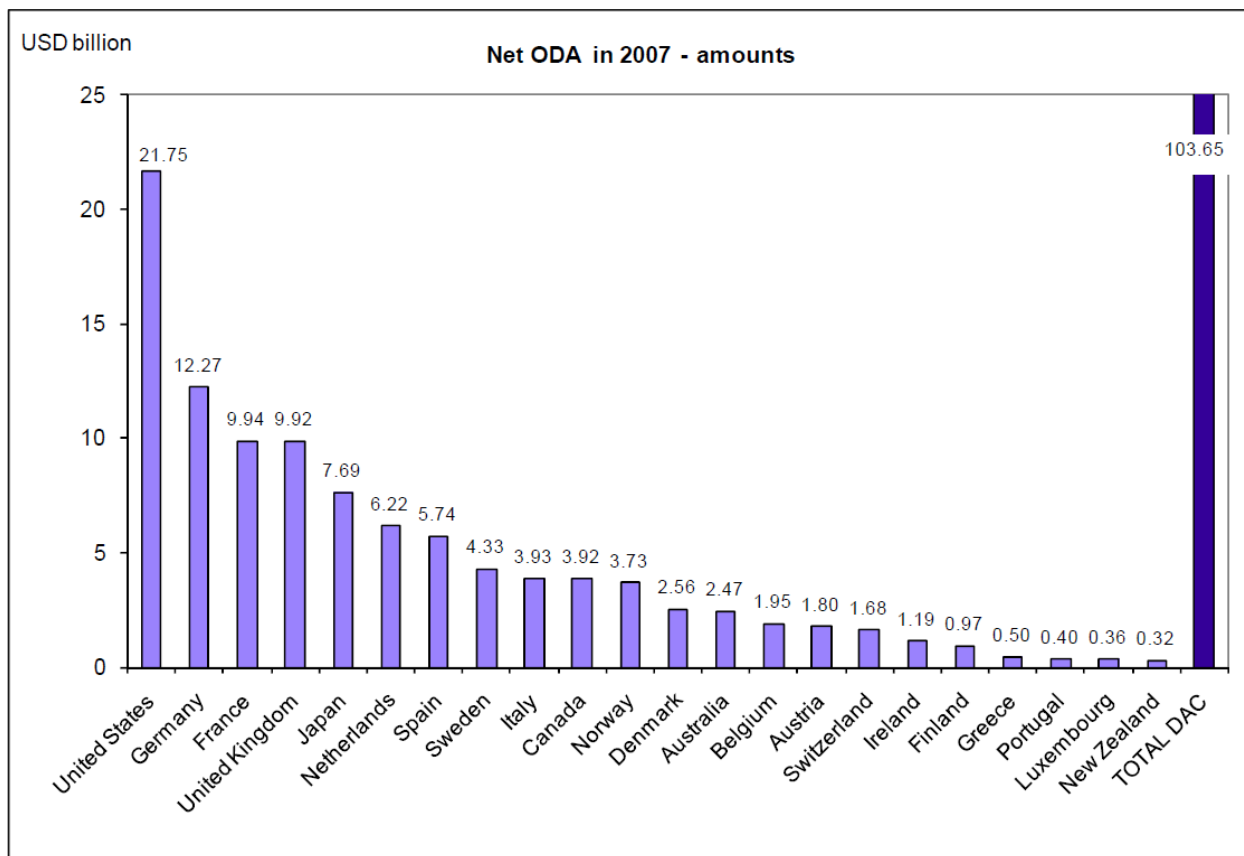


Figure 5. Net official development assistance in 2007, continued. From OECD (Organisation for Economic Co-operation and Development). 2008a. Debt relief is down: Other ODA rises slightly: Tables and charts. Available at http://www.oecd.org/document/8/0,3343,en_2649_34447_40381960_1_1_1_1,00.html (accessed 14 July 2011).

* ODA: official development assistance; GNI: gross national income; UN: United Nations;

DAC: Development Assistance Committee

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APPENDIX 1: SYSTEMATIC REVIEW

Approach to reviewing the literature

After gaining an appreciation for how the separate, but not entirely dissimilar, responsibilities of various government departments and agencies aggregate to form the sum of current US global health policy, I realized the potential for program overlap and competing interests may not be unique to this policy domain. The need for interagency coordination seemed plausible for a number of other domains at all levels of government, including federal, state, and local, and I wanted to investigate how previous institutional attempts fared at developing more coherent and organized strategies within a specific domain. I performed preliminary background searches in multiple databases for policy analyses of institutional bodies similar to the GHI's operations committee and strategic council using queries containing various combinations of terms like interagency coordination, interagency cooperation, policy making, decision making, policy results, institution, shared, presidential, executive, power, and duties. However, the results were surprisingly sparse and quickly narrowed the potential policy domains down to one, environmental science.

In 1989 Ronald Reagan submitted his final presidential budget that contained a report linking various agency efforts into a new multiagency U.S. Global Change Research Program (USGCRP), which outlined a coordinated national research agenda investigating environmental issues like ozone depletion, deforestation, and global warming. The program was headed by an interagency committee initially called the Committee on Earth Sciences, and although its name changed to the Committee on Earth and Environmental Sciences and Committee on Environment and Natural Resources under the Bush and Clinton administrations, respectively, it continued to

serve as a perceived successful example of a functioning interagency management system. This committee, which was chaired by the National Aeronautics and Space Administration (NASA), the National Oceanic and Atmospheric Administration (NOAA), the National Science Foundation (NSF), and later included the Department of Energy (DOE), at one point coordinated the activities of eighteen governmental departments and agencies (Lambright 1997).

Several conditions led to my review of this particular program. First, it existed at the federal level of government and was initiated, at least officially, by presidential authority. Second, it attempted to coordinate the activities of many different government departments and agencies by balancing the research priorities of its members who previously competed for funding and resources to accomplish similar goals. Third, although NASA's Earth Observation System, which was a resource-intensive satellite-development effort, was responsible for a large proportion of the budget appropriated to the USGCRP, no single government entity dominated the research agenda developed by the interagency committee. Fourth, the successes and limitations of this committee illustrate the tensions between congressional, presidential, bureaucratic, and academic stakeholders and highlight the role a structural change within the environmental science policy domain changes their relationships and policy outcomes.

Systematic review

In order to assess the potential for interagency oversight and management to achieve the goals and objectives of a policy whose operationalization depends upon the activities of multiple agencies, I performed a systematic review of the available policy analyses of the U.S. Global Change Research Program and its Committee on Environment and Natural Resources. On 7 June 2011 I performed a Boolean search in the JSTOR database using the following query:

(“Global Change Research Program” OR “Committee on Earth Sciences” OR
“Committee on Earth and Environmental Sciences” OR “Committee on Environment and
Natural Resources”) AND interagency

This search yielded 94 results, most of which dealt with specific scientific research inquiries that referenced either the USGCRP or its leading committee. Of those whose title or subject matter dealt with policy analysis, only four specifically examined the effect of the GCRP and its leading committee on the policy making process. None of these empirically tested any hypotheses, but the insights and themes derived from them are useful when considering the potential effects of a similar interagency body like the GHI’s executive committee and strategic council on the U.S. global health policy making process.

Lambright, 1997

This article outlines the stages of progression common to organizational development within an institution, which progress through an awareness of a need for a new coordinating mechanism, an event that triggers action toward meeting this need, an institutional birthing stage, implementation, evaluation and feedback, and finally either institutionalization or dissolution. Lambright describes the development of the Committee on Environment and Natural Resources in this format, and along the way he identifies the conditions surrounding the success and limitations of interagency coordination using the committee as an example, including common interests, constituency, morale, and leadership.

For Lambright the successful formation of the Committee on Environment and Natural Resources was dependent upon the alignment of the professional, scientific, and bureaucratic interests of its participating members. Its establishment and future maturation also depended

upon the external support of multiple constituencies, including the scientific community, President, and Congress. Lambright states that interagency work requires high morale from its participants because much of the effort it requires is in addition to their regular duties, and morale was necessary to maintain the commitment to keep the committee viable. Leadership strategies, such as funding, use of rhetoric, “end run,” “hidden hand,” and protecting interests, all played a role in the committee’s development, and each of these conditions influenced the committee’s development during its progression through the organizational stages. Using these conditions Lambright frames the developmental path of the Committee on Environment and Natural Resources and finds that the successes and limitations of interagency coordination can both be explained by them. With a focused initial mandate of scientific research into global climate change, the interests of the committee’s members

Pielke, 1995

This article examines the shortcomings of the Committee on Earth and Environmental Sciences (CEES) under the U.S. Global Change Research Program (GCRP) in meeting its legal mandate to provide Congress with ‘usable information’ on which to base policy decisions about global climate change. In the process it outlines the political conditions that led to the addition of this policy relevant mandate to the GCRP’s original directive of coordinating the global change research agenda, and Pielke attributes the failure of the second iteration of the interagency committee to meet this objective to several reasons, including ambiguous definitions, different expectations among stakeholders, and poor accountability on both the executive and legislative branches’ behalf. He also places this policy problem within the broader context of U.S. science policy structure in which a social contract exists between scientific development and the rest of

society, and that the expectation that good science will inevitably lead to good decisions abdicated the need for program oversight.

In addition to these reasons for failing to meet its legal mandate, Pielke analyzes several explanations for the CEES's performance that involve the roles of different participants in the legislative process and their perspectives, and he uses the failure of the CEES to illustrate how scientific research ought to relate to the policy process. He also presents and refutes competing explanations for the CEES's performance failure, progressively addressing congressional fragmentation, administrative pluralism, the effectiveness of the social contract between science and policy, and the surrounding politics. Pielke describes how the CEES demonstrates the role of accountability in the policy process; a convergence of expectations for program performance, congressional oversight, and administrative, congressional, and executive leadership are all needed to reduce the gap between policy goals and the actual state of affairs. He states that program performance depends upon the attainment of goals, assessing output instead of input, and again emphasizes accountability.

Article	Thesis	Themes	Conclusions
Lambright, 1997	The evolution of the Committee on Environment and Natural Resources illustrates the key factors that strengthen and weaken interagency cooperation in government	<ul style="list-style-type: none"> • Common interests • Constituency • Morale • Leadership 	<ul style="list-style-type: none"> • Common professional and scientific interests among committee participants and bureaucratic and financial incentives were all satisfied • Committee had the support of the scientific community, the President, and Congress • Committee participants felt and were special with a legislative mandate and devoted staff • Multiple leadership strategies were triangulated to promote the committee
Pielke, 1995	Appraises the U.S. Global Change Research Program (GCRP) under the Committee on Earth and Environmental Sciences (CEES) with respect to its legal mandate for 'usable information'	<p>Attributes the CEES performance shortfall to:</p> <ul style="list-style-type: none"> • Failures in the legislative process • Participant perspectives • The structure of modern science policy 	<ul style="list-style-type: none"> • The legislative process broke down because the program's mandate was easily avoided and difficult to enforce. • Participants in the policy process expected the mandate would be unenforced and failed to use the law as a guide for implementation. • The structure of post-war science policy helped create an atmosphere where participants expected that enforcement of the mandate would be unnecessary.

APPENDIX 2: INTERVIEW RESPONDENTS

Name	Title	Relationship
Thomas Pickering	Vice Chairman, Hills & Company, International Consultants; formerly, Under-Secretary of State for Political Affairs (Retired)	Co-Chair, Committee on the U.S. Commitment to Global Health, Institute of Medicine, 2009
Harvey Fineberg	President, Institute of Medicine	Co-Chair, Board on International Health, Institute of Medicine, 1997
Harold Varmus	Director, National Cancer Institute	Co-Chair, Committee on the U.S. Commitment to Global Health, Institute of Medicine, 2009

APPENDIX 3: PRIMARY DOCUMENTS

Bill number	Bill title	Record type	Key participants
H.R. 2764	Consolidated Appropriations Act, 2008	Senate hearing	Daulaire (President, Global Health Council), Garrett (Senior Fellow, Council on Foreign Relations), Gayle (President, Cooperative for Assistance and Relief Everywhere), Gregg (R-NH), Hill (Assistant Administrator, USAID), Leahy (D-VT), Rice (Secretary of State), Tobias (Administrator, USAID)
H.R. 1298	U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (President's Emergency Plan for AIDS Relief, PEPFAR)	Congressional record	Biden (D-DE), Boxer (D-CA), Christensen (D-VI), Daschle (D-SD), Enzi (R-WY), Frist (R-TN), Hatch (R-UT), Kerry (D-MA), Lantos (D-CA), Leach (R-IA), Leahy (D-VT), Lugar (R-IL), Nadler (D-NY), Sessions (R-AL), Slaughter (D-NY), Specter (R-PA)
H.R. 5501	Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (PEPFAR reauthorization)	Congressional record	Blumenauer (D-OR), Fortenberry (R-NE), Jackson-Lee (D-TX), Leahy (D-VT), Lee (D-CA), Payne (D-NJ), Pelosi (D-CA), Waxman (D-CA), Woolsey (D-CA)

APPENDIX 4: INTERVIEW PROTOCOL

1. I have read the academic literature carefully, but I would very much like to have your perspective on how particular global health concerns were prioritized by US global health policy. Prior to the passage of the GHI, who would you say were the most influential actors deciding on which global health areas would be prioritized by US government agencies – and by actors, I mean any and all stakeholders inside or outside government whom you think were the most important policy actors in global health policy?
 - a. Generally, what barriers do you think were the most common ones policymakers faced before they could enact the global health priorities?
 - b. How would decision makers navigate these barriers?
2. What about AFTER creation of the GHI? In particular, do you think the introduction of an operations committee and strategic council has changed who the decision makers are, what their relationship is to external influences, and the barriers US global health policy making now faces?
3. I'm also interested in how the relationships between important coalitions may have changed. I know that many different actors and coalitions can exert influence, depending on the particular subject, but prior to the introduction of the GHI, which voices or coalitions would you say were USUALLY MOST prominent in shaping the US global health agenda?
 - a. Has the GHI changed this at all?
 - b. What new voices have appeared, or have previously smaller ones been affected?
 - c. How might the presence of an operations committee and strategic council affect these coalitions?

4. From my reading it seems that US global health policy making has been a combination of individual agendas and responses to important emerging health needs, and I'm trying to delineate the two. In general, to what extent was the previous US global health policy making system tilted by current events or by people's ongoing agendas?
 - a. What about after the GHI? Does the presence of an operations committee and strategic council change this balance of ongoing agendas and the need to respond to current events?
5. My remaining few questions are concerned about the feedback that decision makers obtain from previous policy decisions and how it shapes future behavior. When you are thinking about US global health policy generally, how have global health policymakers viewed accountability? By that I mean to whom do you think most global health policymakers feel accountable? Did that change after the initiation of the GHI?
 - a. And who is best at HOLDING the policymakers accountable? Has the GHI changed that at all?
 - b. My readings have taught me to think of policy as being path dependent – that is, that earlier decisions inevitably influence the context in which future decisions can be made. Political scientists might think about path dependence, but do you think policymakers themselves are thinking about that when they are in the middle of the policy development?
 - c. If so, how does that constrain the process? Or if not, what things insulate policymakers from this sense of future consequences? Can you give me some examples?

- d. Again, do you think the creation of the GHI's operations committee and strategic council will change these dynamics at all?
- 6. Last question! Is there anything else you think I should know about how US global health policy is made or how the GHI and, in particular, its operations committee and strategic council may change it?
- 7. Thank you so much for your time and thoughts! Is there anything else you'd like to say, or anything I haven't asked that I should have?