

COMPETITION, COOPERATION AND LEARNING: THE DEVELOPING ROLE OF THE OECD IN GLOBAL HEALTH GOVERNANCE

Peter G H Carroll, Adrian Kay

*School of Accounting and Corporate Governance, University of Tasmania,
Tasmania, Australia, Peter.Carroll@utas.edu.au*

*Crawford School of Economics and Government, Australian National University,
Canberra, Australia, Adrian.Kay@anu.edu.au*

INTRODUCTION

As Helfer notes, there has been surprisingly little study of the process of change within international, intergovernmental organisations (IGOs) (Helfer 2006: 655-6, see also Kapur 1999). The literature lacks a general theory of change trajectories in IGOs and analytically-driven, in-depth empirical case studies. Instead, the bulk of the studies that have been undertaken have been conceptual and highly aggregated in nature linking change with broader IR perspectives such as functionalism, realism, constructivism, institutionalism or organisational ecology (Haas 1964, Cox and Jacobson 1974, Farley 1981, Wendt 1992, Young 1999, Kapur 2000, Barnett and Finnemore 2004). Most, but by no means all, see change in terms of 'big bang' events and major structural shifts in the international system. While undoubtedly useful, the focus on the whole of organisation level as the unit of analysis does not enable a detailed understanding of organisational change in IGOs and, most importantly, obscures more micro-level reasons behind the changes that take place. In contrast, this paper offers a detailed and tightly focused case study of the health-related work of the OECD as a means to gaining a greater understanding of the processes of change *within* IGOs. This is a case in which there is no salient, sudden exogenous change in the international system that might be appealed to in order to explain OECD change.

The paper has two principal aims: first to describe the health-related work of the OECD over the 1999-2009 period; second, to examine the reasons for the major changes in the nature and extent of that work in order to better understand the forces driving change in IGOs. Health was selected as a case study of IGO change because it provides a clear and salient discontinuity in the variable of IGO change: when the OECD was established in 1961 it was undertaking relatively little work in health and although there had been a gradual increase in health work over time, at the end of the 1990s there was a relatively sudden, marked, step change in the level and scope of the OECD's health work. Hence, it provides us with a valuable opportunity to structure a detailed case study of organisational change and the factors stimulating change. Further, the case allows us to study alongside member state demand factors, issues of the autonomy of the OECD secretariat in agenda-setting in health care work. In doing so, the case casts important light on the role of contingencies in IGO change; in particular key moments, where the intersection of member state demand, OECD secretariat supply capacity and the leadership of key entrepreneurs in the OECD explain change.

CHANGE IN INTERNATIONAL ORGANISATIONS: THE OECD'S GROWING INTEREST IN HEALTH ISSUES

In the late 1990s OECD work on health was scattered across a range of directorates on a range of topics, consisting mainly of improvements to data collection and analysis activities already set in place during the 1970s and 1980s. It was a relatively minor aspect of OECD overall activity, amounting to slightly less than eight million FF for 1999, with about 50% coming from Part 1 of the budget and 50% from

Part 2 in the form of voluntary contributions. This amounted to less than 0.5% of the total resources available to the OECD in that year, clearly signalling that, for most members, either work on health was not a priority or felt it was not appropriate to entrust that work to the OECD (C(2000)87: 5). It was a situation highlighted by Secretary-General Johnson in papers he presented to Council in 1999 and 2000 outlining his views as to the OECD's future challenges. He identified health issues as a major challenge and noted that 'Members have not shown as much interest in this critical area as I would hope (C(99)165: 17) and that '...I am equally concerned about the health agenda..' (C(2000)166: 4-5).

In 1999 overall responsibility for coordination in health matters was vested in Deputy Secretary-General Moe, a move prompted by the need for the Secretariat to develop a coherent position and set of health aims in the negotiations that led up to an agreement to cooperate with the WHO in 1999 and the first OECD health strategy, described below. The agreement was part of a greater trend in the OECD to cooperation with other international organizations that also included a number of projects undertaken with EUROSTAT in order to minimise costs and reduce unnecessary overlap (OECD 1999: 3).

Despite these developments, funds for both existing and new work on health were in short supply as was indicated in a survey of existing and proposed new work prepared by the Secretariat for the Working Party on Social Policy, a subcommittee of the Employment Labour and Social Affairs Committee (ELSAC) in 1997. It had been entrusted with responsibility for the continuing collection of health data and policy-related work and was supported by the Directorate for Employment Labour and Social Affairs's (DELSA) Social Policy Division, in the shape of its Health Policy Unit (DEELSA/ELSA/WP1(97)8).

The OECD Health Project

The important change in the trajectory of OECD health work occurred in 2001, when a major new but temporary health project was approved, with a budget of 19.5 million FF. This signalled that health was now very firmly on to the Council's agenda, in contrast to its previous position (SG/ADHOC/HEA(2001)1/REV1: 7). This shift happened despite the OECD having just completed four years (1995-98) of painful budget cutbacks resulting in a 12.7% reduction in budget and a loss of 263 staff positions (C/PWB(98)99/VOL3/REV1: 3).

This section investigates a number of potential factors that might help explain the change, despite the adverse budgetary situation: (i) the increasing body of evidence and argument as to the value of work on health issues provided by OECD reports; (ii) a generally increasing interest in health issues, especially those related to ageing that, in turn, led to increasing internal and external pressure for greater attention to health by the OECD and other international, intergovernmental agencies such as the World Bank; (iii) a sudden increase in the Secretary-General's support for expanding work on health, leading, in turn, to the development of a cross-directorate, strategic project proposal; (iv) support from both the OECD's Business and Industry Advisory Committee and Trade Union Advisory Committee for the project; (v) the window of opportunity provided by the critical reaction to the WHO's World Health Report 2000.

The first factor, evidence and argument as to the need for and value of increased work on health, became increasingly apparent in the course of the 1990s with a series of OECD reports indicating the growth in health expenditures that had taken place over recent decades, the likelihood that they would increase considerably further with the unprecedented ageing of the OECD members' populations and, hence, the need to ensure that existing health systems were as efficient as possible (see, OECD 1990, 1992, 1993, 1994a, 1994b, 1994c, 1996, 1998a, 1998b, 1998c). The reports urged the need for

increased work on health issues, especially on a comparative basis, in order to remedy weaknesses in existing data and to undertake new work that would enable more efficient policy decisions (OECD 1998c).

As several of those interviewed indicated, by itself the recommendations of the OECD working groups and expert committees are influential, but are rarely the deciding factors in determining national positions. Also, even where the recommendations were credible, it did not necessarily follow that the recommended work would take place within the OECD. This was particularly the case where sensitive policy issues such as health were involved and where national health systems were different in important respects, though those interviewed did agree that the findings and recommendations had had an influence in both stimulating and shaping the various reforms to national health systems that had proliferated in the later 1980s and 1990s.

The increasing OECD evidence, combined with supporting evidence from other national and international sources, was the second factor that helped convince several OECD members as to the need for increasing OECD work. In particular, it led to an increase in their lobbying of the Secretariat and other members in favour of increased work on health. In some cases, this pressure was made in a very pointed fashion, as in 1999, when the influential USA delegate on DELSA's Working Party on Social Policy, noted that:

...the US Health Care Financing Agency (HCFA) had contributed large funds to support the work and it was time that other countries helped out too (DEELSA/ELSA/WP1/M(99)1: 7).

Similarly, several other health-related activities were carried out on the basis of voluntary contributions by a limited number of individual members rather than being financed by all members in the context of the Part 1 budget, such as Japan and Australia (see, for example, DEELSA/ELSA/WP1(2000)1: 7, 10, SG/ADHOC/HEA(2001)2: 2, C(2000)168: 2, C(2001)92: 2).

In addition, from the middle 1990s the major members of the OECD exerted influence on the OECD externally, in the shape of the increasing attention paid to health by the influential G7/8, most of whose members were also members of the OECD and whose delegates met on an informal but regular basis in the corridors and meeting rooms of the OECD. The G7/8 frequently use the major international, intergovernmental organisations such as the OECD to undertake the work necessary to help achieve their agreements, issuing polite requests that are rarely, if ever, rejected and the OECD, for example, highlights its G7/8 activities on its website. While G7/8 communiqués made reference to various aspects of health policy from as early as 1980, it became a major agenda item only in 1996-7 under French and American leadership and has remained a major issue to date (Kirton Roudev Sunderland 2007). In 1996, at the Lyon summit, for example, Japan's Prime Minister Hashimoto proposed the 'Initiative for a Caring World', aimed at enhancing mutual policy learning on social policies, including health, by OECD countries. As a primary means of achieving the initiative the OECD was asked to prepare a synthesis report, financed largely by the Japanese Government, with smaller contributions from the USA and Australian governments, on recent developments in social policy, including health, in member countries (OECD 1998a: 10).

The resulting report stressed the increasing health challenges faced by members and was discussed by OECD Social Policy and Health Ministers in June 1998, together with a comparative report on factors related to health care expenditures (OECD 1998b). The meeting concluded by urging the need for further work on health, resulting in a series of meetings of ELSAC's Working Party on Social Policy to consider how it might respond to the recommendations (OECD 1998b, DEELSA/ELSA/WP1(98)2). However, as the Secretariat warned the Working Party, while the ministers might have strongly recommended the new work:

The resources available for work on social policy remain unclear, even for the short and medium term (DEELSA/ELSA/WP1(98)2).

Given these increasing, internal and external pressures from the OECD's most influential members, it is not surprising that, from at least 1998, Secretary General Johnson began to work to increase the priority given to health work. This included encouraging the development of an integrated, more strategically oriented proposal for a major health project by the Secretariat, and working closely with the American and Australian delegates to identify the extent of support for such a proposal and, where appropriate, persuade members to provide support for the upcoming proposal. In the latter case, following initial discussions with members intended to identify likely support, he made his intentions clear in a note to Council in October 1999, indicating that he would soon be bringing forward to Council some 'concrete proposals' for an increased work program on health, intended to gain a well defined mandate for the Secretariat from the Council (C(99)165: 17). In the former, work commenced with a proposal to the Working Party on Social Policy that invited discussion and support for a future, five year strategy for health policy developed by the Secretariat, though with the suggestions from interested members to the forefront (DEELSA/ELSA/WP1/A(99)1/REV1, DEELSA/ELSA/WP1(99)1).

The strategy document noted that while much health work had been undertaken and was continuing, a number of weaknesses were apparent, including: the limited quality and completeness of the health database; the increasingly out of date work that had been done on members' health systems and the lack of studies of the five new members since 1990; a general lack of analytical work, excluding that undertaken for the EDRC surveys; and the fragmented nature of much of the health work that had been undertaken, often on the basis of voluntary contributions from individual members without an overall strategic direction. It concluded that

...the past contributions of ELSAC could be described as world-class in some respects but also as weighted towards the collection rather than towards the presentation and use of data. Only intermittent attention has been given to studies which have 'completed the circle' by linking policy questions, institutional descriptions, data and analysis (DEELSA/ELSA/WP1(99)1).

The document was submitted to ELSAC in April 2000, as was an additional paper outlining initial proposals for further work on health in other directorates. A revised version of the latter paper, incorporating the bulk of the proposals from the strategy paper, was submitted to, and discussed by, the OECD Council and Executive Committee in May 2000. The focus of the revised proposal was to be on the measurement, analysis and improvement of health systems performance, in addition to the work already proposed (DEELSA/ELSA/WP1(2000)2). It seems to have come about largely as a result of the critical reaction by several OECD member states, notably the USA and Australia, to the WHO's 2000 World Health Report and the surprisingly low rankings the report assigned to the performance of their national health systems. In essence, their dissatisfaction, together with their willingness to provide at least part of the additional funding necessary for the additional work, opened up a fortuitous window of opportunity for the Secretariat to propose an increase in the range of work included in the health project. The additional work, unsurprisingly, was to focus on a more detailed examination of health system performance based on OECD, rather than WHO expertise. In a very explicit indication of member sensitivities the Japanese delegate:

... warned against including explicit ranking in the analysis. Mr. Hurst explained that there are no large differences between the OECD and the WHO in terms of their definition and conceptualisation of performance. However, the OECD will concentrate on understanding the causes of variations in performance and will avoid any country ranking (SG/ADHOC/HEA/M(2001)1: 4).

The revised proposal was favourably received and the Secretariat was invited to submit a proposal for the implementation of what was now a revised, three year health project in the context of the 2001-2002 Programme of Work and Budget (DEELSA/ELSA/WP1(2000)2). The revised budget was, in turn, approved by the Council, allocating FF 3 million from the budget for the project (SG/ADHOC/HEA/M(2001)1).

The increased scale and inter-directorate nature of the revised health project, involving four directorates, was discussed at the first meeting of a new Ad Hoc Group on Health, established to direct the project. As might be expected, its bureau (a small group of delegates that guided the work of the Ad Hoc Group), consisted largely of delegates from the member countries that had been instrumental in promoting the project, with Australia and the Netherlands as co-chairs, plus Canada, Finland, Italy, Japan, Poland, Portugal and Switzerland. The Ad Hoc Group on Health, unusually, reported directly to Council, not to a parent committee. This was in recognition of its cross-directorate nature and, at this time, its uncertain future, as it was established only for the duration of the health project 2001-04, not as a permanent body. Perhaps most importantly, it was also an indication that, while only a temporary body, it was seen as performing a very significant role, both as regards the health project and, possibly, future work on health at the OECD. In addition, a steering group of officials drawn from the four directorates was set up to supervise and coordinate the work, to be supported by designated networks of national experts, with overall responsibility residing with Deputy Secretary Moe (C(2001)170: 2).

While informal discussions with both the OECD's Trade Union Advisory Committee (TUAC) and Business and Industry Advisory Committee (BIAC), had taken place during the development of the project, further, more detailed, though separate consultations with each of them took place on the day of the first and following meetings of the Ad Hoc Group on Health. Both TUAC and BIAC, in line with their earlier views, strongly endorsed the project and offered to support it by providing access to documents, arranging relevant contacts and contributing their knowledge and expertise, with the Secretariat proposing that both could be invited to contribute to some of the expert groups that were likely to be established for the various project components (SG/ADHOC/HEA/M(2001)1).

Although the 1990s commenced with OECD work on health somewhat stagnating, dispersed widely across a number of directorates they ended with the establishment of a major new health project, approved in 2000, cross-directorate in nature and supervised by a new steering group of officials. It also resulted in the successful proposal for an Ad Hoc Group on Health. The change, as discussed, was brought about by a combination of internal and external factors, including, for the first time, a sustained and centrally directed leadership role from the Secretariat, led by the Secretary General. It is not argued that the latter was the key factor, for it would not have been successful without the sustained pressure and supportive activities of a number of member states, including their commitment to provide increased resources. Instead the work of the Secretariat in putting together a carefully crafted, OECD-wide project proposal, was necessary together with the window of opportunity provided by the WHO's World Health Report 2000 for the Council to agree the significant increase in health-related work that eventuated in the 2000s.

THE 2000s: CONFIRMING THE PLACE OF HEALTH ON THE OECD AGENDA

While health now had a more significant place on the OECD's agenda, with the exception of the minor health work not included in the health project, its salience was initially only temporary in nature. The Health Project was approved only for the period 2001-04, with a distinct minority of countries making voluntary contributions to the project in order to supplement the funds from the OECD's Central Priorities Fund. The major topics included in the project were: health systems reforms; health care

quality indicators; private health insurance; long term care policies; waiting times; health related technologies; human resources for health care; and equity of access to health care. As agreed in the revised health project proposal, the project was reviewed by Council following a report on the project's achievements in 2004 (SG/ADHOC/HEA(2004)4). In addition, a separate submission of a detailed proposal for continuing work on health as part of the normal budget process and work programme for 2005-06 was submitted (C(2004)172/REV1).

The report to Council was well received and a meeting of OECD health ministers in 2004 recommended an increase in the resources devoted to health, although the proposed budget and programme of work for 2005-6 received less funding than anticipated. Nevertheless, Health did gain increased funding as indicated in Table 1, below, (SG/ADHOC/HEA/M(2005)1:6-7). The proposal had been to increase the allocation to health work by EURO 640,000 per annum, with EURO 340,000 to be funded from the Central Priority Fund to enable the continued collection of health data previously funded by voluntary contributions from the USA, contributions that were to come to an end in 2005 (SG/ADHOC/HEA(2004)9: 4).

The relative success of the Health Project, at least as judged by the report to Council and the success in gaining increased funding for 2005-06 is not, in retrospect, surprising. Apart from the report to Council and the 2005-06 budget proposal, there was continuing support from the members that had initially supported the health project and, importantly, signs of increasing support from nearly all other members. As the Secretariat noted to Council in regard to funding plans for health work after the conclusion of the health project:

Some 25 countries indicated their willingness to contribute funding – a much larger number than contributed to support the three-year Health Project. This will permit it to carry out the ambitious work programme for 2005–2006, provided that the additional Part I funding which the Secretary-General has proposed to Council, is forthcoming (C(2004)172/REV1: 2).

Support came both directly, via voluntary contributions from members and indirectly. The Netherlands delegate, for example, reported to the Ad Hoc Group that

...the Dutch Minister had taken note of this and, in the light of the Dutch Presidency of the European Union, he had written to all EU Ministers and to the European Commission urging that the OECD receive the support it needs to follow up the Health Project (SG/ADHOC/HEA/M(2005)1: 7-8).

At the same meeting the delegate from the European Commission stated that the EU's draft 2005 work plan in the field of public health included EURO 966,000 for the funding of direct contracts with the OECD, subject to contract negotiations, funds not included in the 2005-06 OECD budget.

Table 1: Financial inputs (2001-2006) C/ESG(2006)5/REV1, in '000 EURO

Year	Part 1 Budget	Voluntary Contributions	Total
2001	Not available	592	Not available
2002	Not available	149	Not available
2003	692	328	1020
2004	719	136	855
2005	1295	1564	2859
2006	1314	1471	2785

In addition, the project had received significantly better than average rankings from members in the first two year's of the OECD's new Programme Implementation Reporting system (PIR), both as regards the perceived quality of the results achieved and, to a lesser extent their impact or potential impact on national policy making (DELSA/HEA(2005)1: 4).

Table 2: Average OECD and Group on Health PIR Ratings for Quality and Impact, 2003 and 2004 (from DELSA/HEA(2005)1. High = 4 Negligible = 0).

	2003		2004	
	Quality	Impact	Quality	Impact
Average OECD	2.83	2.53	2.97	2.62
Average Health	3.03	2.76	3.23	2.88

This is not to suggest that there had been complete agreement over the full range of the health project activities or results, or the programme of work and budget for 2005-6. The U.S. Department of Health and Human Services, for example, along with several other members, expressed its concerns with the initial set of indicators selected for use in the health care quality indicators sub-project on at least two occasions, leading to a further examination and modification of the indicators to be used by the working party (SG/ADHOC/HEA/RD(2003)1). The correspondence noting the Department's concerns also indicated the continuing sensitivity of health matters and a US view that:

We think it is unreasonable to expect OECD will be able to identify measures and provide comparative data that can be used to make statements about the quality of health care in member countries (SG/ADHOC/HEA/RD(2003)1).

In this view the USA was at odds with all other members, though it did not lead to formal US opposition in the Budget Committee or Council.

Similarly, the G7/8 had continued to support health work, as had BIAC and TUAC, although BIAC's support was somewhat qualified. When interviewed in relation to its involvement in the project BIAC noted its general satisfaction but indicated that the process of consultation had not been optimal, with the attendance by Ad Hoc Group members at the pre-meeting sessions declining, in part because of BIAC's inability to present a coherent position at the meetings, in turn caused by the wide variety of interests represented in its Health Task Force. In addition, it was felt that there was a lack of time and opportunity for real dialogue (C/ESG(2006)5/REV1: 17 and SG/ADHOC/HEA/M(2003)1).

A further recognition of the new prominence accorded to health was the progressive increase in the status of the Ad Hoc Group, first in being granted the unusual status of a Group on Health, then, in 2007, achieving full, level 1 committee status as the Health Committee. The Ad Hoc Group on Health had been established by Council in 2001 to oversee the three year Health Project. While an upgrade to full committee status was proposed in 2004 at this time Council was considering widespread reforms to the existing committee system, so that the title of 'Group', was bestowed until the reform process had been completed. This was achieved in 2007 (C(2006)175).

Also, there was a continued and high level of support from most members and the Secretary General, with Angel Gurría becoming the new Secretary General in 2006. The support was evident in a number of sources. The first was the results of the Medium Term Orientations survey administered to all OECD permanent delegations in 2005 (DELSA/HEA(2005)9: 6). The survey asked member countries to nominate output areas for which Part 1 resources should be increased, remain the same, be reduced or terminated in regard to budget Output area 2.1.5 regarding health. The results showed that it ranked fifth out of fifty two in terms of support for increased resources. In addition, health was one of only ten

priority areas nominated by Don Johnson, the outgoing Secretary General for attention by the members in the 2007-8 period. In a separate evaluation, member countries were asked to score the priority areas. Health received the second highest score (DELSA/HEA(2005)9: 6).

Similarly, the performance of the Group on Health in one of the OECD's new series of in-depth evaluations undertaken in 2006 was very good. It was ranked on four criteria, receiving a high rating for relevance, effectiveness and sustainability and a medium to high rating for efficiency (C/ESG(2006)5: 3-4). In its recommendations, importantly, the evaluation recommended and Council agreed that:

- The Group's mandate should be renewed for a period of five years and that it should continue to report to Council as a Level 1 body and
- That the Group would 'benefit from a framework establishing a solid basis for the continuity and stability of its work, while noting that the issue of funding is to be decided within the framework of discussions on the 2007-8 Programme of Work and Budget'. In effect this was a subtle recommendation for an increase in Part 1 funding for 2007-8 (C/ESG(2006)5: 5).

However, based on its analysis, the evaluation report also recommended that:

- the scope, focus and medium to long-term policy objectives of the Group needed to be clarified, based on a formal assessment of the medium to long-term policy needs of Members and key stakeholders as this was not clear in its existing mandate;
- new arrangements for improving the quality of policy-level consultations between the Group and BIAC and TUAC should be established, given, in particular, BIAC's concern as to the decreasing value of the existing type and level of consultation;
- given the continuing concerns of several members and the WHO observer, the Group should clarify the relevant competencies of the OECD and the WHO in the field of Healthcare policy so as to determine the future extent and manner of collaboration between the two;
- a greater effort to diffuse the country-specific reports should be made by the Group, given that they potentially contain lessons and examples that could be of interest to policymakers in other Member countries (C/ESG(2006)5: 6).

The new Health Committee dealt progressively with these recommendations in the following two years and its efforts were rewarded with a further increase in funding for the 2007-8 period.

DISCUSSION AND CONCLUSION

This case study of the growth of OECD work related to health indicates a pattern of agenda change that commences on a very modest scale that slowly diffuses across the organization, with proposals for sudden, major change rarely gaining acceptance. We have identified such a step change in the early 2000s. As the extent and diffusion of work grew coordination issues developed, eventually resolved by a change to the structure of working parties, committees and the supporting administrative structures in the Secretariat. Finally, the pattern of support from members also changed over time, with the USA tending to be to the forefront in its support of new work in the 1980s and 1990s, followed by the European Union members and the European Commission from the middle 2000s, as indicated by the sudden increase in the health work it contracted out to the OECD.

Variation in the interests of the members, notably the larger, wealthier members, or groups of members such as those of the EU or the APEC groupings helps explain OECD change. As their interests change and, in addition, their beliefs that those interests can best be served by entrusting work to an international body such as the OECD, then the direction and extent of the latter's work tends to change.

However, the need to at least gain the acquiescence of all members, if not their positive support, because of the consensus rule, means that change is usually preceded by a lengthy period of discussion and negotiation.

As a causal factor, variation in interest is related to the availability of appropriate funding, either from Part 1 of the budget, or, increasingly, from voluntary contributions. As with all organizations funding for new work is difficult to achieve. It was especially difficult in the OECD because of the very tight budgetary control exercised by its members from the mid-1990s. This meant that for a new work area to gain Part 1 funding funding for other areas had to be reduced, or, on a rarer basis, terminated. Given that all established work had an entrenched constituency, combined with the need to achieve consensus, this was extremely difficult to achieve. In addition, tight budgetary control, combined with growing demands for additional, modified or new work, helps explain the growth of voluntary contributions in the OECD's budgets, including that of health. If a member of group of members wanted an increase in the extent of existing work, or new work to commence and was willing to pay for it, then the work could proceed, subject to a number of constraints. Hence, until the 2000s the bulk of OECD health work was funded by voluntary contributions from a limited number of members or, on occasion, charitable foundations.

The influence of the OECD Secretariat is salient in the case study of health, in at least two senses. First in respect of the quality of its work and the resulting satisfaction of its clients, the member states. In terms of the quality of the health data it collected and, to a more limited extent in regard to its policy work, there is no doubt that the quality of the OECD's health work was well regarded. Second, the ability of members of the Secretariat to persuade influential members and committees of the need for additional or new work and to support the necessary lobbying effort without raising the ire of its members as to their 'proper' place in the politics of the OECD is a critical factor in our case study. The successful development of the health project was the most obvious example of the Secretariat's influence, though even here it would not have succeeded without the active and continuing support of a significant group of members.

The OECD and health case also highlights the role of competition from other organizations for the work in question as a feature of change. Where, for example, an existing international organization such as the WHO was already working in the area, then the task of gaining approval was made more difficult. It was not impossible to gain, but it required, at least in the case of health, a formal agreement with the WHO and a fortuitous window of opportunity that resulted from dissatisfaction from some OECD members with the work of the WHO.

All approaches to change in IGOs have at least a partial focus on the relationship between the organization and its environment. Within those approaches there has been a particular emphasis on the importance of external forces in driving change within the IGO, most notably the interests of their members, usually states. In essence, this is the position for most of those writing in the realist, institutionalist and constructivist traditions. The realists stress the explanatory power of state demands, as do the institutionalists, if to a lesser extent, noting the explanatory power of path dependence or 'stickiness'. Constructivists such as Finnemore (1996) and Wendt (1992), while stressing that international relations are socially constructed, arising out of ongoing processes of social interaction, also place great importance on the interests of states in determining change in IGOs.

It is increasingly rare, however, for adherents from any tradition to deny any role for internal, organizational factors in determining change in IGOs. Haas, for example, in an early and still influential work suggests that staff in IGOs do attempt to expand their mandates (Haas 1964). In a

broader, domestic as well as international context authors such as Niskanen (1971) stresses that organizational change can arise out of the efforts of their staff to gain larger budgets, expanded mandates and, in turn, promotion and related benefits. Our study of the growth of health-related work in the OECD indicates that change is brought about by a varying range of factors, both external and internal, not by any one factor, plus an element of luck. As such it confirms the findings and approaches of authors such as Barnett and Coleman (2005), Helfer (2006), Benner, Mergenthaler and Rotmann (2007), Chwierothe (2008), Van de Graaf and Lesage (2009).

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