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Ranking, Coordination and Global Governance:

The Case of the Access to Medicine Index[1]

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Working paper version.

Article will be published in Business & Politics (accepted 26 October 2015).

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Abstract

As a case study in the proliferation of global rankings, this article examines the initiation, construction of, and response to the Access to Medicine Index, which ranks pharmaceutical companies according to their respective contribution to access to medicine for developing countries. Since it has served as the model for constructing global rankings in the fields of nutrition, seeds, and, possibly in the future, mining and oil, its significance goes well beyond public health. We argue, first, that rankings can be conceived as symbolic classifications that serve predominantly as market based coordination devices. To understand the proliferation of global rankings, we argue, secondly, that they are an integral part of a changing balance of power in the field of global public health consisting of a shift from international organizations as the central mode of governance and coordination to more decentralized and diversified global fields. These global fields are formed by an increasing number and variety of actors, but typically lack a central decision making body. The case of the Access to Medicine Index exemplifies, more broadly, that a historical-sociological field perspective has analytical advantages over the micro analysis of socio-technical devices and purely macro approaches to governance and contemporary market economies.

Introduction

In 2008 the Access to Medicine Foundation (AtM Foundation) published its first biannual index – the Access to Medicine Index (AtM Index) - ranking the twenty largest pharmaceutical companies in the world with regard to how well they perform in promoting access to medicine for developing countries. When the fourth edition was published six years later all ranked companies collaborated with the AtM Foundation in producing the Index and the report was widely covered in the press. The AtM Index has been described as "an authoritative guide"[2] in improving global access to medicine. According to the head of the Foundation, the pressure the Index puts on pharmaceutical companies has caused them to become more open about their efforts,[3] change some of their policies, and make board members or subcommittees responsible for improving access for developing countries.[4] The Index gained considerable support. The AtM Foundation is funded by the Bill & Melinda Gates Foundation, the Dutch Ministry of Foreign Affairs, the UK Department for International Development, and supported by three non-governmental organizations (NGOs).[5] Its chairman represented the Foundation during the 2015 World Economic Forum in Davos, and early 2015 the Index was discussed in the European Parliament.[6] Since the pioneering efforts of constructing the AtM Index, the Gates Foundation also supports similar initiatives such as the Access to Nutrition Foundation (AtN Foundation), which published its first bi-annual Index the Access to Nutrition Index (AtN Index) in 2013 ranking the world's largest food and beverages producers with regard to their commitments, practices, and performance relating to poor nutrition and nutrition related diseases, and the Access to Seeds Foundation (AtS Foundation), which is planning to publish its first Access to Seeds Index (AtS Index) in the fall of 2015 ranking the efforts of the world's largest seeds companies to improve smallholder farmers' productivity.

The use of rankings is by no means a new phenomenon; in recent decades rankings and other publicly available quantitative and comparative indicators are increasingly used in different sectors, apparently to satisfy demands for "accountability, transparency, and efficiency"[7]. They are used by international organizations such as the World Bank and the United Nations (UN), national governments, global businesses, organizations concerned with the compliance of legal standards regarding human rights, corruption, and environmental issues, advocacy groups, and scientific and other experts (e.g. policy makers and consultants). And it has been argued that the production and use of such indicators have "the potential to alter the forms, the exercise, and perhaps even the distribution of power in certain spheres of global governance"[8]. It is therefore of considerable importance to study how such rankings are produced, what their consequences are for specific settings, and how they can be understood analytically.

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[2] The Guardian, 28 November 2012. Article "Big pharma ups its game in providing drugs to people in poor countries". See, http://www.theguardian.com/global-development/2012/nov/28/big-pharma-drugs-poor-countries (accessed on 3 February 2015).
[3] Het Parool, 5 July 2008, page 2-3. Dutch local newspaper from the Amsterdam region. Article "Index zet druk op de farmaceuten".
[4] De Volkskrant, 28 November 2012, p. 21. Dutch national newspaper. Article "Meer profijt medicijnen arme landen".
[5] Cordaid, Humanist Institute for Cooperation with Developing Countries (HIVOS), and Interchurch Organization for Development Co-operation (ICCO).
[6] See www.accesstomedicineindex.org/news (accesed on 26 January 2015).
[7] Espeland and Sauder (2007: 1).
[8] Davis et al. (2012: 4).

In this case study of the AtM Index we thus aim to answer the following questions:

1) When, by whom, and with what purpose was the Access to Medicine Index initiated, who were the early supporters, and why?
2) How has the Access to Medicine Index been constructed and how has this process of construction evolved over time?
3) What were the responses to the Access to Medicine Index and how has it been used by various actors?
4) What are the more general consequences of the introduction of the Access to Medicine Index for the functioning of the field of global public health?
5) How can we understand the initiation and use of this type of rankings?

Although a quite significant case, the AtM Index is not the only one example of its kind. Other rankings exist, such as investors' profitability ratings of pharmaceutical companies, which are already in use for more than a century. More recent rankings have been undertaken to improve transparency and corporate responsibility. Well-known examples include the Dow Jones Sustainability Index (DJSI, founded in 1999) and the Global Reporting Initiative (GRI, founded in 2000). The difference between these initiatives and the AtM Index is that while the DJSI and GRI focus on corporate responsibility on a general level, the AtM Index targets specific companies, large, for-profit pharmaceutical companies, and tries to stimulate them to improve their efforts in the advancement of access to medicine for developing countries. Another reason for focusing on the AtM Index is that it has already been and will be emulated in other sectors, including the food and beverage industry and the seeds industry.

Rankings, indices, and other quantitative and comparative indicators are studied primarily using a social study of science and technology perspective or from a governance perspective, for instance using Foucault's notion of governmentality.[9] As the AtM Index aims to change the way pharmaceutical companies compete, it could also be argued that it should be studied using an economic perspective or by combining economic and political perspectives.[10]

However, even though the social study of science and technology provides interesting analyses of rankings and other valuation devices, scholars within this interdisciplinary field predominantly use a micro-perspective to analyze in detail how exactly specific technologies are constructed and used, thereby often ignoring the broader context in which rankings, such as the AtM Index, were created, used, and may have become successful. Economic and governance perspectives, on the other hand, focus primarily on this broader context to explain indicators' creation and role. To properly understand the initiation and use of this type of indicators, thereby studying both the specifics of the AtM Index, how exactly it has been constructed, and its functioning in the field of global public health, we propose a more meso-oriented, historical-sociological field approach.[11] This approach not only allows us to explain the Index' and its founder's background, the dynamics of the institutional and competitive environment in which the AtM Index was introduced, and the way in which the Index has been constructed, it also helps us understand the consequences of its introduction for the functioning of the public health field.

Although there are different versions of field theory, they share a number of fundamental characteristics which suffice for our analysis.[12] Fields are, briefly put, relatively

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[9] Higgings and Larner (2010).
[10] See, for instance, Tim Büthe's (2012) contribution to Davis et al.'s book *Governance by Indicators*.
[11] See, for instance, Bourdieu, 2005.
[12] Bourdieu (2005), Fligstein (1996, 2001), Fligstein and McAdam (2012), and Martin (2011).

autonomous social spaces where different actors organize themselves around a common interest, frame their policies and actions vis-à-vis one another, and compete for specific stakes. The interaction between these actors is dependent on the position they occupy in the structure of the field and on the volume and composition of the resources of which they dispose. Together, these interactions form a certain structure which, in turn, structures the future interactions of the actors. As a result, fields have a tendency for certain periods of time to reproduce themselves. At the same time the entrance of new actors and changes in the conditions under which fields function result in changing patterns of interaction and occasionally in a transformation of the entire field structure.

We will now first discuss the possible role and consequences of rankings for the functioning of global fields in general, before explaining the research methodology and analyzing the development of the field of global public health. Then we will present the results of our case study on the AtM Index, discussing its initiation, construction, and response, thereby providing an answer to the first three (empirical) research questions. Finally, we will discuss the position the notion of access to medicine has within the field of global public health and conclude by reflecting on how to understand the creation and use of this type of rankings, thereby answering the latter two (more theoretical) research questions.

What do global rankings do?
The coordination of human activities can take place either directly or through some form of mediation. Direct coordination is limited to relatively small groups. Indirect or mediated coordination becomes predominant when the scale of interaction increases and can roughly take two different forms: one based on the delegation of power and responsibility within an organization, the other through cultural or symbolic forms.

International organizations such as the United Nations (UN) or the World Trade Organization (WTO), for example, function on the basis of national representation and political negotiation between country representatives. Since their emergence in the nineteenth century this type of organizations has served as a form of both (indirect) coordination and governance in international affairs.[13]

The second type of indirect coordination is offered by what Cassirer called symbolic forms.[14] The primitive classifications studied by Durkheim and Mauss were religious world views, which guided human behavior to socially legitimate goals. With the advancement of the division of labor classification systems have become more secular and specialized. Classifications of goods, services, and organizations help people make sense of the world and function as *coordination devices*.[15] Rankings, indicators, indices, and other quantitative measures have been described as "technologies"[16] or as "mechanisms"[17] of governance or accountability.[18] On the more general level, however, they are best viewed as *symbolic classifications* in the classical sense of Durkheim and Cassirer.[19]

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[13] Hale and held (2011), MacKenzie (2010) and Reinalda (2009).
[14] Cassirer (1977).
[15] Karpik (2010). See also Lamont (2012).
[16] Davis et al (2012: 6).
[17] Higgins and Larner (2010: 1).
[18] Espeland and Sauder (2007).
[19] Durkheim and Mauss (1963) and Cassirer (1977).

Classifications are collective representations that produce a hierarchy of credibility, that is as a symbolic ordering on the basis of which certain objects, organizations, or people are depicted as more worthy, honorable or prestigious than others.[20] Rankings attribute symbolic value to some and not to others. In the case of organizational rankings, the better ranked are more desirable to work for or do business with than the lesser ranked. If rankings are considered trustworthy, they thus produce a reputational effect, which will have consequences for both the internal functioning of organizations and their external relations. Legitimate rankings therefore cannot be easily ignored.

Among the oldest and best known rankings are the credit ratings of firms and states. Produced by private companies, they have been routinely used in the financial sector to assess the risk of securities issued by companies and governments. These ratings are an essential intermediary between buyers and sellers, and as such a constitutive device for the functioning of modern, large-scale financial markets.[21] Especially since the financial crisis of 2008 credit rating agencies are criticized because of conflict of interest, monopolistic practices, and herd behavior, but the principle of rating the credibility of financial instruments and institutions is not widely disputed. With the expansion of ratings to other sectors, however, criticism has significantly increased.

A well-researched example is that of higher education. Today universities are ranked according to their excellence in research or teaching, their productivity, or their international appeal. While such rankings are used by university presidents and journalists the consequences of introducing such global rankings are controversial. According to different authors this has led to the imposition of market principles to the educational sector,[22] and in the case of business schools to the transformation from substance to image.[23] Rankings are used as instruments to speed up certain reforms in higher education,[24] and curricula are altered in line with the wishes of students and recruiters, as they are the most common actors being surveyed for these rankings.[25] In their study on US law school rankings Espeland and Sauder[26] find that rankings, first of all, cause a redistribution of internal resources, the redefinition of work, and the use of gaming strategies.[27] Further, their research shows some of the possible effects of rankings on the institutions that are ranked and also illustrates that such effects depend on the specific structure of the field in question. Law schools operate in a field in which the stakes are not quite the same as in other fields (e.g. public health or the extractive industry), and competition between the ranked establishments takes on specific forms.

So, global rankings enable the (indirect) coordination of human activities and are best viewed as symbolic classifications; they create a hierarchy of credibility and determine which objects, organizations, or, in this case, firms are most prestigious. As they have the potential to change the balance of power in global governance, it is of great importance to study the structure and development of the field in which they are introduced, who initiates them, with what purpose, how they are being constructed, and how the other actors in the field respond.

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[20] Bourdieu (1991).
[21] Boot et al. (2008), Langohr and Langohr (2008), and Levich et al. (2002).
[22] Amsler and Bolsmann (2012).
[23] Gioia and Corley (2002).
[24] Hazelkorn (2008).
[25] Trank and Rynes (2003).
[26] 2007.
[27] The manipulation of rules and numbers in order to improve appearance and, with that, their ranking.

Methodology

To get an overview of the structure and development of the field of global public health in which the AtM Index was introduced, we have conducted a literature study on the history of global public health and the notion of access to medicine within this field. As the purpose of this literature study is to situate the creation of the AtM Index in the institutional environment of global public health and the pharmaceutical industry, we have restricted our analysis to the period after the Second World War and limited ourselves to describing the development of the field's main characteristics.[28]

The initiation, construction, and response to the AtM Index has been studied, first of all, by conducting 12 semi-structured interviews with representatives of the AtM Foundation, the pharmaceutical industry, a NGO, philanthropic foundations, and the Dutch government (for a complete list of the conducted interviews see Appendix A). Even though we have tried to balance the interviews among the various types of actors involved, we found only one (former) employee of a NGO willing to participate in our research. Interview requests to the Dutch and international offices of Oxfam and Doctors without Borders were unsuccessful. The interviews have been conducted and were analysed by the first author. Second, we have conducted a document analysis of all publications by the AtM Foundation for the period 2008-2014, publications of the other stakeholders involved, and newspaper articles on the AtM Foundation in leading international newspapers, including the Financial Times, New York Times, and The Guardian, using the LexisNexis newspaper database.

The Field of Global Public Health

From the latter half of the nineteenth century, and especially since the Second World War a large variety of intergovernmental organizations was created for the governance and coordination of activities with an international impact, including those related to public health (e.g. the League of Nations' Health Organizations, the World Health Organization, and the United Nations Children's Fund). In recent decades more diversified modes of governance, such as public-private alliances, have been developing in which non-state actors, including private firms, civic organizations, and intermediaries, have obtained an important role (e.g. the Global Fund to Fight Aids, Tuberculosis and Malaria and the GAVI Alliance). By entering the field of global public health, they changed its balance of power. Parallel to these new modes of governance, coordination is increasingly ensured through specific classifications of reality such as market based rankings.[29] The AtM Index is an example of such a ranking that has been initiated with the explicit goal of influencing the activities of the primary actors in the field of global public health.

After World War II an international health system was set up to take responsibility for the improvement of public health in both developed and developing countries. This system was based on the UN-model of national representation and its primary organization was the World Health Organization (WHO). In the developed countries local and national governments continued to take primary responsibility for the improvement of public health; for these

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[28] A more elaborate description of the historical development of global public health can be found in Quak et al (forthcoming).

[29] Davis et al. (2012) and Hale and Held (2011).

countries the WHO primarily functioned as a center of expertise and coordination. In the developing countries, the WHO had a more active role; besides functioning as a center of expertise and coordination, the WHO assisted in the initiation of large scale immunization programs, such as the Expanded Program on Immunization (EPI). This international health system and its primary organizations were part of a more widespread infrastructure of intergovernmental institutions which had been developing since the end of the nineteenth century and experienced a significant growth after World War II.[30]

From its foundation until the early 1980s the WHO initiated several public health initiatives and, through its regional offices, functioned as the central actor in global public health. But this leading role was progressively undermined after the economic crises of the 1970s and early 1980s, the spread of neoliberal policies of economic deregulation, the stimulation of cross-border trade, investment, and competition, and the more limited role for governments and intergovernmental bodies as compared to private actors. The WHO, first of all, had to reckon with the increasingly prominent role of the World Bank, which began to invest in public health after acknowledging in 1980 "that improving health and nutrition could accelerate economic growth".[31] Throughout the 1980s the World Bank became more influential, but it was especially in the 1990s, exemplified by the *1993 World Development Report: Investing in Health*, that it obtained an important role in the field of global public health.[32] The World Bank directly linked the improvement of health to countries' economic development and accompanied its loans to developing countries by a call for the "efficient use of available resources" while favoring "free markets and a diminished role for national governments".[33] Besides seeing its field of expertise being threatened by the World Bank, the WHO also experienced a funding crisis. In 1982 the World Health Assembly[34] decided to freeze the WHO's budget. This was followed by the decision of its biggest donor, the United States, to pay only one fifth of its annual contribution and withhold its contribution to the WHO's regular budget in the mid-1980s. This was done in protest against changes in WHO-policy. From its foundation until the late 1970s, the WHO had primarily focused on two functions: (1) setting normative standards with regard to health and medicines, and (2) providing technical advice and assistance on health issues around the globe. These were both functions which approached the improvement of health from a technical, disease oriented standpoint and which avoided possible political or cultural controversy. In the late 1970s this approach ran into difficulties when it became clear that "technology alone was not enough".[35] To further improve global public health, basic health care systems needed to be built up in developing countries, but this also meant that the WHO would touch upon more politically sensitive issues. In the late 1970s the World Health Assembly passed an international code to stop the marketing of breast milk substitutes in developing countries. Like WHO's Essential Drug Program, which encouraged countries to develop their own drugs, this was opposed by the United States. The United States had substantial economic interest in both of these markets[36] and argued that these initiatives interfered with the requirements of free trade. These decisions resulted in a fundamental change in the budget of the WHO. While in the early 1980s the WHO primarily relied on its regular budget consisting of contributions from its member

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[30] Hale and held (2011).
[31] Brown et al. (2006: 67).
[32] Youde (2012).
[33] Brown et al. (2006: 67).
[34] The World Health Assembly is the WHO's decision making body in which all member states are represented.
[35] Godlee (1994: 1491).
[36] Around that time, Nestle, which had substantial holdings in the United States, controlled one third of the global market in breast milk substitutes. Also, eleven of the eighteen largest pharmaceutical companies of that time were located in the United States.

states related to their population size and gross domestic product, by the early 1990s its extra budgetary funds, consisting of donations, comprised the majority of its yearly funding. While the World Health Assembly had authority over the regular budget, the extra-budgetary funds were controlled by its wealthy donors, such as the World Bank and other multilateral agencies. As a result of diminished funding and power shifts to donor funding, the WHO lost some of its organizational capabilities and its leading position in the field of global public health was under pressure. This provoked the entry of new actors which changed the balance of power and resulted in a profound reconfiguration of the way public health was structured around the globe.

While in the decades after the Second World War an international health field had emerged around the WHO based on national representation, expert advice, and political negotiations between the member states, in the past two decades or so a more diversified and global structure has emerged in which public-private alliances and a global philanthropic foundation have taken center stage, new manufacturers from developing countries, civic organizations, and new intermediaries have entered and claimed a position within this field, and the previously dominant actors, the WHO and the traditional pharmaceutical industry in the developed world, even though they still obtain an important role and dominant position, are respectively forced to rethink their operations and business models. This new structure is more diversified as it not only consists of strictly public organizations, such as the WHO, and private organizations, such as pharmaceutical companies, but also of public-private alliances and a variety of for-profit and non-profit private organizations with an interest in public health. And it is global in the sense that the new dominant organizations do not necessarily operate in line with specific national interests, but instead try to improve health on a global scale. This, however, does not imply that these organizations do not have their own cognitive frames and interests which guide their behavior.

The first important development for the organization of global public health in the past two decades was the entrance of the Bill & Melinda Gates Foundation to the field. While its first initiatives concerning public health took place in the 1990s, it is primarily since 2000 that this foundation has become an important and dominant actor. Through its Global Health Program the Gates Foundation has made large donations to initiatives regarding diseases such as AIDS, tuberculosis, malaria, and polio, and has the goal of helping "all people to lead healthy, productive lives".[37] The Gates Foundation is also one of the founders and an important financier of the GAVI Alliance, a public-private health partnership committed to increasing immunization in developing countries. Other partners include the WHO, UNICEF, the World Bank, national governments of developed (donor) countries and developing countries, other philanthropic organizations, civil society organizations, and vaccine developers and manufacturers from both developed and developing countries. The GAVI Alliance was founded in 2000. The Gates Foundation is also an important financier of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. This financing institution was established in 2002 by a variety of donor and multilateral agencies, including the WHO, the G8, and the Gates Foundation.

Another aspect in the reconfiguration of global public health is the rise of manufacturers from developing countries and small innovative biotech companies. In the decades following the Second World War, the pharmaceutical industry was dominated by large Western pharmaceutical companies that functioned on the basis of a business model which enabled research and development (R&D) investments through patent protection. In recent years, pharmaceutical companies from developing countries, initially focusing on the production of

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[37] See factsheet on website of Bill & Melinda Gates Foundation: http://www.gatesfoundation.org/Who-WeAre/General-Information/Foundation-Factsheet (accessed on 12 January 2013).

generic drugs, are slowly increasing their R&D efforts and have improved their position in the industry. On the other hand small biotech companies focusing on innovative research have claimed their position in the field. Large Western pharmaceutical companies have reacted to these developments by acquiring some of these biotech companies, manufacturing their own (branded) generics, cooperating with manufacturers from developing countries, and introducing tiered pricing schemes. A final important change is the entrance and prominence of, what we call, *new intermediaries*, that is of organizations that are neither producers nor funders, but that have an intermediary role between the primary groups that make up the field. Intermediaries can be defined as those groups that through publications, lobbying, and other initiatives try to influence the relationships between the primary actors in a field.[38] These include NGOs, advocacy groups, centers of expertise (both independent and academic), think tanks, and other independent organizations, such as Médecins sans Frontières, Oxfam, the Center for Global Development, and the Access to Medicine Foundation. Although such intermediaries have always existed, their number, variety, and prominence have since the 1980s greatly increased.[39]

Together, these developments constitute a fundamental transformation of the field of global public health: a shift from a centrally governed international order based on political representation and the mobilization of experts toward a more decentralized field consisting of a plurality of different actors, with an important role for disease specific public-private alliances, the increasing significance of private funding, and without a clear central decision making center. The current field of global public health consists of a variety of interdependent actors concerned with the improvement of public health across the globe, including research institutes, large Western pharmaceutical companies, small biotech firms, manufacturers and developers of generic drugs from developing countries, public health agencies, multilateral organizations (e.g. WHO, UNICEF), public-private-partnerships (e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI Alliance), NGOs (e.g. Médecins sans Frontières, Oxfam), new intermediaries (e.g. Access to Medicine Foundation, Center for Global Development), philanthropic organizations (e.g. Bill & Melinda Gates Foundation, Clinton Foundation, Rockefeller Foundation, Rotary International), as well as special interest groups. These interrelated actors are concerned with the research, development, production, distribution, and use of medicines, the construction and improvement of health infrastructures, public health measures, health governance, and funding. The transformation the organization of public health has experienced in recent decades is summarized in table 1.

Table 1 around here

Because the field of global public health has increased in size and has diversified in terms of the variety of actors involved, whereas the power of central decision making bodies has diminished, a new demand has arisen for coordination. Rankings, we argue, are best conceived as one of these relatively new coordination mechanisms. Historically they can be seen as a response to the demise of the international organization as the previously dominant mode of governance and coordination.[40]

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[38] The primary actors are those organizations concerned with the research, development, production, distribution, finance, and governance of public health across the globe.
[39] Youde (2012).
[40] Levi-Faur (2012).

Now the structure and recent changes of the field in which the AtM Index was introduced has been explained, we turn to the initiation, construction of, and response to this market based coordination device.

Initiation of the AtM Index

The AtM Index is published by the AtM Foundation, an independent non-profit organization based in Haarlem, the Netherlands, which was founded in 2005 by Wim Leereveld, a former pharmaceutical marketing entrepreneur. The foundation's goal is to "help give millions of people on the planet better access to medicines that they urgently need".[41] It aims to do so by publishing the AtM Index and, thereby, (1) supply all stakeholders, including the investment community, with independent information on pharmaceutical companies' access policies and practices, (2) give pharmaceutical companies an instrument to compare their own policies and practices with their competitors, and (3) provide a tool to all stakeholders to discuss access policies and practices.[42] The AtM Foundation wants to provide a "consistent benchmark report every two years"[43] which highlights best practices, holds the best performing companies up "as shining examples to others"[44] and provides pharmaceutical companies "clear guidance, by reporting on what they and their peers are already doing well, and by showing where solutions are still needed".[45] By publishing this Index the AtM Foundation wants to stimulate competition between pharmaceutical companies and encourage them to improve their access policies and practices for developing countries. The Index rewards companies that take responsibility for improving access to medicine for those in need by recognizing their achievements and in this way "helps spark competition".[46] As part of this study we will try to determine whether the AtM Foundation succeeds in these goals and whether the AtM Index is accepted by the other actors in the field of global public health as a legitimate and credible tool to improve pharmaceutical companies' access policies however. However, we will first discuss the background of the AtM Foundation's and its founder.

Wim Leereveld, the Dutch founder of the AtM Foundation, has extensive pharmaceutical marketing experience in a career spanning 40 years. In 2003 he founded a Dutch foundation called 'Stichting Wereldbedrijf' in an effort to foster cooperation between the business world and development aid. After rethinking this idea for some time he renamed it Access to Medicine Foundation in 2005 and decided to focus on the role of pharmaceutical companies in improving access to medicine for developing countries. During his career Leereveld had acquired intensive knowledge about these companies and was convinced that even though a variety of stakeholders share the responsibility, "pharmaceutical companies [are] essential actors in proving access to drugs to those in need"[47]; "as the owners of vital knowledge, technology and infrastructure, [they] have particular roles to play".[48]

Large pharmaceutical companies are regularly called upon to share their patents and increase their efforts to improve access to medicine. While methods of naming and shaming are used by many NGOs and (supra-)national governments largely rely on regulation and

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[41] Access to Medicine Foundation (2008: 3).
[42] Access to Medicine Foundation (2008).
[43] Access to Medicine Foundation (2010a: 27).
[44] New York Times, 17 June 2008, p. 6. Article "Index ranks companies on efforts to get their drugs to poor countries".
[45] Access to Medicine Foundation (2014: 5).
[46] Access to Medicine Foundation (2010a: 10).
[47] Access to Medicine Foundation (2007: III).
[48] Access to Medicine Foundation (2008: 3).

guidelines, Leereveld is convinced it is better to establish a dialogue with these companies. From his work experience he had learned that pharmaceutical companies are constantly comparing themselves with their competitors. When trying to stimulate them to improve their efforts regarding access to medicine, he therefore argues it is best to compare their access policies and practices. This idea was inspired by a report published by Oxfam, VSO, and Save the Children, entitled Beyond Philanthropy: The Pharmaceutical Industry, Corporate Social Responsibility and the Developing World.[49] This report suggested to compare pharmaceutical companies' policies and practices and Leereveld decided to do just that.

In its first years the AtM Foundation received financial support from a variety of governmental organizations, NGOs, and banks.[50] The Foundation did not yet have any results to show, but these organizations believed in the idea behind the Index. Before the Index was first published in 2008 Leereveld presented his idea to representatives of the Gates Foundation. At that time, they were not willing to support the initiative as they perceived it as too much of an NGO-initiative critically analyzing the pharmaceutical industry's efforts. Presentations at the Soros Foundation and pharmaceutical corporation Pfizer were also not greeted with a positive response. But after publication of the first Index in June 2008, Leereveld was invited to present the initiative during a health summit funded by the Gates Foundation. This meeting was also attended by the chairman of the Wellcome Trust,[51] Sir William Castell, who earlier introduced the project to Bill Gates after reading about it in the Financial Times. Gates himself had called rankings an important mechanism in stimulating companies to take responsibility for a variety of social issues in an interview with Time Magazine in August of the same year.[52] And during his speech at the Davos World Economic Forum a few months earlier he had argued that large companies could be stimulated to improve their social responsibility and sustainability policies by recognizing them for their efforts.[53] Since then, together with the Dutch Ministry of Foreign Affairs and the UK Department for International Development, the Gates Foundation has become one of the primary financiers of the AtM Foundation.

So, the AtM Index was introduced in the field of global public health by someone with inside knowledge of how pharmaceutical companies, one of the central actors within this field, work, and who has an independent position towards the other actors in this field. In order to decide upon their actions and strategies, pharmaceutical companies watch each other and the AtM Foundation uses this insight. With the Index it, first and foremost, tries to encourage pharmaceutical companies to increase their efforts to improve access to medicine for developing countries by stimulating competition between them. Instead of using strategies of naming and shaming, as often used by NGOs, or by implementing regulation and guidelines, which is the modus operandi of governmental organizations, the AtM Foundation argues that through this Index it tries to stimulate a 'race to the top' in pharmaceutical companies' access policies and practices by comparing their policies and practices and recognizing their achievements. However, whether constructing a ranking is completely different from the naming and shaming methods used by NGOs is up for debate. By constructing a ranking a small number of organizations are being praised as 'shining examples'. However, at the same

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[49] Oxfam, VSO, and Save the Children (2002).

[50] The UK Department for International Development (DFID), the Dutch Ministry of Foreign Affairs, Oxfam Novib, Hivos, Cordaid, the Interchurch Organization for Development Co-operation (ICCO), European Agency for Development and Health (AEDES), Rabobank, and SNS REAAL.

[51] The second largest charitable foundation in the world, after the Gates Foundation, focusing on improving human and animal health.

[52] Kiviat, Barbara and Bill Gates. 31 July 2008. "Making Capitalism More Creative". Available on http://content.time.com/time/magazine/article/0,9171,1828417,00.htm (accessed on 16 January 2014).

[53] Kinsley (2008).

time, a dozen others are being told that they are not doing enough; they are being 'shamed'. In general, it can be argued that in light of the development of the organization of public health around the globe as discussed above, with this Index the AtM Foundation introduced a new market based coordination device which fits more closely with the recently transformed, more decentralized field of global public health consisting of a plurality of public and private actors. Before going into what the consequences of the introduction of the Index have been for the functioning of this global field, we will now discuss how exactly the process of constructing the Index has taken place.

Construction of the AtM Index

The year before each of the four Indices was published, the AtM Foundation published the Index' methodology. The construction of the methodology for the 2008 Index and its updates in later years (2010, 2012 and 2014) started with a review of the literature and a consultation round among a variety of experts: NGOs, health organizations, pharmaceutical companies' shareholders, academics, and consultants. For the 2008, 2010 and 2012 Indices this process was conducted by a research company on behalf of the AtM Foundation. By the time the methodology for the 2014 Index was updated, the AtM Foundation had established its own research team to undertake this process. For each of the four Indices the scoring of all companies was carried out in cooperation with a market research company. [54]

In 2008 the first phase of the consultation process consisted, first of all, of a background research on access to medicine related reports and other forms of documentation published by third parties such as the UK Department for International Development, Oxfam, the WHO, and the Pharmaceutical Shareowners Group. Then, for each of the four indices, a questionnaire was distributed among experts from academia, consultancy firms, the financial industry, health organizations, and NGOs from developed and developing countries, to collect their opinions on the role and practices of pharmaceutical companies in improving access to medicine for developing countries. A further step in the methodology process was the organization of discussion roundtables (in London and New York) with representatives from all stakeholders for further discussion and to develop a framework for company comparison. In the process of updating the methodology for the 2010, 2012 and 2014 Index a roundtable was also organized in Nairobi or Ghana to engage and get input from developing country NGOs. For the 2008 Index, the pharmaceutical companies themselves were consulted separately. After the other stakeholders were consulted, both individual pharmaceutical companies and industry representatives were contacted to discuss the results of the first phase, to find out which data could realistically be expected to be disclosed, and to refine the indicators and weightings. For the 2010, 2012 and 2014 Index separate consultation phases were no longer deemed necessary when the methodology was updated. A final consultation round with all stakeholders, including the pharmaceutical industry and its representatives, was then organized to get comments on the methodology developed in the previous phases.

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[54] This was done by Innovest for the 2008 Index, RiskMetrics (had acquired Innovest in 2009) for the 2010 Index, and MSCI ESG Research (had acquired RiskMetrics in 2010) for the 2012 Index. Innovest already had significant experience with analyzing companies' social policies and practices and was responsible for the stakeholder process, gathering and analyzing the necessary data, and the report writing. Now the AtM Foundation has ensured funding to publish at least two more Indeces in 2016 and 2018, it is expanding its research team and will, for future, indices, conduct some of these tasks by itself, e.g. the stakeholder consultation process. The scoring for the 2014 Index was carried out in cooperation with Sustainalytics.

To improve the process of constructing the methodology, in 2009 an Expert Review Committee (ERC) was installed consisting of representatives from academia, governmental organizations from both the developed and developing countries, the pharmaceutical industry, investors, NGOs, the WHO, consultancy firms, and the Gates Foundation. The ERC has a purely advisory role and is responsible for guiding the methodology update. The AtM Foundation team remained ultimately responsible and used the comments derived from the consultation process to implement updates to the methodology. In 2011 Technical Subcommittees (TSCs), consisting of health professionals, academics, and consultants, were added to the ERC focusing on specific parts of the Index. While the ERC was created to ensure the political representation of all stakeholders in the construction and update of the Index' methodology, the TSCs were created to ensure technical expertise. Finally, for the 2012 Index, representatives from generic manufacturers were added to the ERC. Additional consultations with stakeholders outside these formal committees also take place. Pharmaceutical companies themselves actively take part in the process of updating the methodology. In 2013, for instance, the AtM Foundation invited representatives of all companies ranked in the 2012 Index to give feedback on the methodology, the processes used by the AtM Foundation, and the results. Eleven of them participated in conference calls with the AtM Foundation discussing these topics.

The consultation rounds resulted in a methodology to determine the score of each pharmaceutical company's access policies. First, in 2008 eight technical areas were distinguished, of which two were merged for the following indices. Each of these technical areas has its own weighting in the total score. These weightings have changed slightly over the years. To determine how the companies perform on each of the eight technical areas, for the 2008 Index a total 28 of indicators were identified which were then divided in 94 metrics on which the various companies were being valued. This setup was changed for the 2010, 2012, and 2014 Index when the companies were ranked for each technical area on the basis of various indicators, which were grouped into four strategic pillars. Again each of the technical areas and strategic pillars had their own specific weighting for the 2010, 2012, and 2014 Indices.

Company selection for all four Indices was done on the basis of market capitalization, but as different pharmaceutical companies have different business models, the weightings were adjusted to take these differences into account. While the 2008 Index consisted of twenty, both generic and originator, companies, in 2010 twenty originator and seven generic companies were ranked separately because of their clearly distinct business models. In 2012 and 2014, the generic companies were excluded because of difficulties with comparability, only originator companies (twenty) were ranked. Compared to the 2008 Index, the pharmaceutical companies were ranked for their access policies and practices in an increasing number of countries[55] for an increasing number of diseases for the 2010, 2012, and 2014 Index.[56] While in 2008, the valuing process of companies' access policies and practices was conducted using a relative

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[55] The selected countries for the 2008 Index are all low and medium human development countries as identified by the UN Human Development Index. For the 2010 Index, countries classified as high or upper middle income by the World Bank were excluded. The 2012 Index focused on low and lower-middle income countries based on World Bank classifications. To include countries that show high inequality, the UN Human Development Index was used in addition to the World Bank classifications. For the 2014 Index the 2013 World Bank country classifications were used to determine low and middle income countries. All of them were included in the Index. Also, the UN Human Development Index was used, including all countries that score under 0.55 on the UN Inequality-Adjusted Human Development Index.

[56] The list of neglected diseases and diseases which accounted for at least 1% of the global burden of disease. This list is based on the Disease Control Priorities Project, an ongoing joint project by the World Bank, WHO, National Institutes of Health, the Population Reference Bureau, and the Gates Foundation which tries to establish priorities for global disease control (Access to Medicine Foundation, 2007 and 2008).

ranking,[57] for the subsequent indices a mix of an absolute and a relative rating system was used; quantitative indicators were rated relatively while qualitative indicators were rated using an absolute rating system. For future indices the AtM Foundation strives for more quantitative indicators and an overall absolute rating system.[58] Table 2 summarizes the characteristics of the four indices as discussed above.

Table 2 around here

Because of the significant changes the Index' methodology experienced for the 2010 Index, one can question its comparability with the 2008 Index. And even though the changes to the 2012 and 2014 methodology were less radical, one could still pose the question how to interpret changes in individual companies' rank.

The average change in rank of individual companies did not differ much between 2010 and 2012 with respectively 3.1 and 3.0 places. However, this decreased to only 2.2 places in 2014.[59] As the changes to the methodology were far more radical in 2010 than in 2012 and 2014, this suggests that individual companies' changes in rank were not caused by changes in the Index' methodology. According to the AtM Foundation, in general companies were more willing to share information for the second Index, resulting in an overall improvement in scores and, for some individual companies, an increase in rank. The best example of this is Gilead Sciences which moved up eleven 11 places in 2010 (from 15th to 4th place) among others by increased disclosure across all areas.[60] In 2012 companies were, again, more willing to disclose information on their access policies and practices. But, according to the Foundation, they also improved their policies and practices as seventeen out of the twenty companies ranked were awarded with higher scores compared to the 2010 Index. Merck KGaA[61] gained most places in the 2012 Index (17th to 8th place), largely because of increased disclosure regarding specific areas, but also because of improvements in areas such as R&D and pricing. AstraZeneca, at the same time, lost nine places (from 7th to 16th place) in the 2012 Index, primarily because it had not made many advancements in its access policies and practices while most other companies did. Finally, the 2014 Index tells us that pharmaceutical companies continue to improve their access practices and policies, however more than half the new products are introduced by only five companies and more than half of these products target one of only five diseases. GlaxoSmithKlinke occupied the first position for the fourth consecutive time, while NovoNordisk and Eisai both rose four places, from respectively 6th to 2nd and 15th to 11th.[62]

The process of constructing the Index' methodology is set up as a joint project between the AtM Foundation and various stakeholders in the field of global public health. Through consultations with NGOs, investors, experts from academia, health organizations, consultants, and pharmaceutical companies themselves, the Index' methodology has been created and updated in the past few years. This can be interpreted as a deliberate attempt from a newcomer to the field of global public health to gain credibility and obtain a position in the field that might

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[57] Companies displaying best practices were awarded 5points (on a 1-5 point scale) and all other companies were rewarded accordingly.

[58] Access to Medicine Index (2007, 2010b, 2012a, and 2013).

[59] This is based on own calculations of the authors on the basis of the companies ranked in two consecutive Indices.

[60] Access to Medicine Foundation (2010).

[61] The company headquartered in Darmstadt Germany, also known as German Merck; not Merck & Company, or Merck Sharp & Dohme, known as Merck in North American and as MSD in the rest of the world.

[62] Access to Medicine Foundation (2008, 2010a, 2012b, and 2014).

enable it to influence the behavior of the other actors, in this case the access policies of pharmaceutical companies. In the next section we will discuss the response to the AtM Index.

Response to AtM Index

All pharmaceutical companies ranked in the 2008 Index were approached during the consultation phase for the construction of the Index' methodology and in order to collect data. However, the Index was greeted "with skepticism by some drugmakers".[63] Thirteen out of 21 companies[64] responded during the 2008 industry consultation round and gave their comments. However, from the twenty companies finally selected only eight[65] were willing to provide data[66], while ten of them were interviewed, and eleven commented on the draft version of their scores.[67] The 2010, 2012, and 2014 consultation processes differed from the 2008 consultation process, but all pharmaceutical companies as well as their representative organizations participated in the consultation processes for these Indices. Also, the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) provided a member for the Expert Review Committee. For the 2010 Index nineteen out of twenty originator companies ranked and three out of seven generics companies responded to Foundation's request for information. All originator companies used the opportunity to give feedback on the company profile included in the 2010 Report. Finally, in 2012 and 2014 all companies responded to the request for information. Besides cooperating with the AtM Foundation in producing the Index, an increasing number of companies has mentioned their inclusion in the AtM Index in their annual CSR/Sustainability reports: four in 2008, six in 2010, seven in 2012, and ten in 2014. Also, various companies have contacted the AtM Foundation to help them expand and improve their access policies and practices.[68] Together, this suggests that the pharmaceutical industry has acknowledged that the Access to Medicine Index has obtained a position in the field of global public health.

Investors are an important stakeholder group as they can pressure pharmaceutical companies to change their policies and practices. When the first Index was published in 2008, ten institutional investors committed to stimulating companies to display sustainable and socially responsible behavior, had signed an investor statement in which they acknowledged that pharmaceutical companies have a role to play in improving access to medicine for developing countries and that they welcome the efforts of the AtM Foundation in this regard. These investors together had a combined assets under management of around EUR 900 billion.[69] In the following years this grew to around thirty institutional investors with a total combined assets under management of USD 3.7 trillion.[70] It are primarily socially responsible investors which have signed the Institutional Investor Agreement, although investment bank Goldman Sachs cooperated with the AtM Foundation by hosting a meeting for pharmaceutical industry analysts explaining the Index after it was published for the third time in 2012 and after

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[63] New York Times, 4 December 2012, p. 6. Article "Pharmaceuticals: GlaxoSmithKline retains top ranking measuring outreach to poor countries".
[64] Initially, 21 companies were identified as potential candidates for the Index, of which was one was deleted for the final list.
[65] These were all originator companies. The three generics companies included in the 2008 Index did not respond.
[66] Only publicly available information was used to rank the other companies.
[67] Access to medicine Foundation (2008).
[68] This does not mean that the AtM Foundation provides concrete advice to individual companies or acts as a consultant, as this would jeopardize their independence.
[69] Access to Medicine Foundation (2007).
[70] Access to Medicine Foundation (2011).

the publication of the 2014 Index four investor meetings were held in New York, London, Paris, and Basel.

Advocacy groups, like Oxfam, Médecins sans Frontières, and Health Action International, have reacted differently to the Index at different points in time. While representatives of these organizations have cooperated with the AtM Foundation in the construction of the Index and the Dutch branch of Oxfam financially supported the Foundation in its first three years, in later stages some were more critical and supported a more activist approach towards the pharmaceutical industry. At the same time, various NGOs continue to participate in updating the Index' methodology.

Since it was first published in 2008, the AtM Index, especially the latest edition, received attention from well-known media across the globe, such as the Financial Times, New York Times, El País, The Guardian, Die Welt, Le Monde, The Economic Times of India, and Time Magazine, with The Guardian calling it "an authoritative guide".[71]

Various key individuals in the field of global public health have also expressed their appreciation and support for the Index. As mentioned before, Bill Gates supports the idea of ranking companies to encourage and measure companies' access policies. Also, Mary Robinson, the former UN High Commissioner for Human Rights, and Margaret Chan, the Director of the WHO, have expressed their support. Finally, the 2014 AtM Index was not only presented at the European Parliament in early 2015, around the same time Leereveld, the AtM Foundation's founder, was also invited to lead a group discussion on health systems in developing countries during the 2015 World Economic Forum in Davos.[72] This high profile public endorsement and prestige have no doubt helped to increase the credibility of the Index, and have encouraged others to use it as a model for indices for other sectors.

In March of 2013 the first Access to Nutrition Index (AtN Index) was published, ranking the largest food and beverage manufacturers with regard to their policies and practices in relation to obesity and under-nutrition. This index was initiated by the Gates Foundation, the Wellcome Trust and the Global Alliance for Improved Nutrition (GAIN).[73] Its development was housed by GAIN and largely conducted by the same research company responsible for the 2012 AtM Index.[74] The idea to start the AtN Index was inspired by the AtM Index. During the 2008 Pacific Health Summit it was discussed that the food and beverage industry had an important role to play in the fight against obesity and under-nutrition. Right before this summit the first AtM Index was published and this inspired representatives from the Gates Foundation and the Wellcome Trust to start the AtN Index. During the development phase of this Index, the AtN Index team regularly consulted the AtM Foundation and its setup also closely resembles the AtM Index.

Besides rankings of the pharmaceutical and food and beverages industry, rankings of seeds and mining companies are also being studied. The Dutch Ministry of Economic Affairs

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[71] The Guardian, 28 November 2012. Article "Big pharma ups its game in providing drugs to people in poor countries". See, http://www.theguardian.com/global-development/2012/nov/28/big-pharma-drugs-poor-countries (accessed on 3 February 2015).

[72] See www.accesstomedicineindex.org/news for articles related to these events and the articles in the various newspapers.

[73] GAIN was created in 2002 at a Special Session of the UN General Assembly on Children. This alliance is located in Geneva and supports public/private partnerships fighting malnutrition. It has received funding from philanthropic organizations (the Children's Investment Fund Foundation, the Bill & Melinda Gates Foundation, the Goldsmith Foundation, and the Wellcome Trust) and national governments (Canada, Dubai, Ireland, the Netherlands, the United Arab Emirates, the United Kingdom, and the United States).

[74] MSCI ESG Research.

and Agriculture, in cooperation with the AtM Foundation, initiated a feasibility study to determine whether a similar index would work in the seeds industry as it experiences similar issues of large for-profit companies defending their operations using patent protection and developing countries experiencing access problems. After a positive response an independent foundation, the AtS Foundation, was setup and developed a methodology for the AtS Index similar to that of the AtM Index. The methodology report was published in November 2014, while the first AtS Index is expected to be published around November 2015.[75] Representatives of the Dutch Ministry of Foreign Affairs have also been in contact with the AtM Foundation and, together with Cordaid, decided to conduct a feasibility study on the ranking of mining companies. These companies have poor track records regarding, for instance, the compliance to community development agreements. In line with the policy of the Dutch government regarding the extractive industry, it was therefore decided to study whether a ranking of mining companies would be helpful in stimulating mining companies in fulfilling their social responsibilities. Finally, during a radio interviews on the Dutch national radio station BNR, Leereveld also mentioned the possibility of a similar index for the petroleum industry[76] and in May of 2015 an Access to Vaccines Index was being announced, for which the Methodology Report will be published in November of the same year.[77]

It seems that the AtM Index has in general received a positive response by the other actors in the field of global public health whereby two developments are of particular importance. First of all, the Index is being used by pharmaceutical companies themselves to compare their access policies and practices with their competitors. It is a tool for pharmaceutical companies to watch each other's performance and activities and, in this way, influences the way they compete. Second, the Index is being used as a template for indices of other global industries. People like Bill Gates, and those that share his vision of a business model approach to philanthropy, use these rankings to pressure companies to improve their policies and practices. At the same time, how exactly the AtM Index might have influenced pharmaceutical companies' access policies is difficult to determine. Also, as current representatives of NGOs have not been willing to participate in this research, an important critical perspective on the role of the AtM Index in the field of global public health is missing.

Access to Medicine in the Field of Global Public Health

As an initiative started by a private foundation, encouraging private, for-profit companies to improve and expand their public role, and being supported by both public and private organizations, the initiation, construction, and response to the AtM Index is a clear example of the transformation the field of global public health is currently experiencing. While public health used to be primarily a public concern, private organizations are obtaining an increasingly dominant position leading to questions regarding their role and its consequences. At the same time, the AtM Index also signifies the prominence the notion of access to medicine has gotten within this decentralized and diversified field.

Even though the issue of access to medicine was already debated within the WHO around the time of this organization´s inception right after the Second World War, it was only

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[75] See accesstoseeds.org/publications/.
[76] See www.bnr.nl/nieuws/340555-1501/video-wim-leereveld-over-de-access-to-medicine-index (accessed on 30 January 2015).
[77] See www.accesstomedicine.org/access-vaccines-index-introducing-first-principles and www.accesstomedicine.org/consensus-emerges-approach-improving-access-vaccines (accessed on 16 September 2015).

in the 1970s, when the "recently decolonized nations of the global South"[78] started to voice their political presence, that access to medicine first became a central concern in the global public health debate. These developing countries, especially those with socialist governments, criticized western pharmaceutical companies regarding their drugs´ quality and price. By the end of the 1970s ´essential drugs´ had become a key term in this debate and the WHO started to compile a list of medicines which needed to be universally available. However, political tensions between developing countries on the one hand and developed countries protecting their pharmaceutical industry on the other – characterized by the decision of the United States to withhold its annual contribution to the WHO in 1986 and 1987 – made the WHO decide to no longer push this controversial essential drugs list in the late 1980s. It was only as a result of the entrance of relative newcomers to the field – NGOs, advocacy groups, and philanthropic foundations, such as Médecins sans Frontières and, especially, the Bill & Melinda Gates Foundation – that in the late 1990s and early 2000s the issue of access to essential drugs was, once again, put on the global public health agenda. Around this time, various pharmaceutical companies, eager to improve their public image and boost employees' morale after several scandals concerning drug safety and marketing practices, also started access to medicine programs for the world's poorest countries. But, instead of framing these medicines as a public good to which all people around the globe are entitled, they reframed "them as private goods that could be donated by altruistically minded corporations".[79] Finally, the introduction of the AtM Index in 2008 is one of the most recent initiatives regarding access to medicine, one that fits well into the current field of global public health in which private actors are playing an increasingly dominant role.[80] Given the importance of public health for the well-being of every country and individual, the notion of access to medicine has a natural appeal. However, this does not mean that both the idea itself and the way it is currently being pursued is undisputed.

By putting access to medicine on center stage and investing huge amounts of (financial) resources dedicated to public health in the development of new medicines and access to existing medicines, developments which are stimulated by the introduction and use of the AtM Index, it is assumed and promoted that medicines are *the* key factor in the improvement of public health around the globe. Also, it is assumed that "scientific and technical aspects of health improvements can be separated from political, social, and economic aspects".[81] However, history has demonstrated that the improvement of public health, represented by a decrease in mortality, is the result of a combination of social, political, and health-care measures. Economic growth is an important precondition for improvements in public health and countries and regions with low inequality levels, such as Costa Rica and Kerala, India, enjoy higher life expectancy levels than regions and countries with high economic inequality. Also, various public health experts argue that the improvement of existing health-systems in developing countries and the more efficient use of existing health measures are more effective ways of improving public health.[82] As the recent proliferation of access to medicine is largely the result of actions by private organizations, it is therefore important to reflect on their activities.

The Gates Foundation is one of the most important and well-funded proponents of stimulating access to medicine. Out of the fourteen challenges for the field of global public health that Bill Gates identified and presented at the World Economic Forum in 2003, nine

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[78] Greene (2011: 16).
[79] Greene (2011: 28).
[80] See Greene (2011) for a more elaborate description of the emergence of access to medicine as a central concern in global public health.
[81] Birn (2005: 516).
[82] Birn (2005).

were directly linked to the improvement of access to existing and new medicines.[83] The Gates Foundation clearly focuses on technical solutions for the world's health problems[84]; it not only invests in the development of new medicines, for instance through grants and the development of new financing models, it also helps developing countries purchase existing medicine through organizations such as the Global Fund to Fight AIDS, Malaria and Tuberculosis and the GAVI Alliance. As a result the Gates Foundation not only largely ignores the political, social, and economic aspects attached to the improvement of public health, it has also obtained a central and dominant position in global public health, leading to questions regarding its "role, effect, and lack of accountability".[85] Because of its connection to all mayor contributors to global public health, including academic research centers, health partnerships, think-tanks, non-profit organizations, and UN agencies, both through grants and board memberships, the Gates Foundation actively influences the global public health agenda. It thereby not only focuses on technological solutions, such as access to medicine and the development of new vaccines, it also prioritizes certain diseases, even though other diseases pose a greater threat.[86]

Besides the direct way of improving access to medicine through grants for the development and purchase of (new) medicine, the Gates Foundation also stimulates indirect ways of using technical solutions to improve access to medicine, such as with the AtM Index. Rankings valuate the policies and practices of individual organizations and, by creating a hierarchy, provide symbolic credit to those that perform best. This is in line not only with the tradition of the sociology of symbolic forms, but also with the statements of people such as Bill Gates who has argued that besides financial profits, recognition is a second market based incentive that can be used to trigger good company behavior. According to Gates, recognition can work as a proxy in markets where financial profits are not feasible, because it helps companies attract and retain the best employees. He argues that we therefore need to develop a system in which the market incentives of profits and recognition are used to make sure that also those people who cannot afford it themselves have access to, for instance, medicines and healthy food. This 'creative capitalism', as Gates calls it, is an "approach where governments, businesses, and nonprofits work together to stretch the reach of market forces so that more people can make a profit, or gain recognition, doing work that eases the world's inequities".[87] The support of the Gates Foundation given to the AtM Index and AtN Index can be interpreted as a way to promote creative capitalism. At the same time, at least until 2008 the Gates Foundation held significant shares, either directly or via its holdings in Warren Buffet's investment vehicle Berkshire Hathaway, in various food and beverage companies, such as McDonald's and Coca Cola whose products are not beneficial to the improvement of public health, as well as pharmaceutical companies, which could lead to conflicts of interest.[88]

And even when companies are actively trying to improve access to medicine and are being rewarded in the form of symbolic credit, such as with the AtM Index, the question remains what the effects are of the actions these companies undertake. Donations of medicine to developing countries and regions, for instance, which is one of the areas on which pharmaceutical companies are scored for the AtM Index, sound as an attractive way to improve public health in the poorest countries. However, these programs are also known to distort local health systems by changing its priorities and weaken local authorities as they become dependent on powerful foreign companies.[89] Also, even though various pharmaceutical

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[83] Greene (2011).
[84] Birn (2005).
[85] McCoy et al. (2009: 1645).
[86] McCoy et al. (2009).
[87] Gates (2008: 10).
[88] Stuckler et al. (2011).
[89] Samsky (2011).

companies are developing access programs, they are also fiercely protecting their patents thereby weakening developing countries' ability to provide good health care to its population. A well-known example is the lawsuit by pharmaceutical company Novartis against the Indian government regarding its anti-cancer drug Glivec.[90]

So, it could be argued that the introduction and use of the AtM Index in the field of global public health is, first of all, an example of the focus on technologies – in this case medicine – as *the* solution to a societal problem – in this case poor health – while the problem at hand requires a more holistic approach, which was already acknowledged by the WHO in the 1970s as we discussed earlier. And second, even though access to medicine has a natural appeal, the issue of access to medicine has been high on the global public health agenda for many decades, and the AtM Index has therefore, not surprisingly, experienced high-profile support, the question remains whether it truly contributes to the improvement of public health around the globe, or whether it diverts attention, and resources, from more effective ways of health improvement, such as the creation and improvement of health-systems in developing countries, stimulating economic growth, and reducing inequality.

Concluding remarks

Since the late nineteenth century various intergovernmental organizations have been founded to meet basic human needs, such as health and nutrition, and fight for large causes, such as ending poverty or ensuring peace. It was primarily within these state based governance structures that international activities were coordinated. National governments and multilateral agencies, such as the United Nations, World Bank, and WHO, fulfilled a central role within these endeavors.

Coordination within the international health system as it developed after the Second World War was organized around the WHO, with states negotiating on the actions to be undertaken. In the current, more diversified and market based field of global public health, other forms of coordination are being developed. Alliances between various public and private organizations, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, have been formed to discuss health policies and practices with a variety of stakeholders, including international organizations such as the WHO, UNICEF, and World bank, and philanthropic foundations such as the Gates Foundation. These partnerships function as governance structures in which a variety of actors discuss and coordinate health policies. But, more indirect methods, such as the AtM Index, AtN Index, and, in the future possibly, similar indices in other global fields, also function as market based coordination devices. These rankings put certain issues on the global agenda and are best viewed as classifications giving companies on top of the rankings symbolic credit.

For a proper understanding of the creation and use of market based coordination devices, such as the AtM Index, we argue that it is most useful to apply a historical-sociological approach as discussed in this article. This not only enables the study of these devices on the micro-level (who initiated these rankings; how are they constructed; who supports them and why; what was the initial response to their introduction; how are they being used; what role are they actually fulfilling in the field in which they are introduced on the long term), it also enables us to reflect on its long-term consequences on the macro or field level.

The AtM Index was introduced in the field of global public health in 2008 to stimulate pharmaceutical companies to improve their access to medicine policies for developing countries. By ranking these companies it produces a hierarchy of credibility for pharmaceutical

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[90] Ecks (2008).

companies and classifies one as more worthy than others. The Index was initiated by someone with inside knowledge of the pharmaceutical industry and an independent position towards the other actors in the field of global public health. He recognized that firms watch each other and used this insight to stimulate them to improve their access policies. The Index' methodology was created and is updated in consultation with the other actors in the field. The Index is being discussed in international media, has received high profile support from, among others, the WHO and Gates Foundation, and is being funded by the same foundation and the Dutch and British government. Also, the index is being used as template for indices of other global industries.

The AtM Index fits the more diversified, public-private character the field of global public health has gotten in recent years. In contrast to the centrally governed international order based on political representation and the mobilization of experts in which negotiations on health priorities took place in the first decades after the Second World War, in this more decentralized field with an increasing importance of private funding, priorities are often set by private organizations and public-private alliances. These organizations favor measurable health goals, such as eradicating specific diseases, and thereby often rely on technological solutions, such as medicine, instead of improving global public health by, for instance, contributing to the health care systems of developing countries. The acknowledgement of the AtM Index as an important tool in global public health can be understood as it being part of this new global health configuration; it functions as a coordination device in a more market based field of global public health and is used to pressure pharmaceutical companies to improve their access policies.

Even though this study sheds light on the construction of the AtM Index and understands its proliferation as being part of the wider transformation of the field of global public health, this study is only one of the first steps needed ; several questions remain open. First of all, even though we have explained how the Index is being constructed, how exactly the consultation process with the various stakeholders and experts took place is still unclear. Which parties argued in favor of which technical areas and indicators to be included in the Index? And what about the weightings of these metrics? How did the AtM Foundation's research team decide on these matters? Which data was made available by the pharmaceutical companies and which not? How exactly was this data interpreted? Answering these questions requires an in-depth analysis of and access to draft versions of the methodology and (the minutes of) the meetings taking place between the various stakeholders and the AtM Foundation on these issues, which might prove hard to obtain and fall outside the scope of this study. Even when the AtM Index exercises its effect on some of the companies' policies, it is still unclear whether institutional and other investors will allow companies to move further in this direction. The precise effect of the AtM index on the companies themselves is also open to further questions. Will companies, for example, not be tempted to resort to the gaming strategies that Espeland and Sauder[91] observed for the US Law Schools that were ranked? The rankings and the whole ranking process itself also raise further issues. How stable are these rankings and the agencies that produce them? If they are in any way successful, this will provoke the production of other, alternative rankings, thus leading to a multiplication of rankings, which may end up by leading to confusion rather than to the transparency that the rankings were initially intended for. Or will the AtM Foundation be able to become a dominant "rule-making institution"[92] in global public health and set the standard for the pharmaceutical industry? And finally, how do rankings relate to other, more fundamental issues and challenges in improving global public health, such as the improvement of health care systems in

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[91] Espeland and Sauder (2007).
[92] Büthe (2010): 44.

developing countries? Is improving access to medicine an effective and efficient way of improving public health around the globe, or does it divert attention and resources away from more effective methods?

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Appendix A: List of conducted interviews

Date	Name	Organization
17 October 2012 20 March 2013	Wim Leereveld	Access to Medicine Foundation
14 Jan 2013	Jutta Hartkoorn-Pasma	Crucell Holland BV
22 Jan 2013	Karen manson	Crucell Holland BV
20 Feb 2013	Tara Prasad	Access to Medicine Foundation
20 Feb 2013	Jayasree Iyer	Access to Medicine Foundation
15 march 2013	Nicola Perrin	Wellcome Trust
4 April 2013	Peter Shelby	International Federation of Pharmaceutical Manufacturers & Associations
8 April 2013	Pim Kraan	Dutch Ministry of Foreign Affairs
9 April 2013	Gerbrand Haverkamp	Dutch Ministry of Economic Affairs
9 April 2013	Frans de Laaf	Oxfam Novib
15 April 2013	Hannah Kettler	Bill & Melinda Gates Foundation

Table 1: Historical development of the organization of public health across the globe

	International health system	**Field of global public health**
Historical period	1945 – 1990	1990 to present
General characteristics	International expert regime with centralized governance structure based on negotiations between representatives of national states, which were also the main funders	Decentralized global field structure with plurality of public and private actors without central decision-making structure
Actors	World Health Organization as central actor Limited role of intermediaries	Position of World Health Organization contested, its role diminished Growth and increasing significance of intermediaries (NGOs, including 'new intermediaries')
Principle	State based	Market based
Governance	Central and stable governance structure (WHO)	Disease specific and more flexible public-private alliances
Coordination	Ensured by central actor (WHO)	Increasing role for rankings as coordination device
Funding	Contributions by national governments and donations	Shift to more private funding
Business model for production and R&D	Patent protection enables large R&D investments Limited degree of tiered pricing	Patents are running out and are contested Search for new model Tiered pricing schemes expanded

Table 2 Overview of the 2008, 2010, 2012 and 2014 ATM Indices

	2008	2010	2012	2014
Companies (based on market capitalization)	20. Both generic and originator companies	27. Separate list for 20 originator and 7 generic companies	20. All originator companies	20. All originator companies
Technical areas (in 2008 referred to as criteria) (weightings 2010: originator (generic) %)	8 1) ATM Management – 20% 2) Public Policy Influence & Advocacy – 10% 3) Research & Development – 20% 4) Patents & Licensing – 10% 5) Manufacturing, Distribution and Capability Advancement – 15% 6) Equitable Pricing – 15% 7) Drug Donations – 6% 8) Philanthropy – 4%	7 1) ATM Management – 10 (10)% 2) Public Policy & Market Influence – 10 (10)% 3) Research & Development – 15 (25)% 4) Equitable Pricing, Manufacturing & Distribution – 20 (30)% 5) Patents & Licensing – 15 (10)% 6) Capability Advancement in Product Development and Distribution – 10 (15)% 7) Donations & Philanthropy – 10 (10)%	7 1) ATM Management – 10% 2) Public Policy & Market Influence – 10% 3) Research & Development – 20% 4) Equitable Pricing, Manufacturing & Distribution – 25% 5) Patents & Licensing – 15% 6) Capability Advancement in Product Development and Distribution – 10% 7) Donations & Philanthropy – 10%	7 1) ATM Management – 10% 2) Public Policy & Market Influence – 10% 3) Research & Development – 20% 4) Pricing, Manufacturing & Distribution – 25% 5) Patents & Licensing – 15% 6) Capability Advancement in Product Development and Distribution – 10% 7) Donations & Philanthropy – 10%
Indicators Metrics (2008)	28 94	112	101	95
Strategic Pillars (2010, 2012 and 2014)		4 Commitment – 30% Transparency – 30% Performance – 30% Innovation – 10%	4 Commitment – 25% Transparency – 25% Performance – 40% Innovation – 10%	4 Commitment – 25% Transparency – 25% Performance – 40% Innovation – 10%
Diseases	24	33	33	47
Countries	88	88	103	106